

Center *for* Mississippi
Health Policy

**Children's Health
Coverage
in Mississippi**

January 2008

A Profile of Children's Health Coverage in Mississippi

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■ Executive Summary

There has been considerable debate about children's health coverage at the national level. The debate has been stimulated in large part by legislation to reauthorize the State Children's Health Insurance Program (SCHIP). Many states have initiated programs to reduce the numbers of uninsured children. Recently, some states have set a goal of universal coverage for children. Given the significance of this health policy issue, the Center for Mississippi Health Policy has researched the status of health coverage for children in Mississippi. This research includes a review of options that policymakers may wish to consider for reducing the number of uninsured children in the state.

The major findings in the report include the following:

Mississippi Children

- Approximately 124,000 children in Mississippi lack health insurance coverage.
- 3 in 4 uninsured children in Mississippi are eligible for coverage (Medicaid or SCHIP).
- 1 in 3 potentially eligible but uninsured children in Mississippi had been covered by Medicaid or SCHIP in the past year.

Mississippi Trends

- Trends show declines in private coverage and in public coverage.
- Trends show an increase in the number of uninsured children.
- The decline in public coverage and the increase in the number of uninsured children occurred in low income families.

Employer Based Health Coverage in Mississippi

- 3 in 4 uninsured children live in a household where at least one adult is working full time.
- The average employee contribution for family coverage increased 12 times faster than average worker earnings from 2001 to 2005, consuming 94 percent of the increase in worker earnings.
- The average employee contribution toward a family premium in Mississippi, \$2,811, is about 8 percent of the family income for a family of three at 200 percent of the Federal Poverty Level.
- Less than half of private sector employees have insurance coverage through their employer.
- Only 28 percent of small employers offer health insurance coverage for employees, and 74 percent of private establishments are small (< 50 employees).
- Only 15 percent of private sector workers have family coverage.

The profile that emerges shows a continuing enrollment decline in employer-sponsored insurance coverage. At the same time, there are sharp increases in premiums for employer-sponsored health insurance. The situation has disproportionately affected low income families. One result has been an increase in the numbers of low income children left uninsured. The decline in public coverage indicates that many low income uninsured children are not enrolling in the public programs designed to provide them with health coverage.

States all across the nation are implementing a wide variety of initiatives designed to reduce the number of uninsured children:

- Enrollment Simplification and Outreach,
- Premium Assistance,
- Three Share Premium Programs,
- Reinsurance,
- Risk Pools,
- Eligibility Expansions, and
- Tax Credits.

Mississippi can significantly reduce the number of uninsured children without implementing any new programs because most of the uninsured children are already eligible for existing programs. Enrolling these children will require outreach to eligible families and streamlining enrollment procedures.

Eligibility expansions can be used to reach additional uninsured children, but the risk of crowd-out grows substantially as eligibility is opened to families at incomes higher than 200 percent of the Federal Poverty Level. Strategies that may be more effective in reaching uninsured children at higher income levels include premium assistance, shared premiums, or tax credits. These initiatives tend to discourage crowd-out and are feasible only when the family has access to private health insurance. These programs could be initiated as part of a more comprehensive effort to encourage small employers to offer or retain health insurance coverage for their employees.

The cost of expanding coverage is generally the biggest barrier to implementation. From the standpoint of state general funds, the most cost effective means of covering uninsured children in Mississippi is by enrolling low income eligible children in Medicaid and SCHIP. In 2007, the Medicaid federal match rate for Mississippi was 3:1. This means that every \$1 spent by the state resulted in an additional \$3 in federal match. The federal match for SCHIP is slightly higher. Children are less expensive to cover than adults: the average cost per enrollee in Mississippi Medicaid is lowest for children.

Strategies that involve employers are promising because they take advantage of employer and employee contributions. These efforts may require subsidies in order to make coverage affordable. Research in Mississippi indicates that low income workers consider affordable premiums to be \$40 to \$75 per month and small employers state they could afford to pay up to \$50 per month per employee.

Mississippi policy and health leaders are faced with a dilemma. In general, as costs rise more people drop their insurance coverage. More employers cease to provide coverage for employees. States begin to cut back on eligibility and benefits for recipients of public programs. Until the underlying cost issues in the health care delivery and financing systems are addressed, these options are only temporary fixes and may prove unsustainable in the long run.

The cost of leaving children uninsured is great. Children without health coverage have poorer access to health care and suffer from unmet medical or mental health needs. The cost of meeting their delayed health care needs is high and must be covered by other means such as state funds or cost shifting to other payers. Addressing uninsured children's health needs is a critical issue for Mississippi's future.

■ Introduction

There has been considerable debate about children's health coverage at the national level. The debate has been stimulated in large part by legislation to reauthorize the State Children's Health Insurance Program (SCHIP). Many states have initiated programs to reduce the numbers of uninsured children. Recently, some states have set a goal of universal coverage for children. Given the significance of this health policy issue, the Center for Mississippi Health Policy has researched the status of health coverage for children in Mississippi. This research includes options that policymakers may wish to consider in order to reduce the number of uninsured children in the state.

Data Sources and Methods

Two sources of national survey data provide the foundation for this report. One source is the Current Population Survey (CPS), a monthly survey conducted by the United States Census Bureau. A segment of the CPS survey, the Annual Social and Economic Supplement (ASEC), is carried out during February through April each year. CPS ASEC health insurance coverage data is collected via telephone and in-person interviews. Health insurance status is provided by a household respondent for all members living within the household. The reference interval in the ASEC for health insurance coverage is the former calendar year. For example, the 2007 CPS ASEC asks questions about health insurance coverage during calendar year 2006¹. This report utilizes CPS ASEC health insurance data referencing calendar years 2000-2006. The data showcase the demographics of health insurance coverage for Mississippi children less than 19 years of age.

CPS ASEC health insurance data have several strengths. This survey includes approximately 78,000 households annually. These data provide representative estimates for both national and statewide health insurance coverage. Calendar year data are released in September of the following year. Thus, the data in this report are the most recent available estimates.

CPS ASEC is also a source of consistent historical time series data and is the official source of estimates used in State Children's Health Insurance Program (SCHIP) federal funding allocations to states. As a result, it is the most widely used source of health insurance coverage data in the United States^{2,3}. CPS data were compiled by the Center for Mississippi Health Policy using the Integrated Public Use Microdata Series (IPUMS) which is described in the Technical Appendix to this report.

The Agency for Healthcare Research and Quality (AHRQ) administers another population based survey approximating health insurance coverage, the Medical Expenditure Panel Survey (MEPS). MEPS is comprised of two major components: the Household Component and the Insurance Component. The Household Component provides data from individual households and their members. The data are supplemented with data from medical providers. The Insurance Component is a separate survey of employers that provides data on employer-based health insurance. The questionnaires are administered via mail with telephone follow-up. The reference interval for health insurance coverage offered is the former calendar year⁴. For this report, 2001-2005 calendar year data from the Insurance Component are used to analyze availability of employment-based coverage for Mississippi children less than 19 years of age.

MEPS Insurance Component data has several strengths as well. Approximately 40,000 establishments and state/local governments are surveyed annually. Questions relate to organizational characteristics and employees' health coverage benefits. Stable national and state level employment-based health insurance estimates are produced as a result⁵. The MEPS Insurance Component is unique in that the employers are surveyed to establish employer-based insurance coverage estimates, and the sample is representative at the state level.

Terms Used in the Report

The following definitions apply throughout this report unless otherwise specified:

"Child" or "children" refers to individuals from birth up to 19 years of age.

"Health insurance" and "health coverage" are used interchangeably and refer to all types of health benefits coverage including employer-sponsored health insurance, private individual policies, Medicaid, Medicare, the State Children's Health Insurance Program (SCHIP), and other forms of private or public coverage that provide a defined set of benefits to persons enrolled in the plan or program.

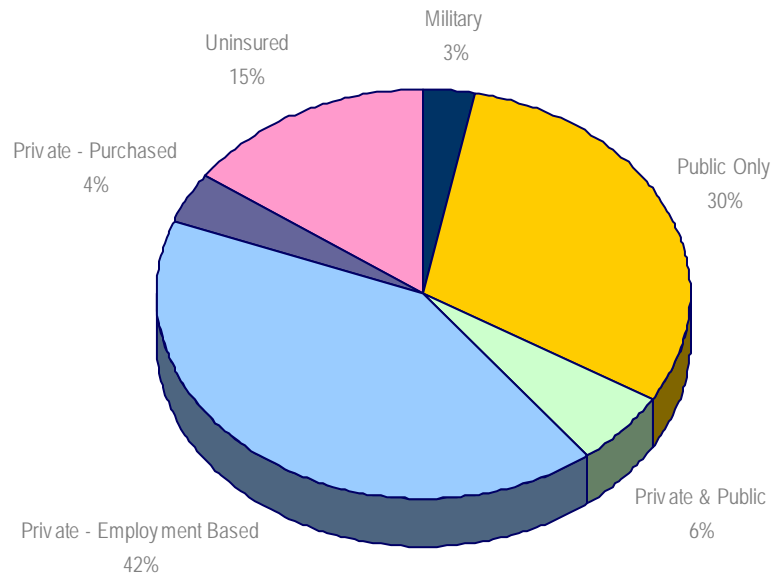
"Low income" refers to household income below 200 percent of the Federal Poverty Level (FPL). For 2007, for example, a family with a household income below \$34,340 would be classified in this category.

"Small employer" means a private employer with fewer than 50 employees.

Children's Health Insurance Coverage in Mississippi

Approximately 43 percent of children in Mississippi are covered by some type of private health insurance plan. Nearly all are employment-based plans under which they are covered as dependents. About a third of children are covered by some type of public program, primarily Medicaid or SCHIP. Six percent are covered by both private and public coverage during the year, which could be simultaneously or consecutively during the year. A very small proportion (3 percent) is covered under a military plan, and 15 percent, approximately 124,000 children, are uninsured.

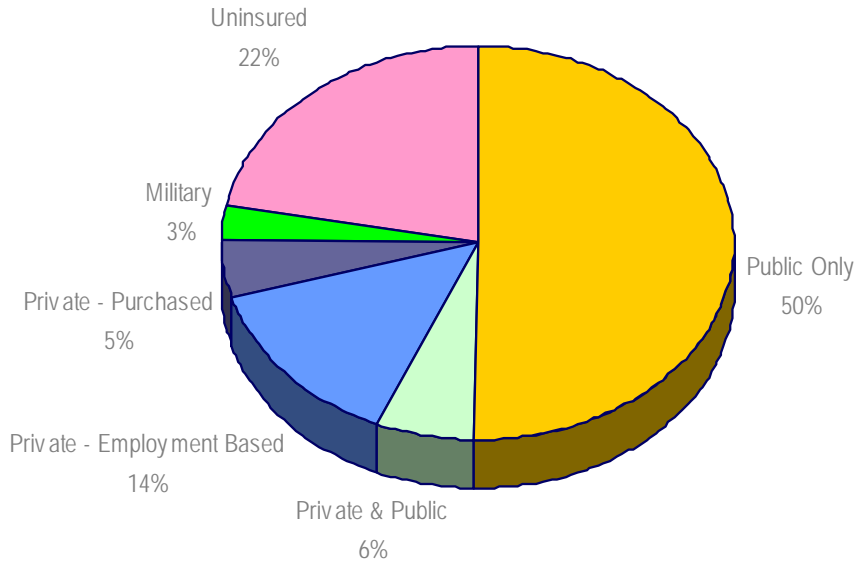
Figure 1: Health Coverage by Type for All Children (0 - 18) in Mississippi, 2004 - 2006



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C₄MHP using IPUMS-CPS (see Technical Appendix).

Fewer low income children are covered under private plans. Only 20 percent are covered by private health insurance plans. Among private plans, most are employment-based plans. The majority are covered by public programs, primarily Medicaid. Six percent have had both public and private coverage, which could be either simultaneous or consecutive, and 22 percent are uninsured.

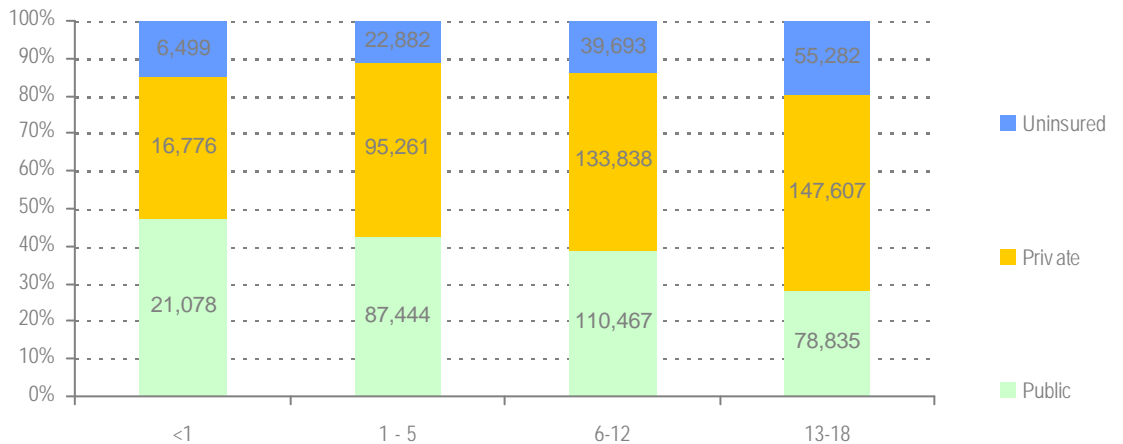
Figure 2: Health Coverage by Type for Low Income Children (0 - 18) in Mississippi, 2004 - 2006



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

The proportion of children covered under private plans increases with age. Public coverage declines with age. The proportion of children who are uninsured is highest for the oldest age group.

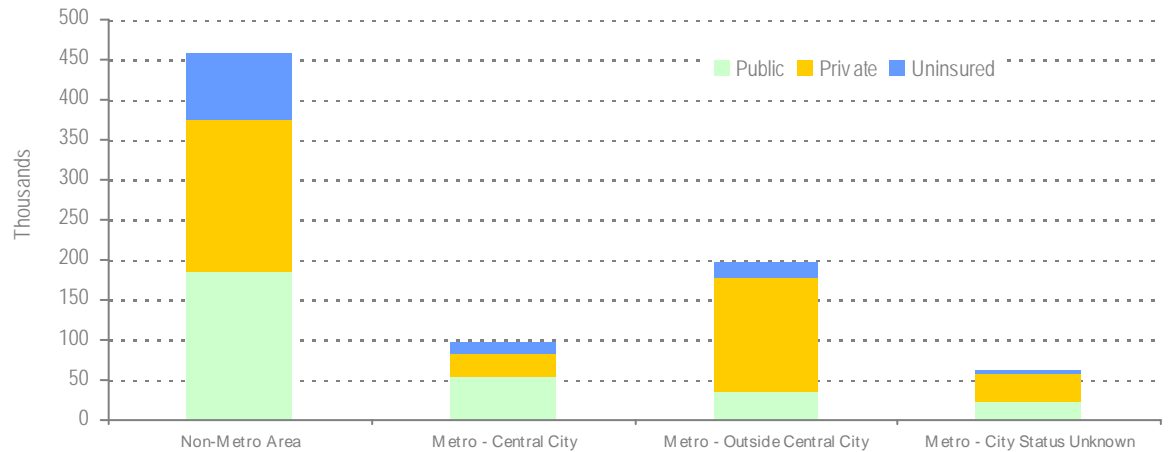
Figure 3: Health Coverage by Age for All Children (0 - 18) in Mississippi, 2004 - 2006



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

Insurance coverage for children in Mississippi is related to area of residence. Slightly more than half (56 percent) of all children live in rural areas. Among those with no insurance, two-thirds (66 percent) live in rural areas, 13 percent in cities, and 15 percent in suburbs. Among children with public coverage, 62 percent live in rural areas. Children in cities are more likely than those in rural areas to access public insurance. Among those with private insurance, the proportion living in suburban areas is highest.

Figure 4: Type of Coverage for All Children (0 - 18) in Mississippi by Location 2004 - 2006



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

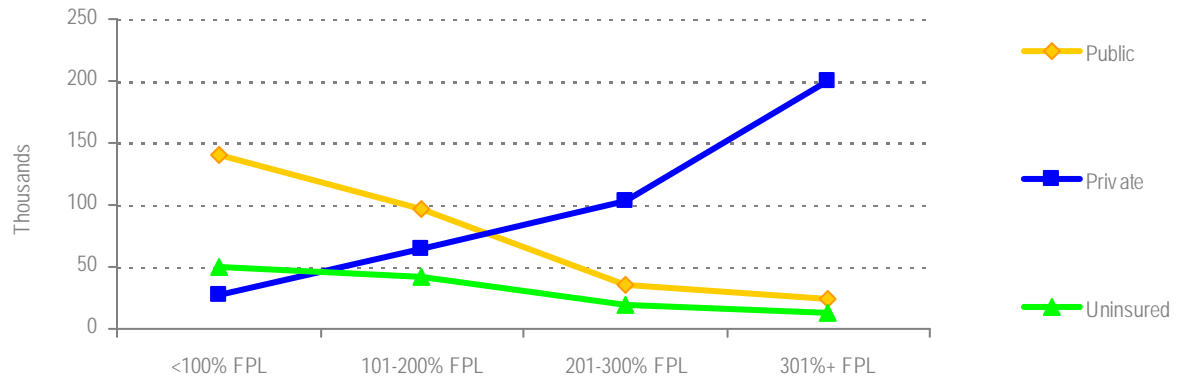
Type of Coverage for All Children (0 - 18) in Mississippi by Location, 2004 - 2006

Location	Number of Children	Percent of Children	Type of Coverage			Percent of Uninsured	Percent Private	Percent Public
			Public	Private	Uninsured			
Non-Metro Area	458,616	56.2%	185,175	190,814	82,627	66.4%	48.5%	62.2%
Metro - Central City	97,423	11.9%	54,816	26,753	15,854	12.7%	6.8%	18.4%
Metro - Outside Central City	196,442	24.1%	35,014	142,482	18,946	15.2%	36.2%	11.8%
Metro - City Status Unknown	63,184	7.7%	22,820	33,434	6,930	5.6%	8.5%	7.7%
Total	815,665	100.0%	297,825	393,483	124,357	100.0%	100.0%	100.0%

Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

The number of children covered by public health benefit programs declines and the number covered by private insurance increases as family income rises. For these measures, family income is measured as a percentage of the federal poverty level. The percentage of children who are uninsured also drops as family income increases.

Figure 5: Type of Coverage for All Children (0 - 18) in Mississippi by Percentage of the Federal Poverty Level (FPL), 2004 - 2006



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

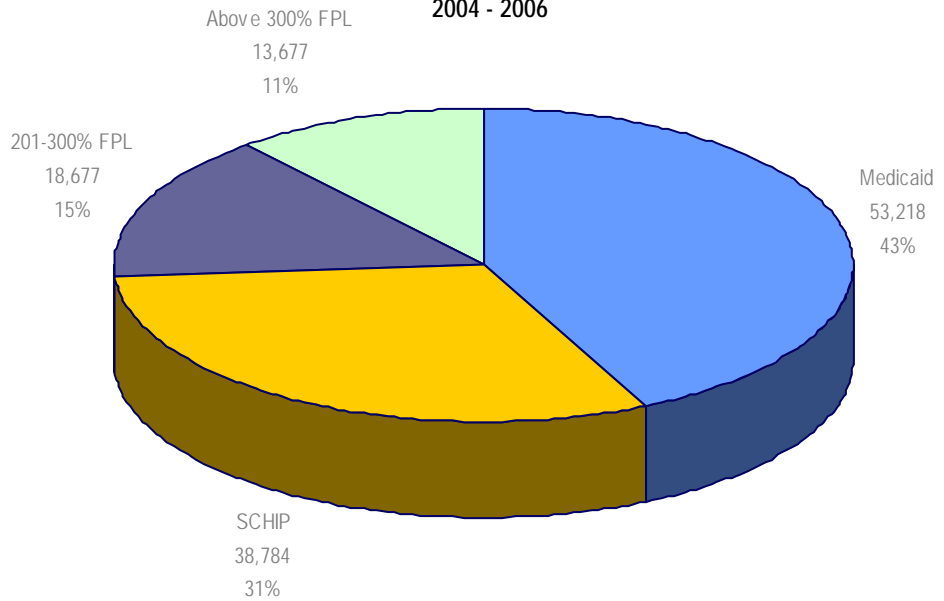
The overwhelming majority (81 percent) of children with private coverage are insured as dependents of persons with employer-sponsored insurance. Approximately 7 percent are insured through the military. Almost 11 percent are covered through a private policy (not employer-based) as a dependent. Less than 1 percent of children are covered by a private policy where they are the insured.

Almost all (99.7 percent) of children covered through a public program are covered by Medicaid or the State Children's Health Insurance Program (SCHIP). The remainder (0.3 percent) is covered by Medicare (generally because of disability).

■ Uninsured Children

Three out of every four uninsured children in Mississippi (74 percent) live in families whose incomes would likely qualify the children for Medicaid or the State Children's Health Insurance Program (SCHIP). About 43 percent would be eligible for Medicaid and 31 percent would be eligible for SCHIP based on their age and poverty level. Approximately 26 percent of uninsured children have family incomes above the threshold to qualify for Medicaid or SCHIP.

Figure 6: Uninsured Children (0 - 18) in Mississippi by Potential Eligibility Based on Age & Poverty Level, 2004 - 2006

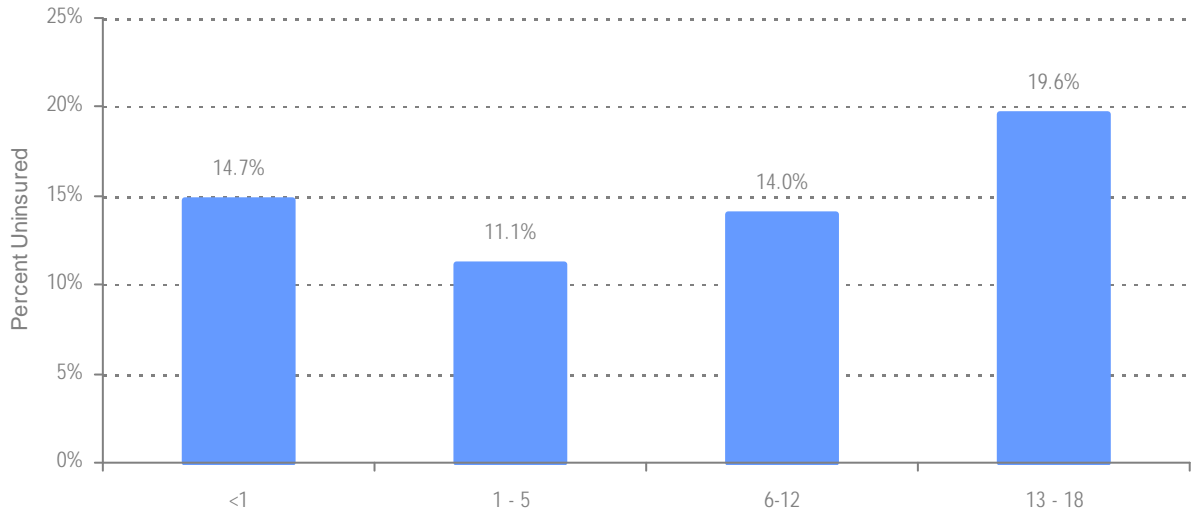


Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

A review of multiple years of Census data provides the number of eligible but uninsured children previously covered by Medicaid or SCHIP. The results for Mississippi indicate that 1/3 of currently eligible but uninsured children had been enrolled in Medicaid or SCHIP at some time during the previous year.⁶

The number of uninsured children and the rate of uninsurance among children in Mississippi are highest for the oldest age group, 13-18 year olds. The uninsurance rate is lowest for children ages 1 through 5.

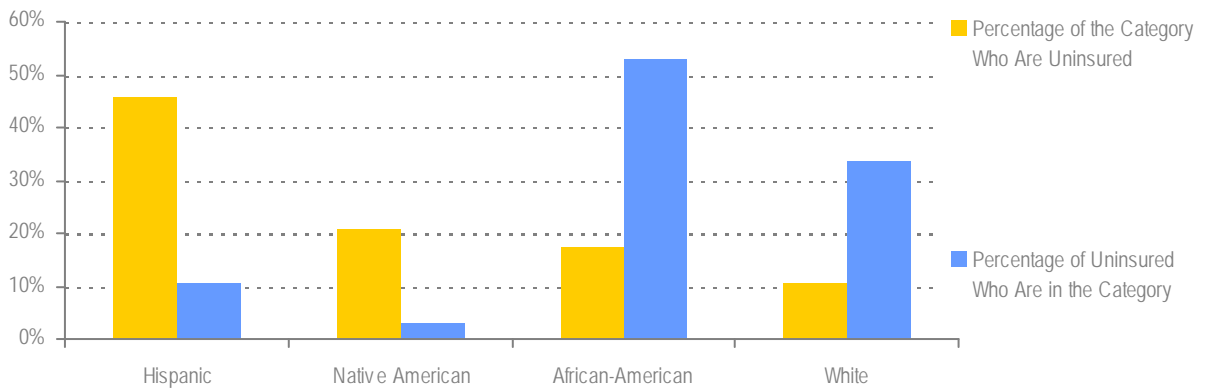
Figure 7: Uninsured Children (0 - 18) in Mississippi by Age Group, 2004 - 2006



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

In regard to race and ethnicity, the uninsurance rate is highest for Hispanic children (45.6 percent), followed by Native Americans (20.8 percent), African Americans (17.5 percent), and Whites (10.6 percent). In terms of absolute numbers, most of the uninsured children are African American (52.7 percent), followed by White (33.6 percent), Hispanic (10.6 percent), and Native American (3.1 percent).

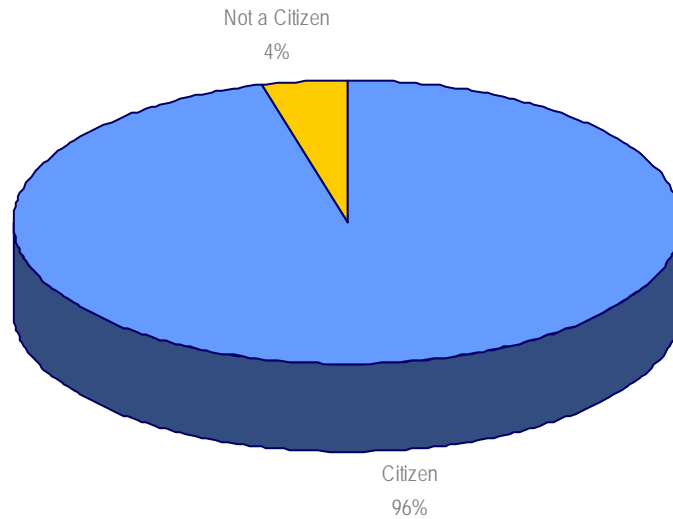
Figure 8: Uninsured Children (0 - 18) in Mississippi by Race/Ethnicity, 2004-2006



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

All but 4 percent of uninsured children are citizens of the United States.

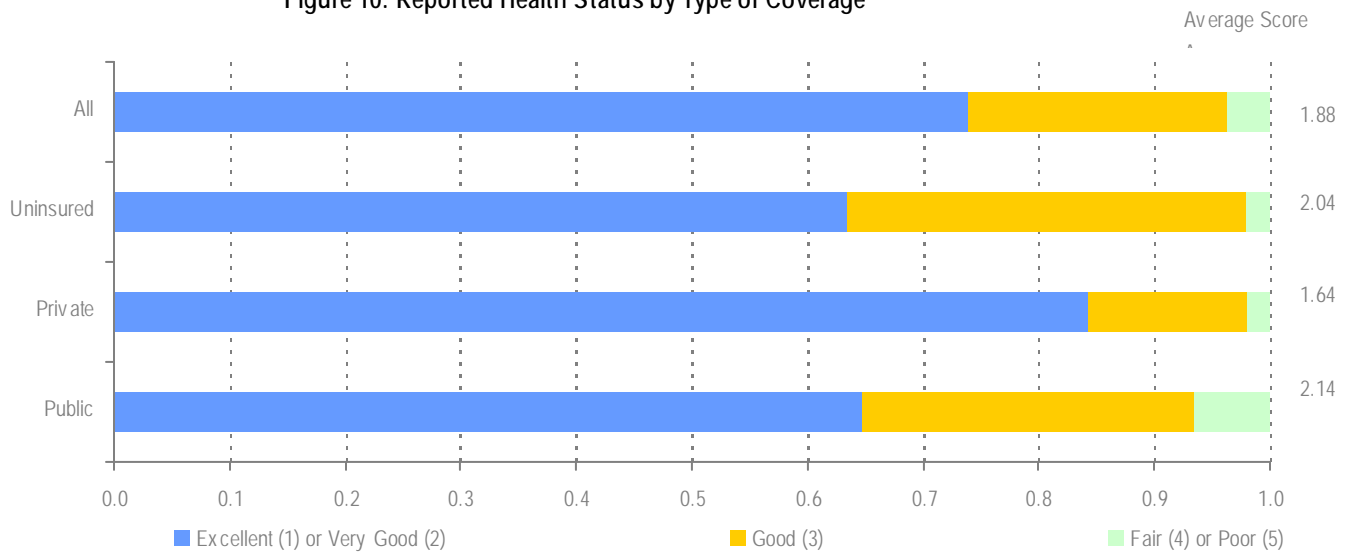
Figure 9: Uninsured Children (0 - 18) in Mississippi by Citizenship Status, 2004 - 2006



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

The self-reported health status for children is highest among the privately insured. Using a scale where 1=Excellent and 5=Poor, uninsured and publicly insured children were more likely to report higher scores, reflecting less than excellent health status.

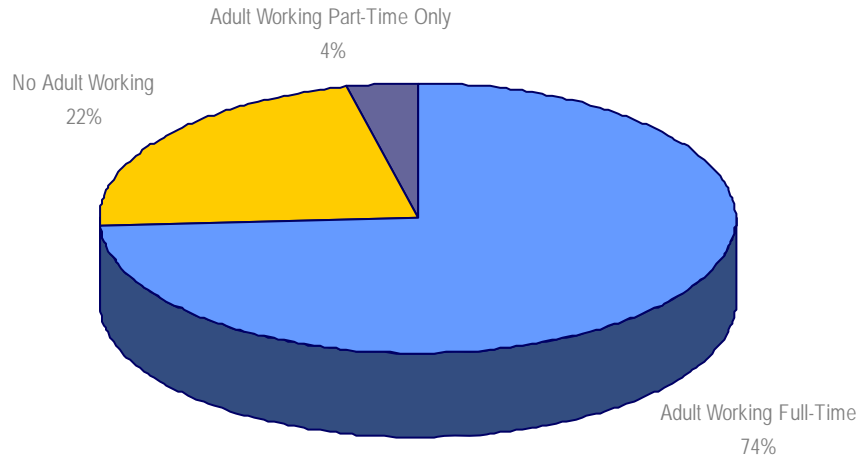
Figure 10: Reported Health Status by Type of Coverage



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

Seventy-eight percent of uninsured children live in households where at least one adult is working. In 95 percent of these households, at least one adult is working full-time.

Figure 11: Uninsured Children (0 -18) in Mississippi by Work Status of Adults in the Household

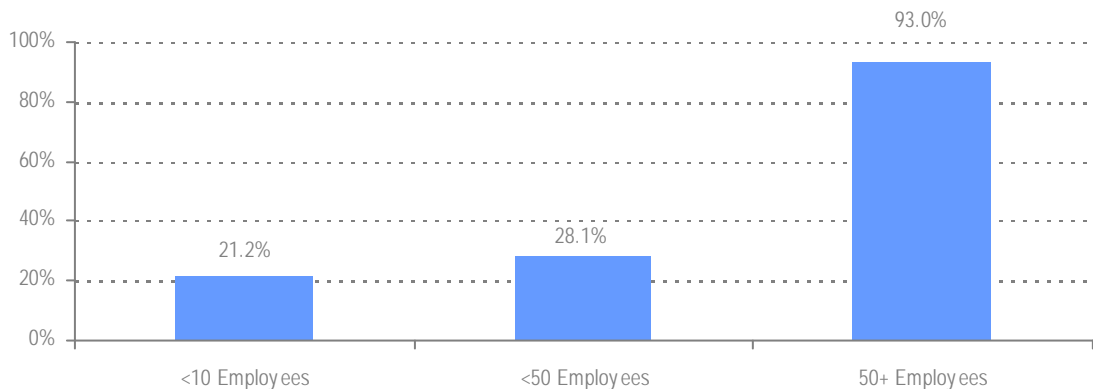


Source: 2005, 2006, and 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

■ Employment-Based Coverage

The fact that adults in the family are working full time does not mean that the family has access to health insurance coverage. Less than half (45 percent) of all private employers in Mississippi offer health insurance coverage for their employees. Most (93 percent) larger employers (those with 50 or more employees) offer insurance. Only 28 percent of small employers (those with fewer than 50 employees) offer health insurance to their employees, and 21 percent of firms with fewer than 10 employees offer health insurance. Seventy-four percent of all private employers in Mississippi are small establishments with fewer than 50 employees.

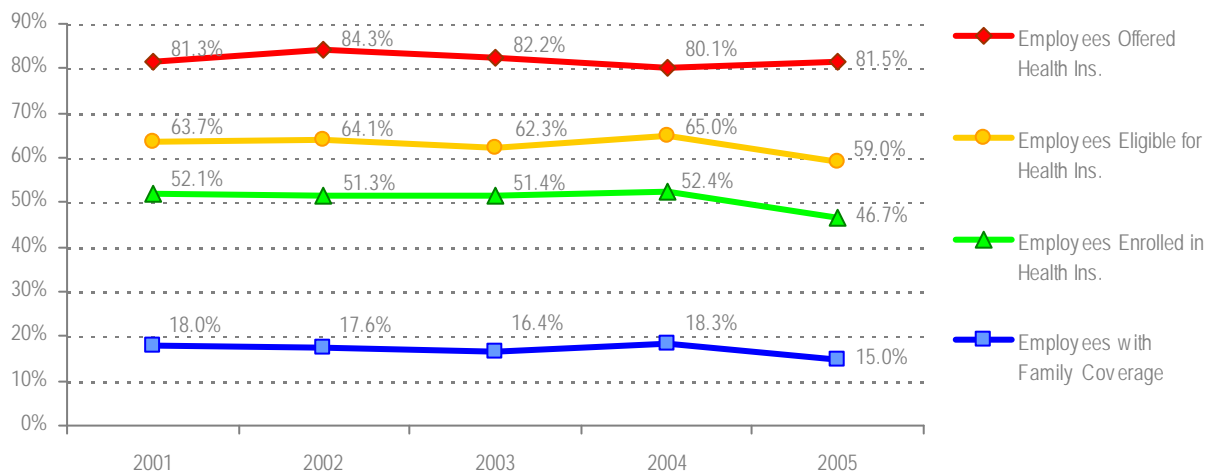
Figure 12: Percentage of Private Establishments in Mississippi Offering Health Insurance by Size of Firm, 2005



Source: Medical Expenditure Panel Survey Insurance Component State Tables. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.meps.ahrq.gov>

Approximately 59 percent of all employees working for private establishments in Mississippi are eligible and qualify for health insurance coverage. Less than half (46.7 percent) of private sector employees are enrolled in health insurance, with 15 percent enrolled in family coverage.

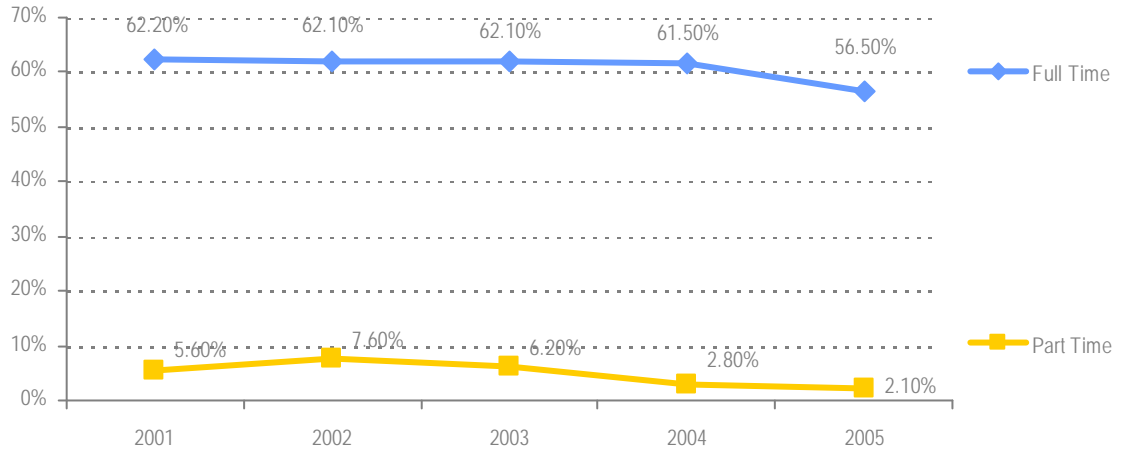
Figure 13: Health Insurance Enrollment for Employees in Private Establishments in Mississippi, 2001 - 2005



Source: Medical Expenditure Panel Survey Insurance Component State Tables. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.meps.ahrq.gov>

Enrollment rates are much lower for part-time employees than for full-time employees. Only 12 percent of part-time employees in establishments that offer insurance were eligible to enroll. Only 2 percent were enrolled in an employer plan.

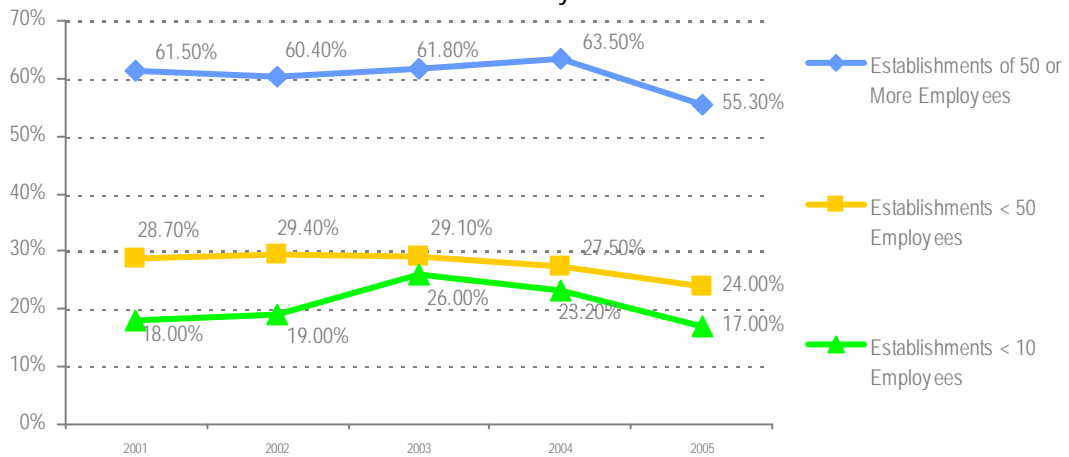
Figure 14: Percentage of Full-Time & Part-Time Employees in Private Establishments in Mississippi Enrolling in Health Insurance, 2001 - 2005



Source: Medical Expenditure Panel Survey Insurance Component State Tables. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.meps.ahrq.gov>

Enrollment rates are lower for employees working in smaller firms.

Figure 15: Percentage of Employees in Private Establishments in Mississippi Enrolling in Health Insurance by Size of Firm



Source: Medical Expenditure Panel Survey Insurance Component State Tables. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.meps.ahrq.gov>

Family premiums and the contributions required by employees have steadily increased since 2001. For low income families, this cost can be a significant barrier to enrollment in an employer's health insurance plan, even if one is offered.

From 2001 to 2005, the average employee contribution for family coverage grew 12 times faster than the rate of average worker earnings. In terms of dollars, 94 percent of the increase in earnings would have been consumed solely by the rise in health insurance premiums.

Figure 16: Change in Average Worker Earnings and Premiums for Family Coverage in Mississippi, 2001 – 2005.

	<u>2001</u>	<u>2005</u>	<u>Dollar Change</u>	<u>Percent Change</u>
Average worker earnings	\$20,916	\$22,042	\$1,126	5.4%
Average total family premium (in dollars) per enrolled employee at establishments that offer health insurance	\$7,258	\$9,987	\$2,729	37.6%
Average total employee contribution (in dollars) per enrolled employee for family coverage at establishments that offer health insurance	\$1,753	\$2,811	\$1,058	60.4%

Sources: U. S. Census Bureau's American Community Surveys and the Agency for Healthcare Research & Quality's Medical Expenditure Panel Survey.

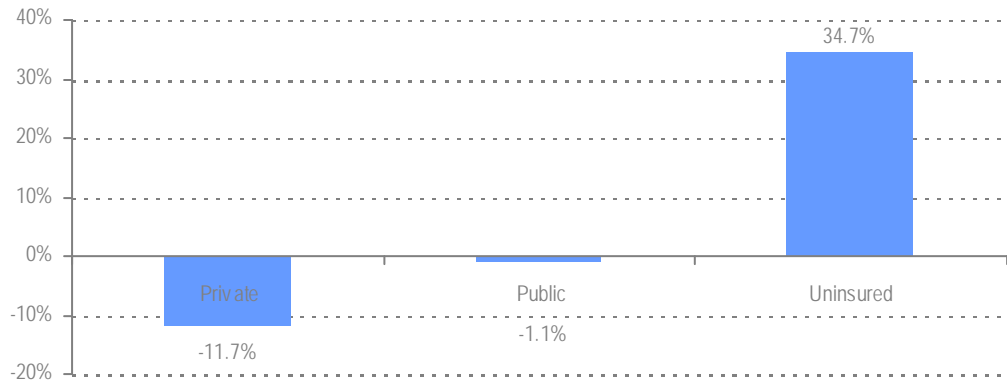
The upper income level in Mississippi for children to be eligible for Medicaid or SCHIP is 200 percent of the FPL. In 2007, this meant a household income of \$34,340 for a family of three. The average employee contribution toward family coverage in a private employer-sponsored health insurance plan in Mississippi (\$2,811) is approximately 8 percent of that total.

■ Trends in Coverage

Three-year averages for 2000 – 2002 were compared to three-year averages for 2004 – 2006 to identify trends in health insurance coverage for children. As discussed in more detail in the Technical Appendix, the data for the latter period reflect an adjustment that results in an overall lower uninsured estimate of less than one percent. While trends over time can be affected by this recent data edit, the differences are small comparing adjusted to unadjusted data, so adjusted data are utilized in these analyses for time trend comparisons.

The general trend shows a decrease in private insurance coverage, a smaller decline in public coverage, and an increase in the number of uninsured children.

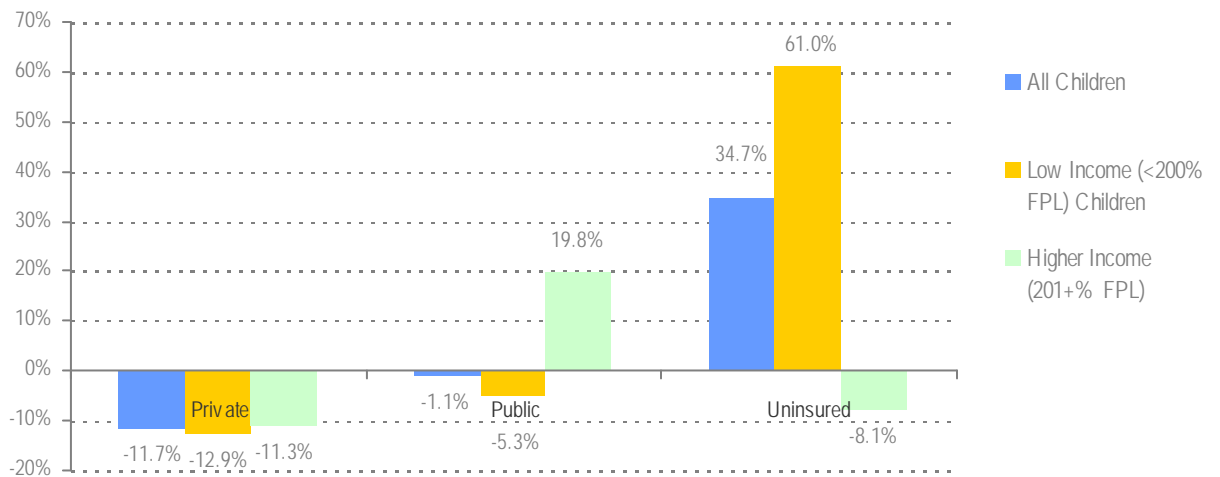
Figure 17: Percentage Change in the Number of Children (0 - 18) in Mississippi by Type of Coverage, 2000-02 vs. 2004-06



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

For low income children the changes were more striking, with the number of uninsured low income children rising 61 percent. The decline in public coverage and the increase in the number of uninsured children occurred in low income families.

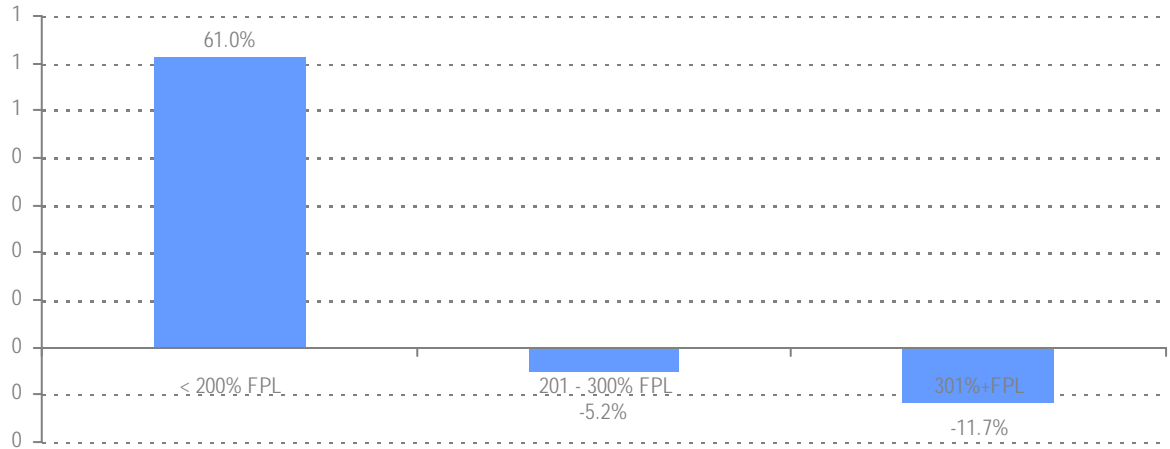
Figure 18: Percentage Change in the Number of Children (0 - 18) in Mississippi by Income Level and Type of Coverage, 2000-02 vs. 2004-06



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix.)

Almost all of the increase in uninsurance rates can be accounted for in the low income group of children. The number of uninsured children at higher income levels dropped while the number of uninsured low income children increased considerably.

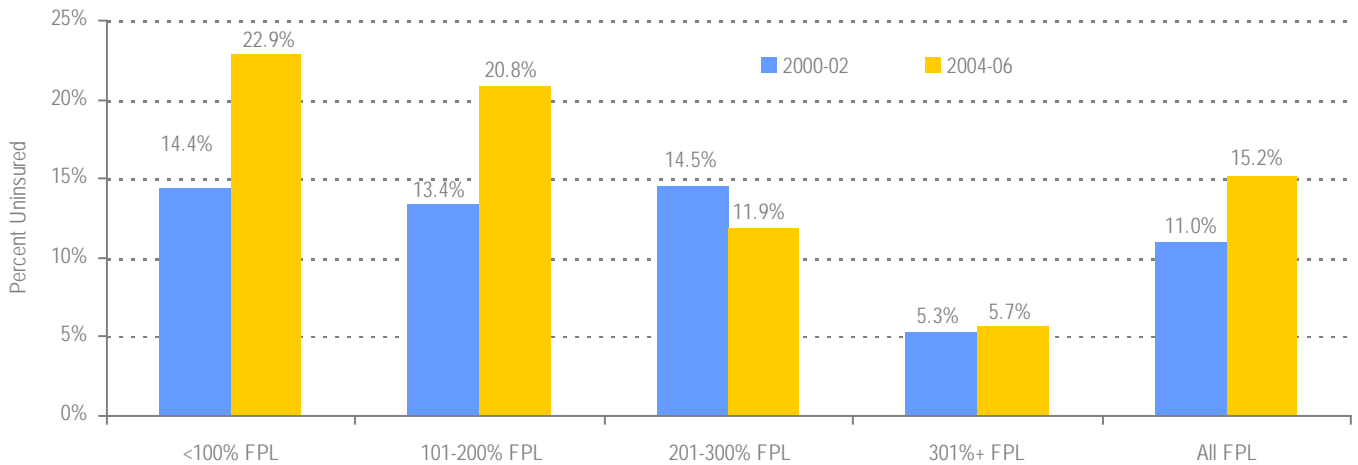
Figure 19: Percentage Change in the Number of Uninsured Children (0 - 18) in Mississippi by Federal Poverty Level, 2000-02 vs. 2004-06



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

Consequently, the uninsured rate increased more for low income children than for children in higher income groups in Mississippi.

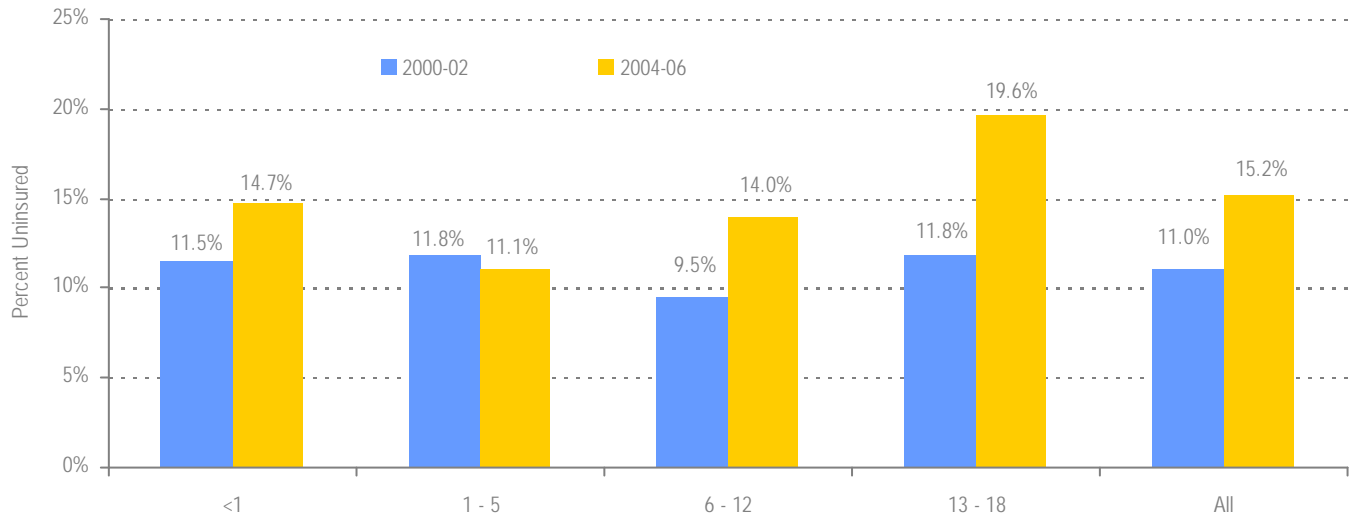
Figure 20: Uninsured Rate of Children (0-18) in Mississippi by Federal Poverty Level 2000-02 vs. 2004-06



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

The uninsured rate increased for children in all age groups except those in the 1 through 5 age group. The rise in uninsurance was most pronounced for the children in the 13 through 18 age group.

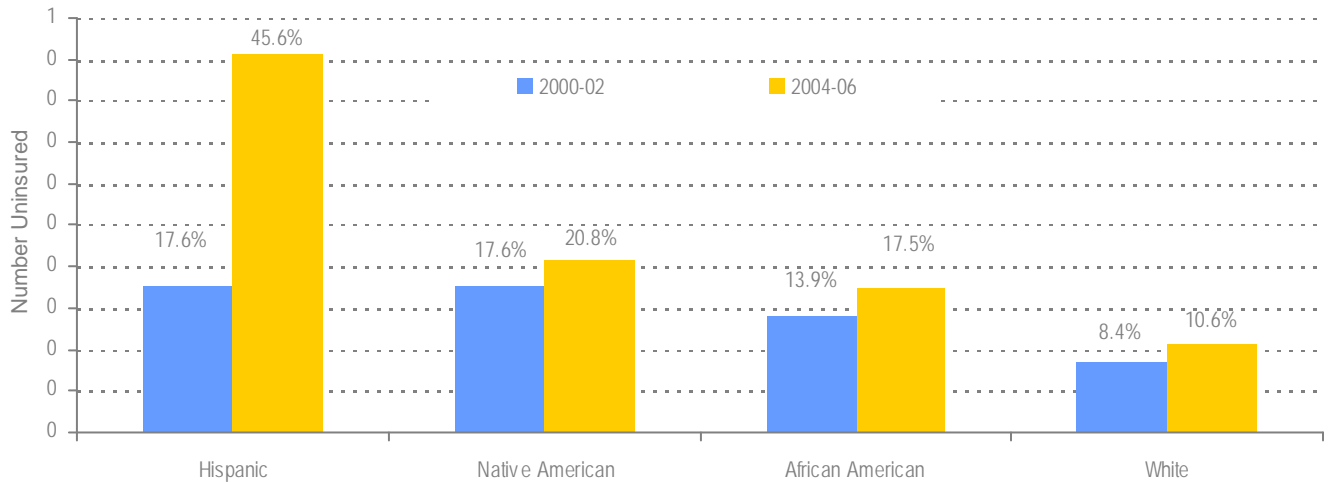
Figure 21: Uninsured Rate of Children by Age Group 2000-02 vs. 2004-06



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

The uninsured rate increased in every racial/ethnic group. The increase was greatest for Hispanic children. The numerical change was highest for African-American children, followed closely by Hispanic children.

Figure 22: Percentage of Children (0 - 18) in Mississippi by Race/Ethnicity 2000-02 vs. 2004-06



Source: 2005, 2006, & 2007 Current Population Survey data compiled by the C4MHP using IPUMS-CPS (see Technical Appendix).

Number of Uninsured Children and Percentage Uninsured by Race/Ethnicity in Mississippi, 2000-02 vs. 2004-06

Race/Ethnicity	Number of Uninsured Children		Percentage Uninsured	
	2000-02	2004-06	2000-02	2004-06
Hispanic	2,156	13,141	17.6%	45.6%
Native American	1,325	3,825	17.6%	20.8%
African American	52,821	65,167	13.9%	17.5%
White	36,022	41,588	8.4%	10.6%

Note: Numbers in the "Other" category for race/ethnicity were too small to be meaningful, and the category was omitted from this analysis. Small numbers of respondents can generate unreliable estimates, therefore data for which there are 50 or fewer unweighted observations within the state are not displayed.

■ The Value of Health Coverage for Children

Impact on Access to Health Care

Research demonstrates that children who are insured are more likely than uninsured children to have better access to care as measured by the number of physician visits, office-based visits, hospital-based visits, entry into the system and whether a child has a regular source of health care.⁷ Children's health insurance coverage provides access to the health care system where health problems can be detected and treated early. Early detection, prevention and treatment can have a significant impact on a child's quality of life.

Low income children with Medicaid coverage have greater access to care than uninsured children.⁸ Children enrolled in Medicaid also receive more preventive services than their uninsured counterparts do.⁹ Evidence suggests that SCHIP may produce similar results.¹⁰ One study found that uninsured children were more likely than those with Medicaid coverage to have no usual source of health care and to rely on the emergency room for routine care.¹¹

Expanding insurance coverage to uninsured children removes financial barriers, thereby improving access to health care.¹² Children grow and develop rapidly, placing them at special risk of illness and injury. Delayed identification and treatment of health risks and problems may affect a child's mental, physical, and emotional health. Regular and early monitoring are effective means of preventing and minimizing poor health outcomes. If problems are not detected and treated in a timely manner, children can experience serious health consequences in childhood and later in adulthood.

Risks of Uninsurance

There are significant differences between insured and uninsured children in the rate of delayed or unmet needs due to the cost of general medical care, dental care, vision care, prescription drugs, and mental health services. Research indicates that uninsured children are at greater risk of delaying care in a variety of ways:¹³

- Three times more likely *not* to have seen a doctor in the past year;
- More than 13 times as likely to lack a usual source of medical care;
- Almost five times more likely to have a delayed or unmet health care need;
- More than three times as likely to have an unmet need for mental health services;
- Five times more likely to have an unmet dental need;
- Five times more likely to have an unmet vision care need;

- Almost four times more likely to have an unmet need for prescription drugs;
- Twice as likely as the insured to die while in the hospital when admitted due to injuries.

Researchers found that being uninsured for even brief periods of time had a measurable effect on the health of children.

Impact on Health Status

Existing studies of Medicaid and SCHIP expansions lend conflicting and inconclusive results regarding changes in health status. It is difficult to measure whether having insurance coverage results in better health. Several factors can complicate these studies. Health needs that exist at the time of expansion influence results, as persons with poor health status are more likely to value and therefore seek out health coverage.

One study examined hospitalization changes among children living in poor residential areas compared to children living in non-poor areas. Data before and after Medicaid expansions were examined.¹⁴ The research reviewed hospitalizations for ambulatory sensitive conditions, such as asthma, that can be averted or alleviated with primary health care. The overall results of this study were mixed, however. The evidence implied that the expansion of Medicaid did improve the health of children age two to six, but little evidence showed that the expansions improved the health for children age seven to nine.¹⁵

Another study focused on the health status of poor children ages 1 to 12, in the early 1990s after seven million additional children enrolled in Medicaid.¹⁶ Health status in the study was measured by parental report of the child's health status and activity in the previous two weeks. Although the number of children with health coverage increased, their health status did not change. A third study examined data from the National Health Interview Survey (NHIS) and state-level vital statistics of child mortality. The findings implied that Medicaid eligibility reduced child mortality, but had either a negative effect or no effect on the mothers' assessments of their children's health status.¹⁷

Self-reported improvements have been documented in several studies. One study showed that following an increase in enrollment, 25 percent of parents said that their child's health improved.¹⁸ Another study compared the health status of children enrolled in New York's CHPlus program after one year with that of newly enrolled children. The research showed that enrollment led to health improvements. Approximately 55 percent of parents who had children with asthma stated that their children's health improved due to routine office visits and medications received in the year following enrollment in the CHPlus program.¹⁹

Policymakers and health leaders would benefit from Mississippi-specific studies of enrollment benefits, perceived health, and health outcomes among insured Mississippi children. Research in this area will need to take into account the amount of churning (see page 25) that occurs in order to properly measure the effect of coverage on health status.

Impact on Public Funds and Insurance Premiums

When one patient population pays a price for health care that is below cost, providers compensate by allocating unpaid costs to other patients.²⁰ This cost-shifting amounts to a hidden tax levied by providers on behalf of the uninsured.²¹ Essentially, all hospitals and physicians provide some care for which they are not paid directly.²²

Approximately 35 percent of the total charges for health care services provided to the uninsured are paid out-of-pocket by the uninsured themselves.²³ Researchers have found that the remaining \$43 billion of these charges for the uninsured are primarily paid by two sources. About one-third is reimbursed by a number of government programs, and two-thirds is paid through higher premiums for people with health insurance.²⁴ It should be noted that while many states have publicly funded uncompensated care programs that reimburse providers for the costs of uninsured patient care, Mississippi does not have such a program except for certain specific categories of patients, such as trauma.

The contribution that philanthropy makes toward paying for care for the uninsured is small. Philanthropy is estimated to cover only 1 to 2 percent of the cost of this care.²⁵ The combined contribution of government is equivalent to one-third of the uncompensated care provided by hospitals and physicians in the U.S. This government support includes Medicaid and Medicare Disproportionate Share Hospital (DSH) payments. Payments such as DSH theoretically are designed to help fill the shortfall in public insurance payments for Medicaid and Medicare patients.²⁶ Furthermore, a national estimate of public sector underpayments showed that private payers pay an average of 22 percent more than their costs to make up for this public sector shortfall.²⁷

As previously mentioned, two-thirds of the cost of uncompensated care is covered by those who have private health insurance. It is estimated that in 2010, health insurance premiums for families who have insurance through their private employers, on average, will be \$1,502 higher in the U.S. (\$1,335 in Mississippi) due to the unreimbursed cost of health care for the uninsured. The U.S. estimated average of health insurance premiums for individuals who have insurance through their private employers will be \$532 higher (\$448 in Mississippi) in 2010 due to the unreimbursed cost of health care for the uninsured.

It is also estimated that in 2010, \$60.4 billion in uncompensated care will be provided nationwide, with Mississippi contributing approximately \$700 million to the estimated costs. These estimates do not take into account uncompensated care provided to underinsured persons who have insurance coverage but might not be able to pay all of their cost sharing due to high deductibles, large co-payments, and uncovered services.²⁸

These compounding factors create a vicious cycle: rising health insurance premiums cause people to drop insurance coverage, thereby driving up the number of uninsured. The result is higher insurance premiums due to cost-shifting. As a result, the trend of employers reducing and eliminating coverage will likely continue, which perpetuates this ongoing cycle in the health care system. Employers will also continue to face financial pressure to reduce benefits for those who are insured, further complicating the situation.

Under federal law, emergency rooms in hospitals must at least stabilize patients regardless of insurance status and ability to pay. As a result, emergency rooms have become the last resort for Americans needing access to health care. Demand for emergency services is increasing while the number of emergency departments is decreasing. Between 1994 and 2004, total visits increased by 18 percent nationwide while the number of emergency departments decreased by 7 percent. Treatment cost in an emergency department is much higher than in a primary care setting.²⁹ Therefore, a growing number of uninsured patients accessing care through emergency departments increases costs and exacerbates overall cost shifting.

Impact on Education and Future Earnings

A healthy, well-educated workforce increases productivity and economic benefits. Education is critical in creating a more productive workforce. Having health insurance has been linked to better school attendance. A Florida study showed that uninsured children are 25 percent more likely to miss school than insured children.³⁰ Providing health insurance to children can increase their chances of reaching their full potential. Insured children are less likely to have social and emotional developmental delays that may affect their ability to learn, which will better prepare them to do well in school.³¹ Having health insurance means that a child is more likely to get the health care he or she needs. Improving health improves educational attainment and increases earnings potential by 10 to 30 percent.³²

■ Churning and Crowd-out

Churning

Insurance coverage is dynamic: people go for periods without coverage, change private policies, fluctuate between public and private coverage, and gain and lose public coverage. This shifting among various coverage options is referred to as “churning.”

Most estimates of the uninsured are based on point-in-time use studies and therefore do not provide observations that show the total number of people who had brief periods without insurance at some point during the course of a year.³³ Churning is significant for several reasons:

- Churning complicates the measurement of the uninsured.
- Churning contributes to crowd-out of private coverage in the sense that every break in coverage provides an opportunity to move to public coverage.
- Churning adds to administrative costs associated with enrollment and re-enrollment, “new member” services, provider billing, and reporting.
- Gaps in health insurance are associated with poor access to health care.

Children who experience a lack of stable health insurance coverage are less likely to receive care or needed medications than those with continuous private health coverage.³⁴ The cost of care can increase as well after a gap in coverage, and the health status can deteriorate when facing delays in care.³⁵ Additionally, gaps in coverage could affect quality of care. During gaps in coverage, care may be different from the periods of insurance. In addition, short tenures in care make it difficult to monitor patients effectively, and, when necessary, start corrective action.³⁶ Switching from coverage to coverage does not guarantee positive outcomes, as this type of changeover can cause a delay in seeking follow-up care as well.³⁷

Much research on churning has focused on the 1996 panel of the Survey of Income and Program Participation (SIPP). The survey showed that approximately 32 percent of the U.S. population under the age of 63 lacked health insurance for at least one month during the four-year study period.³⁸ The Commonwealth Fund performed an analysis of churning based on the 1998–2000 Medical Expenditure Panel Survey (MEPS). This analysis included young children, while the SIPP only includes children ages 15 and older.³⁹ The MEPS analysis indicated that children were the least likely to be consistently uninsured, although 23 percent still faced a spell without insurance. Two-thirds of children who were initially uninsured eventually found health coverage. Nearly two-thirds of children initially covered by Medicaid or SCHIP remained in these programs. However, one-third of children who were initially uninsured remained uninsured, and 29 percent of those with Medicaid coverage had a period without coverage.⁴⁰

Most of the research on churning in regard to children has focused on children with public coverage. Studies have documented that up to half of the children in SCHIP are dropped at renewal periods.⁴¹ Even though Medicaid covers roughly five times as many children as SCHIP, the enrollment patterns for Medicaid children have been examined less frequently than SCHIP.⁴² Moreover, the majority of the research has examined drop-off patterns versus enrollment patterns. This has made it difficult to study how many children eventually re-enroll in Medicaid, or how long coverage gaps tend to be.⁴³

One of the first studies to describe patterns of enrollment in Medicaid and gaps in enrollment in several states showed that at least 60 percent of children had been in Medicaid for at least one year.⁴⁴ States differed in the proportion of children experiencing churning. The average length of coverage was 5.4 months. Most of the children with breaks in Medicaid coverage had only one gap during the three-year period. More than 70 percent of children with breaks in coverage had only one instance (in some, almost 90 percent) of non-coverage. Some children, (8-24 percent) with gaps had two instances. There was a direct relationship between the volume of children with gaps in coverage and the number of coverage gaps. The two states having higher proportions of children with gaps were also the states with the highest average number of coverage gaps. The states in which fewer children experienced breaks in coverage were states in which children tended to have only one coverage gap.⁴⁵

Churning involving Medicaid is heavily influenced by factors other than changes in income or other eligibility criteria. Research shows that almost half (45.4 percent) of all children who lose Medicaid coverage are still eligible.⁴⁶ Additionally, other research indicates that families' failure to submit renewal paperwork on time and administrative delays after submission play major roles in loss of coverage.⁴⁷ Research into the outcomes of disenrollment also shows that many of these children are re-enrolled after a short period of time.⁴⁸ No studies have estimated the economic impact of health services sought during non-covered months.

Measurement of Churning

National survey data can follow health insurance patterns of people who change coverage over specific periods of time. The duration and frequency of gaps in coverage can be measured, and changing patterns with different types of insurance coverage can be shown as well. These data help describe the stability of health insurance coverage for individuals.⁴⁹

Public programs, however, generally do not use population-based data. They use program administrative data to record enrollment, and state information systems generally do not have the ability to accurately measure churning in public programs.⁵⁰ Measurement of churning is further complicated by several factors including the following:⁵¹

- *Retroactive coverage:* Federal Medicaid law states that applicants can be eligible for up to three months of retroactive Medicaid coverage. So if children lose eligibility and apply three months later, they are eligible to receive retroactive coverage for those previous three months. This obviously helps families, but this

type of coverage is not equivalent to actual coverage in “real time.” Theoretically, when attempting to measure churning, it would be optimal to eliminate or separate retroactive coverage episodes. The majority of state information systems only have the option of showing the entire period for which Medicaid reimbursement is available, which includes retroactive eligibility. As a result, the data will usually minimize the magnitude or prevalence of churning.

- *Transitions:* Most states have separate SCHIP and Medicaid programs. It is not unusual for children to make transitions between the programs, and these transitions ideally should only be classified as gaps if there is a period without insurance. Unfortunately, state data systems often are not designed to distinguish between transitions in coverage and terminations, which can cause overestimation of churning.
- *Length of coverage gap:* No standard definition of a “churning related” gap has been created.

Some information from program management reports can be helpful, but the information is still limited about churning. There are states that attempt to track and measure how many people leave and enroll in programs each month. Additionally, renewal rates can show the percentage of people who complete the renewal process with success. This is important because the failure to complete the renewal process is associated with churning in public programs.⁵² Most states also collect data on the causes of failure to renew coverage, but many times the information is not complete or precise.

Crowd-Out

Expansions of public insurance programs have the goal of increasing health coverage and access to care. Increasing eligibility for public programs generally results in a number of previously uninsured individuals gaining coverage. A common side effect, however, is that persons previously insured through private insurance plans may drop their private coverage to enroll in the expanded public program. This effect is referred to as “crowd-out.”

Researchers at the University of Minnesota have outlined three major crowd-out pathways.⁵³

1) An enrollee drops private coverage for public coverage. In this situation, an individual drops private insurance for public insurance, but it is assumed that if the public program were not available, the individual would have kept the private coverage.

2) A public program enrollee refuses an offer of private coverage. This occurs when an individual or family has public insurance and stays in that public insurance program, even though the individual has the opportunity to obtain private insurance and would be privately insured if the public program were not available.

3) Employers encourage crowd-out. Sometimes employers might encourage or require their employees to drop their coverage in favor of a

public insurance program, but would not do this if the public program expansion were not available.

Researchers do not agree on the definition of crowd-out. Some consider any shift from private coverage to public coverage to constitute crowd-out. Others limit the definition of crowd-out to shifts that would not have occurred in the absence of the public program.⁵⁴ Researchers supporting the more narrow definition generally do not classify enrollment in the public insurance program as crowd-out if individuals would otherwise have become uninsured.⁵⁵

In Mississippi and the nation, there has been an overall trend for several years of small employers ceasing to offer health insurance coverage for employees. Individuals' enrolling in public coverage because they have lost private coverage represents an example of those who would have otherwise become uninsured if it were not for the public program.

Data sources, however, do not often reveal the reason for a change from private to public coverage. This complicates the measurement of the more narrow definition of crowd-out. Although a number of research studies have attempted to measure crowd-out using different statistical methods, there has not yet been a standard and ideal method.⁵⁶

Since there is not a standard method of measuring crowd-out, the range of estimates of crowd-out is large, and the individual estimates are imprecise. The range of crowd-out estimates spans from 0 to rates of 60 percent.⁵⁷

Cutler and Gruber studied the outcomes from public health insurance expansions for children in the 1980s and 1990s, and determined that approximately 40 percent of public program enrollees represented crowd-out.⁵⁸ Another study by Blumberg, Dubay, and Norton found an overall crowd-out effect of only 4 percent.⁵⁹ The most recent research has been a working paper by Gruber and Simon, in which they estimate that for every 100 children who are enrolled in public insurance, 60 children lose private insurance.⁶⁰

The Congressional Budget Office reviewed the wide range of research related to crowd-out and concluded that the reduction in private coverage due to the implementation of the State Children's Health Insurance Program was somewhere between 25 percent and 50 percent of the increase in public coverage. The Congressional Budget Office paper also notes that the potential for crowd-out is greater for families in higher income categories because these families have better access to private coverage.⁶¹

Researchers note that states interested in expanding public insurance programs must understand the public view of subsidized insurance programs as substitutes for private insurance.⁶² It is almost impossible to design public programs that will enroll substantial numbers of the uninsured and avoid crowding out private insurance. Strategies can be implemented to delay crowd-out, but its occurrence cannot be totally eliminated.

■ State Strategies to Reduce the Number of Uninsured Children

States have actively pursued a variety of strategies to reduce the number of uninsured children. This section will outline the most prominent of these efforts.

Enrollment Simplification and Outreach

Researchers studying reasons for non-enrollment in public programs have surveyed families to determine barriers. Survey findings indicate that a primary reason that eligible children are not enrolled is that families find it too difficult to navigate through the enrollment and renewal procedures.⁶³

In addition, research has shown that parents of eligible children often are unaware that their children might be eligible for coverage. Responses from the 1999 National Survey of America's Families (NSAF) showed that although 90 percent of low income families had heard of Medicaid or SCHIP, the majority did not know enough about the eligibility rules to understand that their children might qualify for one of the programs.⁶⁴

In response to findings from this and similar research, states began to simplify enrollment procedures and to conduct outreach campaigns. By 2002, 97 percent of states had eliminated asset tests and requirements for a face-to-face interview. States also simplified renewal procedures, with most allowing twelve months of continuous enrollment with annual reapplication by mail.⁶⁵ A few states have been more aggressive in simplifying enrollment. Strategies include reducing the degree of income verification required, allowing self-declaration of income followed by some form of audit or verification, or authorizing presumptive eligibility for children.⁶⁶

Following the advent of SCHIP in 1998, states developed outreach and marketing strategies designed to make families aware of the new program. States branded programs with catchy names, developed media campaigns, contracted with community based groups to conduct local outreach, and distributed a wide range of printed materials advertising the program.⁶⁷ The result was not only an increase in SCHIP enrollment, but even greater numbers of children enrolling in Medicaid. State budget constraints eventually led states to curtail outreach and media campaigns.⁶⁸

One lesson learned from states' experience with enrollment simplification and outreach efforts was that combining effective marketing campaigns with enrollment simplification significantly increased the number of enrolled children.⁶⁹ The lesson also applies in reverse: when budget pressures cause states to cut back on these programs, states rescind outreach and marketing initiatives in order to reduce enrollment.⁷⁰

Premium Assistance

Low-income families with uninsured children who have the option of employer coverage may not enroll their children in the employer's plan because they simply cannot afford the coverage. As noted earlier in this report, the average employee contribution for family coverage in Mississippi is about \$3,000. This figure represents a significant portion of a low-income family's income (page 16).

Nationally, 55 percent of uninsured children in families with incomes between 133 percent and 200 percent of the federal poverty level have access to employer coverage.⁷¹ Recognizing that this option might be used by low-income families to cover their children if they had assistance in paying the premiums, many states have established premium-assistance programs. The goals of premium-assistance programs are to encourage low-income families' participation in private coverage. In addition, the efforts hope to prevent crowd-out and achieve cost savings by bringing in employer contributions to help offset costs.

Premium-assistance programs use state, Medicaid, or SCHIP funds to subsidize the purchase of private health insurance. They may also utilize enrollee contributions to help pay premium costs. States have long been able to do this under Medicaid, and these programs are generally referred to as "Health Insurance Premium Payment" (HIPP) programs.⁷² With the advent of the State Children's Health Insurance Program (SCHIP) and expansions to higher income populations, more states have demonstrated interest in implementing these programs. Some states have also established state-funded premium-assistance programs.

Since employers already pay approximately 70-75 percent of the premium cost for family coverage, premium assistance can be a cost effective strategy.⁷³ Rhode Island's RItE Share premium-assistance program for example, saves the state money by sharing responsibility for coverage. Rhode Island's RItE Share premium-assistance program saves the state about \$178 per month for every family enrolled, compared to Rhode Island's RItE Care (Medicaid and SCHIP) managed care program.⁷⁴

Premium-assistance programs encourage parents to be covered as well, since dependents cannot receive coverage unless the employed parent is enrolled in the employer's health plan. It has been shown that when parents use health care, children are more likely to access care. This is especially true when parents and children are both insured.⁷⁵ In states that have expanded Medicaid coverage to parents, 81 percent participate in Medicaid. Fewer (57percent) of children in states that lack family-based coverage programs participated in Medicaid.⁷⁶

Illinois' "Kid Care Rebate" program has been in existence for longer than most. It was funded with state-only dollars before federal waivers were an option for states. Families interested in covering their children under the KidCare Rebate program receive a monthly subsidy of \$75 per child to purchase qualifying private coverage, either through an employer or an individual policy. The state reports that the program is both cost-effective and supportive of families who want access to certain providers and want to be enrolled in a private plan.⁷⁷

Most states do not operate a single, integrated premium-assistance program due to differences in federal regulatory requirements between Medicaid and SCHIP. Under Medicaid, some states allow their premium-assistance enrollees to use a traditional Medicaid card to access services not covered by their employer plans (referred to as "wrap-around" coverage) and also to avoid co-payments in excess of the Medicaid-allowable level. Wisconsin and Iowa discovered that costs are usually minimal since the majority of enrollees would rather use their "mainstream" employer benefits.⁷⁸

States have had some success with premium-assistance programs, but states have also faced common challenges such as the following.⁷⁹

- Premium-assistance programs to date have not reached large numbers of children.
- Administrative costs can be high.
- Employer-based health insurance plans usually do not cover all services available under Medicaid or SCHIP.
- Plans often have higher co-payments than the public programs.
- Filling the gaps in employer coverage with wrap-around coverage has been the most difficult challenge with states' premium-assistance programs under SCHIP.

The researchers point out the characteristics of the more successful programs:

- They require applicants to enroll in employer coverage for which they are eligible, if that coverage is cost effective.
- They develop strategies to offer wraparound coverage.
- They minimize the administrative burden on employers.

To date, fourteen states have implemented premium-assistance programs under SCHIP.⁸⁰ Nationwide, enrollment in premium-assistance programs has been relatively low. One study showed that enrollment constituted less than one percent of the relevant eligibility groups in Medicaid and SCHIP.⁸¹ Rhode Island has been the sole state that has seen considerable growth in its program.

A threat to future premium-assistance programs is found in the rate of premium increase in the private insurance market. These rates have been increasing faster than Medicaid costs on a per-capita basis.⁸² If states cap premium subsidy amounts to limit their costs, enrollees must assume greater cost, further limiting enrollment.

Three-Share Premium Programs

In a three-share program premiums are shared three ways. The payers are the employer, the employee, and a third-party (usually a governmental entity). Often small employers do not provide commercial health insurance to their employees because they cannot afford the premiums. In cases where employer insurance is offered, lower wage employees often cannot afford to pay their contribution. The objective of the three-share program is to offer benefits packages that are affordable to both small employers and their employees. They are also known as "multi-share" programs because the public share of the premium can be funded by multiple levels of government and/or private funds.⁸³ While these programs do not target children in their design, low-income families do benefit from the coverage expansion.

Three-share programs typically offer a more restricted benefits package and a closed, local provider network compared to other private insurance plans. These restrictions are generally in place in order to make the plan affordable. As a result, enrollees in three-share programs might not be eligible for coverage if they want to receive medical care outside of their local area.

Three-share premium programs have been implemented in several states, including Michigan, Florida, Ohio, West Virginia, New Mexico, and Oklahoma. Access Health, started through the Muskegon Community Health Project in Michigan, was the first program established and has served as a model for other states. As of 2003, Access Health had 1,500 enrollees in 400 businesses. Premiums of \$148 per month were split among employers, employees, and the state of Michigan. The program can ultimately serve up to 3,000 full or part-time workers.⁸⁴ The public share is financed through a special financing arrangement in which counties send funds to the state (intergovernmental transfers). The state pays Disproportionate Share Hospital (DSH) funds to hospitals, and the hospitals contribute funds to the nonprofit organization in each county that administers the three-share program.

Michigan, Florida, West Virginia, and Ohio are all locally based three-share programs while New Mexico and Oklahoma have statewide three-share programs. The key differences between locally based programs and statewide programs are the sources of public funding and the administration of the program. Locally based programs are developed and administered at the local level and use local funds to pay for a portion of the coverage. Typically they limit coverage to a closed, local network of providers.⁸⁵

New Mexico's State Coverage Insurance Program (SCI) had approximately 4,700 enrollees in 2006 and covered working adults up to 200 percent of the Federal Poverty Level (FPL) in businesses with 50 or fewer employees. New Mexico estimates 174,000 uninsured could qualify for the program and projects 40,000 enrollees within five years. Cost sharing is on a sliding scale basis, with the premium and co-payment amounts corresponding to three income groupings (0-100 percent FPL, 101-150 percent FPL, and 151-200 percent FPL). The employer pays \$75 per employee per month, the employee pays \$0-\$35 per month, and public funds pay the premium balance.⁸⁶ The following chart illustrates the sliding fee arrangement:

	<u>0-100% FPL</u>	<u>101-150% FPL</u>	<u>151-200% FPL</u>
Employer Pays	\$75	\$75	\$75
Employee Pays	\$0	\$20	\$35
Combined	\$75	\$95	\$110

If the SCI plan is purchased through an employer, the employer is responsible for paying \$75 per employee per month toward the premium. The employee, once approved, pays any amount over \$75 due each month toward the premium. If an individual purchases the SCI plan on their own (and not through an employer) he is responsible for paying both the employer and employee portion.

Another statewide three-share program is the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC). O-EPIC covers workers up to 185 percent FPL in businesses with 50 or fewer workers, and the program has proposed to cover 50,000 residents.⁸⁷ As of June 2006, 440 employers and 803 employees/spouses have enrolled. The employer pays at least 25 percent of the premium. Employees pay 3 percent of their gross income or 15 percent of the premium (whichever is less), and the state pays the balance of the premium.

A major consideration in the design of three-share premium programs is the determination of each party's share. The state must determine what premium amount employers and employees would consider "affordable" and therefore willing to pay in order to obtain coverage. Research shows that low income individuals will not purchase health insurance if their contribution totals more than 5 percent of their income.⁸⁸

The primary disadvantage of the three-share programs is found in the limitation of benefits when compared with traditional Medicaid or commercial insurance plans. Limited benefit plans have not been widely accepted. Insurance companies have been disinclined to market them, and consumers have not readily purchased them. While employers report that limiting benefits is an acceptable way to reach the objective of offering an affordable health insurance plan, they also state that they do not want such benefits for themselves.⁸⁹

Reinsurance

Reinsurance is insurance for organizations that accepted risk, such as insurance companies or employers that self-insure their employees' health care costs.⁹⁰ It is not activated until a deductible threshold is met. There often is a "ceiling," or upper limit, on reinsurable expenses. Reinsurance policies also have coinsurance rates, which are amounts that the policyholder must pay for particular services that apply to expenses between the deductible and ceiling.⁹¹

In any large group insurance plan, a small proportion of the plan members will be responsible for a majority of the costs (known as the "pareto group"). This is commonly referred to as the "80/20 rule" in that 20 percent of the members represent 80 percent of the cost, although depending on the benefit structure, the actual proportions can be more like 8 percent of the members accounting for 80 percent of the cost. Clearly, if the excessive costs for the pareto group are excluded, the costs for the remainder of the group will be significantly lower. Government reinsurance plans cover these very high costs, resulting in more affordable premiums.

Arizona and New York

Arizona and New York are two states that have established successful reinsurance programs. Since 1986, the Arizona Health Care Cost Containment System (AHCCCS) has administered the Arizona healthcare reinsurance program. It is managed through a public/private partnership called the *Healthcare Group of Arizona (HCG)*. The program was initially subsidized by Arizona's state legislature with \$8 million of general funds in 2000. Four years later the subsidy was reduced to \$4 million. HCG was then required to become financially self-sufficient (funded by premiums only) starting July 1, 2005.⁹² Therefore, employers and employees were responsible for financing all costs of the program. HCG protects carriers using aggregate stop-loss reinsurance financed from member premiums. As of December 2006, the program had an enrollment of 24,000 including more than 8,500 small business groups. More than 90 percent of the businesses enrolled have three or fewer employees.

HCG operates a reinsured product for small business, political subdivisions and the self employed. There are no income limits in the program; however, HCG does have requirements regarding employee participation. Employers must not have offered group insurance for six months. Benefits are delivered by managed care organizations, and employees can select between several benefit plan options. In 2006, HCG added dental and vision benefits.

The *Healthy New York Program (Healthy NY)* is the state of New York's reinsurance program that began in 2001. The state reimburses health plans for 90 percent of claims paid between \$5,000 and \$75,000 per member per year. All Health Maintenance Organizations (HMOs) are required to offer Healthy NY. In December 2006, Healthy NY had approximately 131,000 enrollees, and has enrolled over 300,000 since it began. Approximately 55 percent of enrollees are working individuals, 28 percent are enrolled through small-groups, and 17 percent are sole proprietors.⁹³

To be eligible for Healthy NY, individuals, small employers, and sole proprietors must have been uninsured for at least the previous 12 months or have lost their insurance due to a qualifying event. Small employers are eligible for the program if they have no more than 50 employees, and 30 percent of their employees must earn less than \$35,500 (adjusted annually for inflation). Employers must contribute a minimum of 50 percent of the premium, and at least 50 percent of employees must participate in the program or have coverage through other sources.

New York allocated \$89.4 million for Healthy NY in 2003, \$49.2 million in 2004, and \$22 million for the first half of 2005. The New York State Insurance Department administers the program and is authorized to spend up to 10 percent of allocated funds on marketing. Some of the subsidy is funded through tobacco taxes.

One significant difference between these two state programs is the type of incentive for insurers. Healthy NY requires the insurer to retain a portion of the risk of an enrollee's costs exceeding a threshold (\$5,000 currently). Between \$5,000 and \$75,000, the insurer is responsible for 10 percent of the costs, and above \$75,000, the insurer is responsible for all of the costs. This arrangement provides an incentive for insurers to carefully manage the care of those who have medical bills over \$5,000. Arizona does not offer incentives for the insurers to manage medical care of high-cost individuals, but does encourage insurers to reduce their total costs. All of the insurer's expenses will be audited if he or she submits a claim for reinsurance, not just the expenses of the high-cost enrollees.⁹⁴

The New York and Arizona plans also represent two types of reinsurance structures. Healthy NY provides protection to insurers for the risk of unusually high costs incurred by any individual. New York is essentially providing a backup pool of funds to pay for catastrophic cases. The insurers do not have to build such reserves into their premiums, allowing premiums to be set at lower levels. In contrast, HCG in Arizona provides protection to insurers for the risk that the entire group of enrollees may have above average, but not extraordinary, expenses—a situation that typically occurs when the enrollees are more likely to have chronic health problems. In this case, Arizona lowers premiums by subsidizing the higher-than-average expenses of all the enrollees.

Risk Pool Models

Most states have established high risk pools to provide access to health insurance coverage for persons considered "uninsurable" by commercial insurance companies. With high-risk pools, states subsidize health insurance coverage for these individuals, who have been denied insurance coverage by commercial carriers or have been offered coverage but could not afford the costly premiums charged due to their health status.

Most states cap premium rates for high risk pools at 125 to 200 percent of the standard market rates.⁹⁵ States usually provide supplemental funding to make up the difference between the premiums paid and claims paid. The funding often comes from taxes imposed on state health insurers or through allocation of general revenue or special funds. The majority of states use risk pools in compliance with the Health Insurance Portability and Accountability Act (HIPPA) provisions regarding individuals leaving employer group coverage. Mississippi offers a high risk pool through the Mississippi Comprehensive Health Insurance Risk Pool Association.⁹⁶

A study of risk pools in states concluded that risk pools have not had a significant effect on making health insurance available and affordable for individuals who would otherwise be uninsured.⁹⁷ Premiums for risk pool coverage are higher than standard market rates. Co-payments and deductibles can be substantial. Additionally, benefits such as maternity and mental health care are usually limited in state risk pools. Risk pools provide an important resource for individuals with poor health status who can afford the premiums and other cost sharing, but are not a viable solution for low income uninsured families unless supported by some type of public subsidy.

Eligibility Expansions

Some states have taken action to cover more uninsured children by raising eligibility limits for public programs such as Medicaid and SCHIP, thereby qualifying more children for the programs. While most states set the maximum income eligibility level for these programs at 200 percent of the Federal Poverty Level (FPL), by 2006, 17 states had extended the upper limit to 300 or 350 percent. One state, Illinois, is in the process of implementing universal coverage for children.⁹⁸

Tax Credits

The offering of tax credits as a means of subsidizing the purchase of health insurance for the uninsured has been debated for several years at the federal level. In addition to serving as a way to subsidize health insurance coverage for the uninsured, tax credits may address the inequities in tax policies that currently discriminate against those who purchase their own health insurance.⁹⁹ In 2002, Congress passed limited legislation that authorized advanceable tax credits to subsidize the purchase of health insurance for workers displaced by international trade.

Very few states have seriously studied this option. Eight states have authorized tax credits or deductions to small employers for offering health coverage.¹⁰⁰ The California Health Care Foundation commissioned a study to model the impact that tax credits could have in California. The study examined three options: subsidizing the individual purchase of health insurance, subsidizing employer offerings of health coverage, and subsidizing employee take-up of employer coverage. The researchers concluded that of the three alternatives, tax credits aimed at encouraging employers to offer coverage represent the most efficient approach. Offering tax credits to individuals was the next most effective option and provided the best means of reaching the lowest income residents. The high cost of individual coverage reduced the efficiency of this particular strategy. The least effective alternative was subsidizing employees to enroll in employer coverage.¹⁰¹

The authors of this study note that the number of uninsured who could be covered under any of the tax credit alternatives was relatively modest. They point out that tax credits should be considered as one strategy in the context of a comprehensive approach to expanding health coverage. In this model, tax credits only provide a financial subsidy and do not address the many institutional barriers that prevent uninsured individuals from obtaining coverage.¹⁰²

■ Policy Options

Policymakers and health leaders continue to debate strategies for financing children's health care. It is well understood that in Mississippi, children without health insurance coverage are still served by the health care delivery system. Their health care is frequently delayed and often dependent upon safety net providers and hospital emergency departments. Hence, most states prefer to provide coverage for uninsured children that will help them get timely preventive and primary care rather than financing their delayed care through cost shifting by providers.

The following options represent evidence based policy approaches to improved health care coverage for children that best fit the profile of uninsured children in Mississippi.

Health Policy Options for Expanding Coverage

- Enroll uninsured children who are already eligible
- Simplify the enrollment process
- Allow flexibility in determination appointment times/locations
- Conduct outreach to eligible families
- Provide premium assistance for higher income families
- Implement shared premiums
- Offer tax credits for coverage
- Offer incentives for small Mississippi employers

Mississippi can significantly reduce the number of uninsured children without implementing any new programs, because most of the uninsured children are already eligible for existing programs. Enrolling these children will require outreach to eligible families and streamlining enrollment procedures. These children are in families of low-wage earning, working adults who need flexibility in scheduling eligibility determination appointments so that their employment is not negatively affected. The research is clear that simplifying enrollment procedures facilitates enrollment of eligible children. Enrollment simplification and outreach can be implemented without compromising program accountability and integrity.

Eligibility expansions can be used to reach additional uninsured children, but the risk of crowd-out grows substantially as eligibility is opened to families at incomes higher than 200 percent of the Federal Poverty Level. While there are approximately 19,000 uninsured children in families with incomes between 200 and 300 percent of the Federal Poverty Level, there are more than 100,000 children in this income group who have private health insurance coverage. The cost effectiveness of expanding coverage declines at higher income levels because for every three uninsured children who gain coverage, there will be one or two children who move from private coverage to public coverage.

Other strategies may be more effective in reaching uninsured children at higher income levels, such as premium assistance, shared premiums, or tax credits. These initiatives tend to discourage crowd-out and are feasible only when the family has access to private health insurance. These programs could be initiated as part of a more comprehensive effort to encourage small employers to offer or retain health insurance coverage for their employees.

To be effective in expanding coverage, however, these programs must provide a subsidy that is sufficient to lower employer and employee premiums to an "affordable" level. The definition of "affordable" is subjective and must be understood from the perspective of the employee and employer. Research sponsored by the Division of Medicaid in Mississippi in 2005 studied the opinions of small employers and low income workers regarding the affordability of health insurance premiums. Low income workers indicated that they considered premiums of \$40 to \$75 per month to be acceptable. At the same time, most small employers stated that they could afford to pay up to \$50 per month per employee toward health insurance coverage for their employees.¹⁰³ Given that the average annual group premium for small employers in Mississippi is \$4,033 for single coverage and \$9,964 for family coverage, it would take an annual subsidy in the range of \$2,500 for single coverage and \$8,500 for family coverage to induce low income employees and small employers to participate.

Cost Effectiveness

The cost of expanding coverage is generally the biggest barrier to implementation. From the standpoint of state general funds, the most cost effective means of covering the uninsured is by covering children under Medicaid and SCHIP. Children are less expensive to cover than adults: the average cost per enrollee in Mississippi Medicaid in FY 2004 was \$1,197 for children, \$2,459 for non-elderly adults, \$7,743 for disabled persons, and \$9,416 for the elderly.¹⁰⁴ Seventy-six percent of this cost is paid by federal funds with the remaining 24 percent covered by state dollars. The federal matching rate is even higher for SCHIP at 83 percent.

For strategies that would not be eligible for federal funding, those that involve employers are more cost effective for the state because they take advantage of employer and employee contributions. These efforts by their nature also expand coverage to adults, however, which increases the cost of the programs.

Value

The cost of covering uninsured children should be compared to the cost of leaving them uninsured. As documented in this report, children without health coverage have poor access to health care, suffer from unmet medical and mental health needs, delay receiving care, and rely on emergency rooms for care. The cost of meeting their delayed health care needs is higher and not covered by federal matching funds. Providers shift these costs to those who can pay for care. The "hidden tax" on health insurance premiums due to this cost shifting has been estimated to represent three to ten percent of premiums.¹⁰⁵ Additional immeasurable costs include the impact of lingering and exacerbated health problems on the lives of uninsured children and their families.

The Balancing Act - Children's Health Coverage in Mississippi

Policy decisions regarding children's coverage involve balancing conflicting objectives and minimizing unintended consequences. Policymakers must balance access and accountability. Taking actions to improve access must be balanced with systems to ensure accountability and program integrity. For example, states that have allowed self-declaration of income have instituted verification and audit procedures that verify income against data from state tax or labor departments.

Policymakers must also balance efficiency and equity. This was a major consideration when SCHIP was created by Congress in 1998. In order to ensure efficient use of the funds appropriated and to prevent crowd-out, only uninsured children were authorized as eligible to enroll in SCHIP. This rule meant that insured children in low income families were not eligible for SCHIP creating serious equity issues.¹⁰⁶

As discussed in the section describing Three Share Premium Programs, any insurance plan must balance premium costs, scope of benefits, and provider access. If benefits or provider access are severely limited, employees will not consider the plan worth purchasing. Understanding perceptions of families and employees will facilitate progress toward the ultimate goal of increasing coverage.

Mississippi is poised to consider significant improvements in insurance coverage for children. The Mississippi Center for Health Policy will continue to provide accurate and unbiased health policy research to assure informed deliberations.

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Technical Appendix

Integrated Public Use Microdata Series (IPUMS) is a publicly accessible set of data created directly from the Current Population Survey Annual Social and Economic Supplement (CPS ASEC). Variables in IPUMS-CPS are coded identically from 1962 to 2007 and extensive documentation covering comparability issues for each of these variables is provided. This data extraction tool and technical notation make CPS ASEC data analysis over time more feasible¹. IPUMS-CPS data for 2001-2007 are utilized in these analyses and statewide estimates are reported as three year averages. Three years of data ensure there are proper sample sizes for stable state level estimates. Small numbers of respondents can generate unreliable estimates, thus, data for which there are 50 or fewer unweighted observations within the state are not displayed. All rates are based on weighted estimates with the complex survey design corrected for using SAS version 9.1.3 software. MEPS 2002, 2003, 2004, 2005, and 2006 health insurance survey data are also included in this report. Sample analyses in both data sets are limited to children less than 19 years of age.

There are a few caveats to keep in mind when using CPS ASEC data to estimate state level health insurance coverage. According to the U.S. Census Bureau, the CPS ASEC estimates represent people lacking health insurance for the previous calendar year. Since the data are collected at one time in reference to health insurance status for an entire past year, it is possible respondent's classification may be erroneously recalled or based on current status rather than that of the prior year as instructed. In order to provide a more reliable estimate of health insurance, the Census Bureau added a health insurance verification question to the CPS ASEC in 2000. Persons reporting no health insurance coverage are now asked an additional question about whether they are actually uninsured².

Some researchers debate that the CPS ASEC actually reflects a point-in-time health insurance estimate rather than a yearly estimate. When comparing CPS ASEC to other all year measures of health insurance coverage, the CPS ASEC tends to estimate more people to be uninsured. For the CPS ASEC years 2005-2007, IPUMS-CPS data reflect an adjustment administered as a revision to the health insurance edit used in processing the data³. This adjustment results in an overall lower uninsured estimate of less than 1%. Trends over time can be effected by this recent data edit. Since differences are small comparing adjusted to unadjusted data, adjusted data are utilized in these analyses for time trend comparisons.

It is known that the number of people reporting Medicaid as their source of health insurance is lower in the CPS ASEC and MEPS compared to administrative data captured by state Medicaid programs. Several surveys of Medicaid enrollees show that most of those who misclassified their Medicaid coverage identified another source of health insurance coverage, and fewer still erroneously reported being uninsured. The researchers conclude that the Medicaid undercount has a modest impact on estimates of uninsurance⁴. Evidence is still unclear, however, on how to properly correct for the Medicaid undercount. Therefore, no adjustments for the Medicaid undercount were made in these analyses.

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