HEALTH CARE COVERAGE AND ACCESS FOR CHILDREN IN AN URBAN STATE: THE NEW YORK PERSPECTIVE

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Since the demise of national health care reform in 1994, profound market-driven changes in the health care sector have occurred in the nation's states. As laboratories for democracy, states have pursued a wide array of policies that present new opportunities and risks for ensuring access to health care for all citizens. State-level experiments continue since the congressional enactment in 1997 of the State Children's Health Insurance Program, which gave states expanded flexibility to design and manage programs to reduce the number of uninsured children. As the devolution of responsibility for health and welfare programs continues and a new federalism takes hold, understanding the efforts of individual states to preserve health care coverage and access is increasingly significant.

New York State, the nation's third most populous state, is an especially important bellwether for the impact of trends that are occurring around the country. With a historically bipartisan approach to health care policy issues, New York has long been a leader in providing public support for health and social services. It has by far the largest and most generous Medicaid program in the country. More than 3.3 million New Yorkers were enrolled in Medicaid, and total program expenditures were more than 40% higher than the next highest spending state in 1995.¹ Excluding disproportionate share payments, New York spends more per Medicaid beneficiary than any other state and more than twice the national average on both a per capita and per low-income-person basis.* Beyond Medicaid,

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*Tabulations by The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

the state maintains bad-debt and charity-care pools that help subsidize care for the state's low-income and uninsured populations.

The strength of New York's commitment to health care for its low-income citizens is evident in its initiatives to provide health insurance for low-income children. In the middle and late 1980s, the state undertook expansions of Medicaid eligibility, including the provision of benefits up to 185% of poverty, well above the federally mandated 133% of poverty, to pregnant women and infants. In addition, New York implemented the Child Health Plus (CHP) program in 1991 to subsidize coverage for low-income children who were not eligible for Medicaid. CHP initially provided \$20 million annually in subsidies for outpatient coverage to low-income children up to age 13 and in Medicaid-ineligible families with incomes up to 222% of the federal poverty level. Children in families with incomes below 160% of poverty were fully subsidized, and those families with incomes between 160% and 222% of poverty paid an annual premium of \$25 per child. Eligibility for CHP was later extended to children aged 13 through 15.

CHP was expanded significantly in 1996 under the New York Health Care Reform Act, which increased funding from \$106 million in 1997 to \$207 million in 1999. At the same time, the program was expanded to include children through age 18 and to cover inpatient services. New York's CHP is the largest of 13 non-Medicaid-subsidized state child health insurance programs.

CHP has been recognized as a model for expanding children's health insurance coverage and is one of only three existing state programs with benefits packages that were deemed to meet all the requirements of the new federal child health insurance initiative. An independent evaluation by researchers at the University of Rochester, Rochester, New York, found that CHP has contributed to improving coverage and access to high-quality preventive and primary health care services for low-income children.²

COVERAGE

Despite these efforts, New York's children and their parents are at increasing risk of being uninsured. In 1996, 3,100,000 New Yorkers—17% of the state's total population—were uninsured, and the problem of the uninsured is growing faster in New York State than in the nation. Among nonelderly New Yorkers—that is, children and adults under age 65—19.1% were uninsured in 1996 compared with 13.9% in 1991. Nationally, the percentage of nonelderly uninsured grew from 15.9% to 17.6% during the same time period.³ In just 5 years, New York State's nonelderly rate of uninsurance went from being better than the nation's to worse.

A lack of insurance prevails among New York State's children. Approximately

FIGURE Private coverage in New York State has declined substantially. Source: March 1992 and 1997 *Current Population Survey*, US Bureau of the Census. Tabulations prepared for United Hospital Fund by Kenneth E. Thorpe.

663,000 children through age 18—13% of all children in the state—are uninsured.* The problem is especially severe in New York City, where approximately 19% of children are uninsured, compared with 9% in the rest of the state; about three in five uninsured children in New York State live in New York City.†

The growth in the number of uninsured can largely be attributed to erosion of private, employer-sponsored coverage, which is occurring faster in New York State and New York City than nationally (Figure). The proportion of nonelderly New York State residents with private coverage declined from 70.8% in 1991 to 63.1% in 1996.³ The decline has been particularly rapid in New York City, where fewer than half (49.1%) of the nonelderly population had private coverage in 1996, compared with 58.2% in 1991. The decline in private coverage has been widespread and has affected workers in firms of almost all sizes. Among firms in New York State with 1,000 or more workers, the proportion of workers aged 18 to 64 with private coverage declined by 5.6% between 1990 and 1996. During the same period, the proportion of workers in businesses with fewer than 25 employees that had private coverage declined by 11.9%. Such dramatic decreases in private coverage for New Yorkers have not been fully offset by Medicaid expansions during that period. The ongoing erosion of private coverage, com-

*Tabulations by State of New York Department of Health from *Current Population Survey*, US Bureau of the Census, March 1994–March 1997.

†Ibid.

bined with recent drops in New York State's Medicaid enrollment, bodes poorly for containing the future growth of the state's uninsured population.

Most uninsured children in New York State share a common characteristic: they are growing up in low-income working families (Table I). More than 22% of children living in poverty in New York State were uninsured in 1996. Approximately two-thirds of all uninsured children in New York State in 1996 lived in households with incomes below 200% of the federal poverty level. At the same time, more than three-quarters of uninsured children living below the federal poverty level had at least one parent who was employed in 1996.³ More than 275,000 uninsured children living below 200% of the federal poverty level lived in households in which at least one parent worked full time for the entire year.³

ACCESS AND CARE EXPERIENCES

To examine the health care experiences of low-income children in New York State, the Commonwealth Fund conducted *The Commonwealth Fund New York State Low Income Survey* of a total of 2,540 adult (aged 18–64) New York State residents having household incomes below 250% of the federal poverty threshold. When the adult respondent was the parent of a child under age 18, the parent reported on his or her child's insurance coverage, health care, and health status. In total, 1,072 low-income parents aged 18–64 reported on their children. Of these parents, 482 resided in New York City; the remaining 590 parents resided elsewhere in New York State. All respondents completed 25-minute telephone interviews in either English or Spanish, depending on the respondent's preference. Louis Harris and Associates, Inc., conducted the interviews from October 1996 to March 1997. Results were weighted to the *March 1996 Current Population Survey* for New York State to reflect the known population and demographic distribution of the state, the number of children in the family, and child insurance status.

Among the low-income children for whom data were obtained, 40% lived in

TABLE I Percentage of Uninsured Children by Age Category and Household Income, New York State, 1996*

Age	0–100% Poverty	101–150% Poverty	151–200% Poverty	201–300% Poverty	301%+ Poverty	Total
0–5 years	18.3	25.3	17.0	11.5	4.9	12.3
6–11 years	21.5	20.1	18.9	12.4	5.7	14.7
12–18 years	27.2	33.1	34.7	11.6	4.3	17.9

*Tabulations by Kenneth E. Thorpe for United Hospital Fund from *Current Population Survey*, US Bureau of the Census, March 1997.

households with incomes below the federal poverty threshold, 24% lived in households with incomes between poverty and 150% of poverty, and the remaining 36% lived in households with incomes between 150% and 250% of poverty.

INSURANCE COVERAGE

One in five (21%) low-income children in New York State was uninsured at the time of the survey, and uninsured children were concentrated among the lowest-income families. Among uninsured children, 52% lived in households with incomes below poverty, 31% lived in households with incomes between poverty and 150% of poverty, and the remaining 18% lived in households with incomes between 150% and 250% of poverty. Of uninsured low-income children, 82% belonged to a working family, and 72% belonged to a two-parent family. Uninsured children were likely to have uninsured parents; 70% of uninsured children's parents were also uninsured. One-quarter (25%) of low-income children in New York State were covered by Medicaid, 46% were covered by private health insurance, and 8% had another form of coverage.

ACCESS

Uninsured children were two to three times more likely than insured children to face barriers to health care access and to go without primary and preventive care (Table II). One in three uninsured children did not have any physician visits within the past year compared with insured children (33% vs. 14%), did not receive a routine checkup or immunization within the past year (32% vs. 20%), and lacked a regular doctor (30% vs. 9%). Uninsured children were less likely than insured children to go to a doctor's office as their usual source of medical care (44% vs. 56%) and were more likely to go to a hospital emergency room or outpatient department than insured children (16% vs. 7%). Parents of uninsured children were four times more likely than parents of insured children to report that it was extremely, very, or somewhat difficult for their children to get medical

TABLE II Access to Health Care for New York State Low-Income Children by Insurance Source, in Percent*

	Uninsured	Total Insured	Medicaid	Private Insurance	Other
No regular doctor	30	9	12	6	22
Difficult for child to get needed care	21	5	8	3	11
Uses emergency room or hospital outpatient department as regular source of care	16	7	10	4	14
Family has problems paying medical bills	41	25	22	25	30

*From *The Commonwealth Fund New York State Low Income Survey*, Louis Harris and Associates, Inc.

care when needed (21% vs. 5%). These parents were also almost twice as likely to report that their family had problems paying their medical bills (41% vs. 25%).

IMPLICATIONS

Findings from the Commonwealth Fund survey portray the serious consequences associated with being uninsured and indicate that New York must renew its commitment to health care coverage and access for all its citizens. For children, new federal financing presents a historic opportunity to provide nearly universal insurance coverage and ensure that the state's youngest residents receive a healthy start in life. By building on its previous success with Medicaid and Child Health Plus, New York can retain its position as a leader among states in ensuring adequate health care for low-income populations.

The recent enactment of the State Children's Health Insurance Program will provide \$256 million annually to New York State to expand children's coverage. Following an agreement in principle by New York's governor and legislative leaders, the state plans to use these funds to expand Child Health Plus further and to make some incremental expansions in Medicaid eligibility standards.* Under this plan, eligibility for Child Health Plus would be increased immediately to 230% of the federal poverty level and would increase to 250% beginning July 1, 2000. Premium contributions would be eliminated for families with incomes below 160% of poverty and decreased for families with incomes between 160% and 222% of poverty, and copayments for Child Health Plus services would be eliminated. Simultaneously, Child Health Plus benefits would be expanded to include dental care; speech and hearing services; vision care; inpatient mental health, alcohol, and substance abuse services; and durable medical equipment. The agreement would also expand and improve the state's Medicaid program by accelerating the ages at which children are eligible for Medicaid, eventually increasing income eligibility levels, and guaranteeing 12 months of continuous eligibility in Medicaid regardless of fluctuations in family income during that period. In combination, these new funds and changes in program design hold promise for making insurance available to nearly all the state's children.

OUTREACH AND ENROLLMENT

As New York moves to implement this agreement, numerous difficult issues will require ongoing attention. Equally important as expanding coverage is expanding the ability to use existing insurance programs to the fullest by implementing effective outreach and enrollment strategies. In New York State, two-thirds

*Child Health Plus Expansion Means Healthier Kids [press release]. Albany: New York State Office of the Governor; June 18, 1998.

of uninsured children are already eligible for either Medicaid or Child Health Plus, but remain unenrolled.* In New York City, an estimated 75% of uninsured children are eligible for one of these two programs, but remain unenrolled. Even without any further expansions of eligibility, the problem of uninsured children in New York could be virtually eliminated if all eligible children participated in these public programs.

However, low-income individuals are in a position to receive mixed messages. At the same time that welfare reform discourages individuals from participating in public benefit programs, New York needs to encourage low-income parents to claim health care benefits to which they are entitled. For the child health insurance expansion to succeed, outreach and enrollment must be a priority. Overcoming enrollment barriers will require several integrated strategies, including marketing efforts that are driven by consumer needs and preferences. Outreach activities should recognize and counter the stigma that is often associated with public benefit programs. Other strategies for enrolling eligible children can be accomplished administratively. Presumptive eligibility, simplification of application forms and processes, and the integration of Medicaid and Child Health Plus could help to increase coverage and improve the continuity of care received by children.

CROWD-OUT

New York's child health insurance expansion must also contend with complex implementation issues. For example, the federal legislation requires states to describe how their approach will avoid "crowd-out," in which public coverage substitutes for existing private coverage. Evidence regarding the extent to which crowd-out actually occurs is mixed. National studies have come to different conclusions as to how much substitution occurred when Medicaid expanded coverage for pregnant women and children.^{4,5} Officials in states, including New York, with experience with child insurance expansions prior to the passage of Title XXI have reported that crowd-out is not a significant phenomenon.^{6,7} When crowd-out does occur, it is usually among higher-income families; lower-income families often have no other coverage to give up.

To guard against crowd-out, New York plans to collect quarterly data on new enrollees' previous insurance status. In addition, New York State officials have proposed to deter crowd-out through premium charges for families with incomes above 160% of poverty and the continuation of existing programs to subsidize

*Tabulations by State of New York Department of Health from *Current Population Survey*, US Bureau of the Census, March 1994–March 1997.

premiums for small businesses. Strategies to avoid crowd-out should avoid eligibility restrictions, like mandatory waiting periods of uninsurance, which may unnecessarily deny coverage to children who have no other options. Caution should also be exercised to establish premium contributions that are sufficient to discourage crowd-out but not so high as to become unaffordable for low-income families.

IMMIGRATION

An additional issue with particular resonance for New York is eligibility for immigrant children. Child Health Plus currently is open to all New York State children who meet its income criteria, and there are no restrictions based on immigration status. Children born in the US to immigrant parents are considered to be US citizens; these children, as well as legal immigrant children who arrived in the US before August 22, 1996, are likely to remain eligible for either Medicaid or Child Health Plus. However, Title XXI health insurance coverage has been deemed to meet the definition of a federal, means-tested public benefit and places eligibility restrictions even on certain classes of legal immigrant children. In addition, certain families risk adverse consequences when applying for benefits for legally eligible children. In New York State, 759,677 children live in families with at least one noncitizen parent and at least one citizen child.⁸ Given the large waves of immigration into New York, particularly New York City, in the past decade, the clarification of immigrant eligibility rules by the federal government will have a major impact on New York's insurance expansion initiatives.

CONCLUSION

New York and the nation stand at the brink of an unprecedented opportunity to improve health care coverage and access for children. New York can continue to be a national leader in ensuring access to coverage and care for low-income children by combining eligibility expansions with effective outreach and enrollment efforts. Between half and three-quarters of a million children could benefit if these activities are successful. As monumental an accomplishment as that would be, however, three-quarters of the state's total uninsured population would remain without coverage. Successful advocacy for low-income children should serve as models for additional efforts to provide health care coverage to their parents and to other uninsured adults in the state. During a strong state economy and renewed interest in health care issues, the time is now to seize this momentum and fulfill New York's historic commitment to health care for all its citizens.

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