
No Shelter From the Storm:

*America's
Uninsured Children*

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No Shelter from the Storm: America's Uninsured Children

Campaign for Children's Health Care

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Campaign for Children's Health Care

P.O. Box 34143

Washington, D.C. 20043

Phone: 202-879-0299

Fax: 202-347-2417

E-mail: info@childrenshealthcampaign.org

Written by Families USA for the
Campaign for Children's Health Care

*This publication is available online at
www.childrenshealthcampaign.org*

INTRODUCTION

In recent years, much attention has been paid to the growing number of Americans who lack health insurance. Unfortunately, less attention has been paid to a startling and often-overlooked fact: One out of every five uninsured Americans is a child.

Through no fault of their own, these youngest and most vulnerable members of society lack coverage for the health services they need to develop into healthy, productive adults. And despite the common misconception that these children somehow manage to get the care they need even though they are uninsured, the truth is that uninsured children fare far worse than their insured counterparts when it comes to a host of crucial medical services, including doctor visits, dental care, vision care, and prescription drugs.

Over the past 10 years, the advent of the State Children's Health Insurance Program (SCHIP) and the increased push for children's coverage that the new program created have led to marked declines in the number of uninsured children. Nevertheless, a great deal of work remains to be done. The most recent Census data show that, for the first time since 1998, the rate of uninsured children increased, from 10.8 percent to 11.2 percent.¹ One in nine children is uninsured, and *more than half of all uninsured children live in two-parent families.*^{2,3}

Gone are the days when working parents could rely on employer-based health insurance to cover the whole family. Today, low-income parents often do not have access to a health plan at work, or their employer's plan may be unaffordable. Fortunately, a large proportion of uninsured children are eligible for Medicaid or SCHIP, although better outreach is needed to get them enrolled.

This report takes a closer look at uninsured children—who they are and what kinds of services they miss out on as a result of being uninsured. It is based on data projections from the Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS) conducted by the U.S. Census Bureau (2004-2006), as well as the 2005 National Health Interview Survey conducted by the National Center for Health Statistics. See the Technical Appendix on page 19 for a more detailed methodology.

KEY FINDINGS

Who Are Uninsured Children?

■ The Number of Uninsured Children

- There were more than 9 million uninsured children (ages 0-18 years) in the U.S. in 2005 (Table 1). One out of every nine children is uninsured.
- One out of every five uninsured people is a child.⁴
- The five states with the largest number of uninsured children are California (1,368,999), Texas (1,366,638), Florida (718,603), New York (441,434), and Illinois (376,332). Together, the uninsured children in these five states account for nearly half of all uninsured children in the country (Table 1).
- The five states with the highest rates of uninsured children are Texas (20.4 percent), Florida (17.0 percent), New Mexico (16.7 percent), Nevada (16.4 percent), and Montana (16.2 percent) (Table 1).

■ Working Status of Families with Uninsured Children

- The majority of uninsured children—88.3 percent—come from families where at least one parent works (Table 2).
- Among 70 percent of uninsured children living with a parent, at least one family member works full-time, year-round.⁵
- Still, 70.8 percent of uninsured children come from low-income families (families with incomes at or below two times the federal poverty level—\$33,200 a year for a family of three in 2006) (Table 3).⁶

■ Composition of Families with Uninsured Children

- Among uninsured children living with a parent, more than half—59 percent—live in two-parent households (Table 4).
- In more than half of all two-parent families with uninsured children, *both parents work* (Table 4).

Table 1

Number and Percent of Uninsured Children by State, 2003-2005

State	Total Number Of Uninsured Children	Percent of Children Who Are Uninsured	State	Total Number Of Uninsured Children	Percent of Children Who Are Uninsured
Alabama	85,036	7.4%	Montana	37,049**	16.2%
Alaska	21,197**	10.7%	Nebraska	30,844**	6.6%
Arizona	264,518	16.1%	Nevada	106,244	16.4%
Arkansas	72,713**	10.2%	New Hampshire	20,781**	6.4%
California	1,368,999	13.5%	New Jersey	263,974	11.5%
Colorado	176,124	14.4%	New Mexico	87,452	16.7%
Connecticut	76,555	8.6%	New York	441,434	9.1%
Delaware	23,621**	11.3%	North Carolina	274,783	12.2%
District of Columbia	10,409**	8.9%	North Dakota	14,300**	9.2%
Florida	718,603	17.0%	Ohio	245,404	8.3%
Georgia	306,913	12.6%	Oklahoma	145,949	16.1%
Hawaii	20,341**	6.4%	Oregon	104,562	11.6%
Idaho	47,679**	11.7%	Pennsylvania	280,831	9.3%
Illinois	376,332	11.0%	Rhode Island	18,815**	7.0%
Indiana	162,515	9.7%	South Carolina	102,595	9.5%
Iowa	51,420**	7.0%	South Dakota	17,831**	8.8%
Kansas	49,462**	6.8%	Tennessee	151,480	10.2%
Kentucky	93,135	8.9%	Texas	1,366,638	20.4%
Louisiana	135,239	11.3%	Utah	88,458	11.0%
Maine	20,922**	6.9%	Vermont	8,186**	5.6%
Maryland	132,686	9.1%	Virginia	171,642	8.9%
Massachusetts	106,570	6.7%	Washington	133,440	8.4%
Michigan	170,686	6.4%	West Virginia	36,421**	8.8%
Minnesota	86,154	6.6%	Wisconsin	101,855	7.3%
Mississippi	104,210	12.9%	Wyoming	14,520**	11.6%
Missouri	121,442	8.2%	U.S.*	9,035,420	11.6%

Source: Analysis conducted by Mark Merlis for Families USA based on the Census Bureau's most recent Current Population Survey.

* The national rate is based on 2005 data only.

** Numbers should be read with caution, as sample sizes in these states are very small.

Table 2

Percent of Uninsured Children with a Working Parent, by State, 2003-2005*

State	Percent of Uninsured Children With a Working Parent	State	Percent of Uninsured Children With a Working Parent
Alabama	89.0%**	Montana	91.3%**
Alaska	90.1%**	Nebraska	90.1%**
Arizona	87.3%	Nevada	86.3%
Arkansas	92.8%**	New Hampshire	92.5%**
California	90.0%	New Jersey	87.5%
Colorado	94.5%	New Mexico	89.7%
Connecticut	89.7%**	New York	85.7%
Delaware	88.0%**	North Carolina	88.8%
District of Columbia	90.0%**	North Dakota	94.7%**
Florida	88.4%	Ohio	84.9%
Georgia	84.1%	Oklahoma	88.6%
Hawaii	87.8%**	Oregon	91.6%
Idaho	93.6%**	Pennsylvania	86.8%
Illinois	84.3%	Rhode Island	84.0%**
Indiana	92.2%	South Carolina	89.5%
Iowa	94.5%**	South Dakota	89.1%**
Kansas	94.2%**	Tennessee	87.2%
Kentucky	87.3%	Texas	89.4%
Louisiana	78.7%	Utah	91.4%
Maine	89.3%**	Vermont	96.5%**
Maryland	80.8%	Virginia	79.4%
Massachusetts	88.4%	Washington	89.1%
Michigan	87.7%	West Virginia	71.0%**
Minnesota	91.1%	Wisconsin	93.3%
Mississippi	82.2%	Wyoming	94.5%**
Missouri	86.9%	U.S.***	88.3%

Source: Analysis conducted by Mark Merlis for Families USA based on the Census Bureau's most recent Current Population Survey. Note that this table excludes uninsured children who did not live with a parent at the time of the survey.

* Children are considered to be in working families if at least one family member works full- or part-time.

** Numbers should be read with caution, as sample sizes in these states are very small.

*** The national rate is based on 2005 data only.

In Table 3 on the next page, annual family income is expressed as a percentage of the federal poverty level. Translated to dollar figures based on the poverty level for 2006, these categories would be roughly the following for a family of three in all states except Alaska and Hawaii:

- Up to Twice the Poverty Level \$33,200 or less
- Between Two and Four Times the Poverty Level \$33,201-\$66,400
- Above Four Times the Poverty Level \$66,401 or more

Table 3

Percent of Uninsured Children by Family Income, by State, 2003-2005

State	Family Income		
	Up to Twice the Poverty Level	Between Two and Four Times the Poverty Level	Above Four Times the Poverty Level
Alabama	76.2%	16.3%	7.5%**
Alaska	64.5%**	28.1%**	7.4%**
Arizona	74.1%	18.9%	7.0%**
Arkansas	61.9%**	28.9%**	9.2%**
California	74.0%	17.3%	8.7%
Colorado	71.6%	9.6%	8.8%
Connecticut	59.1%	22.2%	18.8%
Delaware	75.0%**	17.7%**	7.3%**
District of Columbia	82.1%**	8.8%**	9.0%**
Florida	69.5%	22.4%	8.1%
Georgia	72.7%	19.9%	7.4%
Hawaii	72.4%**	22.1%**	5.4%**
Idaho	68.5%**	24.9%**	6.5%**
Illinois	72.6%	17.9%	9.5%
Indiana	63.8%	23.3%	12.9%
Iowa	70.9%**	21.8%**	7.3%**
Kansas	74.2%**	15.8%**	10.0%**
Kentucky	79.4%	14.5%	6.1%**
Louisiana	78.0%	16.8%	5.3%**
Maine	62.9%**	24.1%**	13.0%**
Maryland	70.5%	15.1%	14.4%
Massachusetts	62.0%	18.7%	19.3%
Michigan	67.0%	20.9%	12.0%
Minnesota	61.0%	25.2%	13.8%
Mississippi	78.0%	16.3%	5.7%
Missouri	73.4%	19.5%	7.1%**
Montana	69.2%**	24.4%**	6.3%**
Nebraska	72.9%**	21.5%**	5.6%**
Nevada	70.3%	23.1%	6.5%
New Hampshire	54.8%**	29.1%**	16.1%**
New Jersey	60.5%	24.1%	15.5%
New Mexico	79.6%	14.5%	5.9%
New York	69.2%	21.3%	9.5%
North Carolina	77.4%	16.7%	6.0%
North Dakota	73.9%**	18.3%**	7.8%**
Ohio	70.7%	19.4%	9.9%
Oklahoma	68.2%	24.1%	7.7%
Oregon	69.6%	22.9%	7.4%**
Pennsylvania	76.9%	16.5%	6.5%
Rhode Island	63.9%**	18.2%**	17.9%**
South Carolina	72.7%	20.2%	7.1%**
South Dakota	64.7%**	25.6%**	9.6%**
Tennessee	76.9%	16.3%	6.8%**
Texas	75.1%	19.0%	5.9%
Utah	64.7%	23.2%	12.1%
Vermont	42.4%**	33.6%**	24.0%**
Virginia	70.5%	19.0%	10.5%
Washington	63.4%	21.1%	15.5%
West Virginia	68.2%**	24.2%**	7.6%**
Wisconsin	71.3%	19.9%	8.7%**
Wyoming	53.2%**	32.9%**	14.0%**
U.S.*	70.8%	20.7%	8.5%

Source: Analysis conducted by Mark Merlis for Families USA based on the Census Bureau's most recent Current Population Survey. Numbers may not add due to rounding.

* The national rate is based on 2005 data only.

** Numbers should be read with caution, as sample sizes in these states are very small.

Table 4

Uninsured Children in One- and Two-Parent Families, 2005

	Number of Uninsured Children	As Percent of Uninsured Children Living with a Parent
Family Composition		
Two-parent families	4,573,220	59.0%
Single-parent families	3,178,000	41.0%
Family Composition and Working Status		
Two parents, both working	2,325,366	30.0%
Two parents, one working	2,131,586	27.5%
Single parent working	2,395,127	30.9%
No parents working	906,893	11.7%

Source: Analysis conducted by Mark Merlis for Families USA based on the Census Bureau's most recent Current Population Survey. Note that this table excludes uninsured children who did not live with a parent in 2005. Numbers may not add due to rounding.

■ Race and Ethnicity of Uninsured Children

- Hispanic and black, non-Hispanic children are disproportionately represented among the ranks of the uninsured. More than 22 percent of Hispanic children and about 13 percent of black, non-Hispanic children are uninsured, compared to 7.5 percent of white, non-Hispanic children (Table 5).
- However, many white, non-Hispanic children (3.4 million) are also uninsured (Table 5).

Table 5

Race and Ethnicity of Uninsured Children, 2005

Race and Ethnicity	Number of Uninsured Children	Percent of Children In Racial/Ethnic Group Who Are Uninsured	Percent of All Uninsured Children By Race and Ethnicity
White, non-Hispanic	3,415,389	7.5%	37.8%
Black, non-Hispanic	1,472,773	12.9%	16.3%
Hispanic	3,460,566	22.4%	38.3%
Other*	686,692	12.1%	7.6%
Total	9,035,420	11.6%	100.0%

Source: Analysis conducted by Mark Merlis for Families USA based on the Census Bureau's most recent Current Population Survey.

* Other is defined as children whose parent or guardian does not identify the child as black, non-Hispanic; Hispanic; or white, non-Hispanic; as well as children whose parent or guardian identifies the child as a person of multiple ethnicities or races.

■ Age of Uninsured Children

- Children of all ages are uninsured, but the likelihood of being uninsured is highest for children ages 13-18. Nearly 14 percent of children in this age group are uninsured, and nearly two out of five uninsured children fall in this age group (Table 6).
- Still, 10.3 percent of children ages 6-12 and 10.8 percent of children ages 0-5 are uninsured (Table 6).

Table 6

Uninsured Children by Age, 2005

Age	Number Uninsured	Percent of Age Group Uninsured	As Percent of All Uninsured Children
0-5	2,623,360	10.8%	29.0%
6-12	2,847,701	10.3%	31.5%
13-18	3,564,360	13.8%	39.4%
Total	9,035,420	11.6%	100.0%

Source: Analysis conducted by Mark Merlis for Families USA based on the Census Bureau's most recent Current Population Survey. Numbers may not add due to rounding.

Uninsured Children Get Less Medically Necessary Care

■ Less Contact with Doctors

- The likelihood of *not* having seen a doctor in the past year is more than three times greater for uninsured children than it is for insured children (Table 7 and Figure 1).
- Less than half (46 percent) of uninsured children had a well-child visit in the last year, compared to nearly three-quarters of insured children (Table 7 and Figure 1).

■ Less Likely to Have a Usual Source of Care

- Uninsured children are more than 13 times as likely to lack a usual source of care (Table 7 and Figure 1).

■ More Likely to Have Unmet Needs for Care

- Overall, uninsured children are nearly five times more likely than insured children to have at least one delayed or unmet health care need (Table 7).
- Uninsured children are five times more likely than insured children to have an unmet dental need (Table 7 and Figure 1).

- Uninsured children are five times more likely than insured children to have an unmet vision care need (Table 7 and Figure 1).
- Uninsured children are nearly four times more likely than insured children to have an unmet need for prescription drugs (Table 7).
- Uninsured children are more than three times as likely as insured children to have an unmet need for mental health services (Table 7).
- Uninsured children are more than nine times as likely as insured children to have any other type of delayed care or unmet medical need (Table 7).

Table 7

Access to Health Care and Unmet Health Care Needs among Children, 2005*

	Children Insured A Year Or More	Children Uninsured A Year Or More
Doctor Visits in the Past Year		
0 visits	9.9%	31.1%
1 or more visits	90.1%	68.9%
Had at Least One Well-Child Visit in the Past Year		
Yes	74.0%	46.4%
No	26.0%	53.6%
Have a Usual Source of Care		
Yes	97.5%	67.0%
No	2.3%	30.3%
Delayed or Unmet Needs in the Past Year Due to Cost**	7.2%	34.7%
Unmet Dental Need	1.9%	10.0%
Unmet Vision Need	4.6%	23.3%
Unmet Prescription Need	1.5%	5.6%
Unmet Mental Health Need	0.6%	1.9%
Any Other Delayed or Unmet Medical Need	2.1%	20.0%

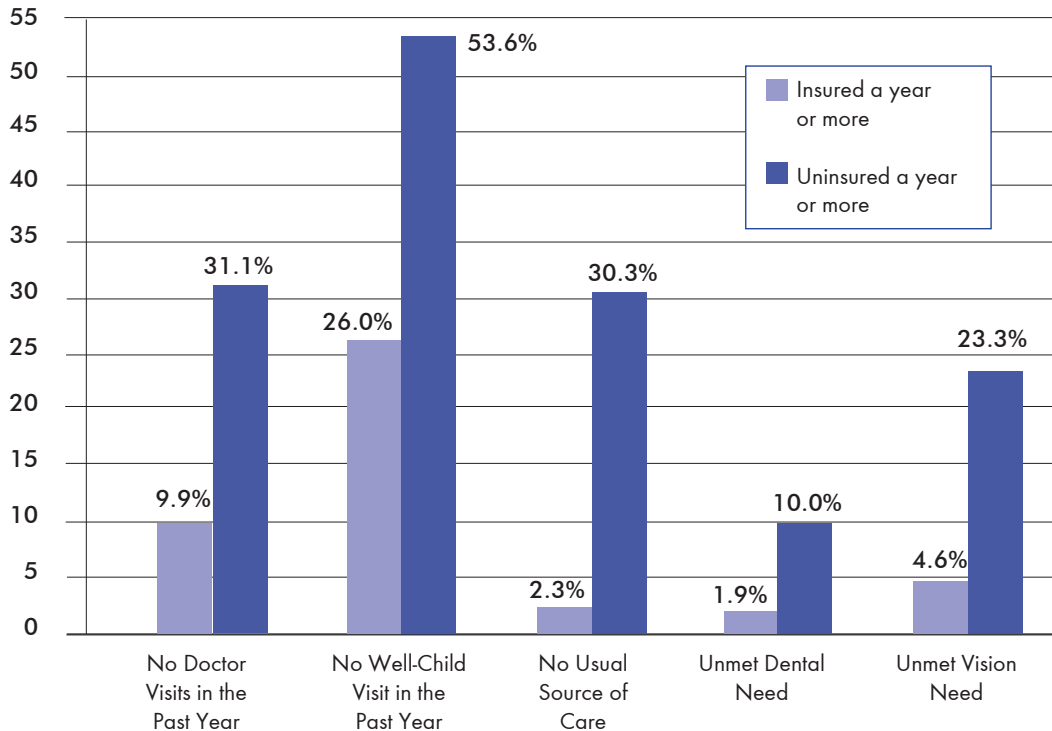
Source: Analysis conducted by the Urban Institute for Families USA based on the 2005 National Health Interview Survey. Numbers may not add due to rounding.

* Sample includes children ages 2-17 only.

** Delayed or unmet needs include medical, dental, vision, prescription, mental health, and any other medical needs.

Note: Numbers in Figure 1 are from this table.

Figure 1

Unmet Health Care Needs among Insured and Uninsured Children, 2005

DISCUSSION

According to the Census Bureau, more than 9 million children were uninsured in 2005. Below, we discuss who these children are and explore the effects of being uninsured on children's use of, and unmet needs for, health care services. We also examine variations in uninsured rates across the 50 states and the District of Columbia. We look at the differences in unmet health care needs between children who were uninsured for a full year and children with coverage gaps of less than a year. Finally, we look at how these differences in unmet health care needs are exacerbated among children in poorer health.

Uninsured Children Come from Working Families

The overwhelming majority of uninsured children live with one or more parents who work. As Table 2 shows, 88.3 percent of uninsured children living with a parent are in households where at least one parent works. In fact, of the 70 percent of uninsured children who live with a parent, at least one person works full-time.⁷ This trend holds true at the state level, as well (Table 2). The majority of uninsured children in every state

and the District of Columbia live in working families, and about half of the uninsured children in any given state live in households with a full-time, year-round worker.

These families are part of the workforce but are struggling to make ends meet. Many have low-wage jobs that typically do not offer health insurance, or those jobs offer expensive family coverage that low-income families cannot afford. Since 2000, the percentage of firms offering health benefits has declined from 69 percent to 60 percent. And since 1999, the average amount that workers pay each month for employer-based family coverage has increased by more than 75 percent, from \$129 to \$226.⁸ The rising cost of employer-based coverage places it out of financial reach for many working families; between 2000 and 2004, the proportion of children covered by a parent's employer-based coverage declined from 64.2 percent to 60.1 percent.⁹ The decline is even more pronounced among low-income children with family incomes between one and two times the poverty level. The percentage of these children covered by employer-based coverage declined from 49.5 percent in 2000 to 41.6 percent in 2004.¹⁰

State Variation in Uninsured Rates

At the state level, the rate of children without health insurance is the product of many factors, including the state's eligibility criteria for Medicaid and SCHIP, its enrollment policies for these programs, and its economy. While it is impossible to precisely explain the variation among states, there are certain circumstances and policies that cause some states to have higher uninsured rates than others. For example, of the 13 states with Medicaid or SCHIP eligibility levels that were higher than twice the poverty level in 2005, all but three had uninsured rates for children that were below the national average.¹¹ On the other hand, all of the states that require families to pass an asset test to be eligible for children's coverage rank near the bottom of coverage rates among all states, and all have uninsured rates of 11 percent or higher.

Instead of creating barriers to coverage (like asset tests and low eligibility levels), many states have simplified the enrollment/renewal process to make it easier for children to get coverage and keep it. For example, many states have done one or more of the following:

- created combined applications and renewal forms for Medicaid and SCHIP;
- instituted 12-month continuous eligibility (which allows children enrolled in Medicaid or SCHIP to remain enrolled for 12 months at a time regardless of occasional changes in family circumstances that could affect eligibility, such as income);

- instituted presumptive eligibility (which allows children to be “presumed” eligible for Medicaid or SCHIP temporarily if their family income is below state eligibility levels, so that the child can receive services while a full application is pending);
- eliminated the types of verification that must be presented when a child applies for coverage (states can eliminate requirements for verification of income, residency, and age); and
- created “family applications” that families can use to apply for coverage for both the children and the adults in the family (consistent with research that has shown that children whose parents have health insurance are more likely to have coverage themselves¹²).

Aside from these policy enhancements, other factors that can cause changes in enrollment in public programs (and hence changes in the uninsured rate) are changes in premiums and other out-of-pocket costs, as well as enrollment freezes (which bar any new children from enrolling) in SCHIP.

- Increases in premiums or cost-sharing can make coverage unaffordable. Families of existing enrollees may drop coverage, and families of uninsured, eligible children can be deterred from enrolling.
- States have enacted enrollment freezes (allowed in SCHIP, but not in Medicaid) to reduce program costs in the past. This shuts out children who are eligible but not enrolled.

Many Uninsured Children Are Eligible for Medicaid or SCHIP

The majority (68 percent) of uninsured children are eligible for Medicaid or SCHIP¹³ because they are in families with low incomes. Even though most uninsured children are in working families, 70.8 percent come from families with incomes no higher than two times the federal poverty level, or \$33,200 a year for a family of three in 2006 (Table 3).¹⁴ And while eligibility levels vary by state, all but nine states cover children with family incomes up to two times poverty. In addition, some children in families with higher incomes are eligible for coverage: 13 states had Medicaid or SCHIP eligibility levels for children above two times poverty in 2005.

Low-income workers are less likely to be offered health insurance through their jobs. And even if low-income workers are offered employer-based coverage, the price

tag is often much too high. The average cost of employer-based family coverage would consume 16 percent or more of monthly income for families with modest incomes, whose budgets are already stretched to pay for housing, transportation, food, childcare, and other household expenses.

In order to ensure that the continued erosion of employer-based coverage does not affect children in a significant way, it is important to protect and bolster Medicaid and SCHIP. Of all the different groups of people served by these programs, children are the least expensive to cover, and they stand to gain a tremendous amount from obtaining health coverage. In addition to health benefits like higher immunization rates, a greater likelihood of having a usual source of care, and a greater likelihood of having a well-child visit, insuring children has also been shown to reduce racial and ethnic disparities, promote social and emotional development, and help children do better in school.¹⁵ Medicaid and SCHIP are particularly important sources of coverage for children from low-income families. Although the children who are eligible for but not yet enrolled in these programs can be difficult to reach, with effective enrollment strategies, they could be covered.

Children of All Races and Ethnicities Lack Health Insurance

Census Bureau data show that, while children of all races and ethnicities are uninsured, black, non-Hispanic and Hispanic children are disproportionately represented among the uninsured. Nearly one in eight black, non-Hispanic children and more than one in five Hispanic children lack health insurance, compared to the average of one in nine for all uninsured children (Table 5). Looking at it from a different perspective, Hispanic children comprise the largest proportion of uninsured children, at 38.3 percent. They are followed by white, non-Hispanic children (37.8 percent) and black, non-Hispanic children (16.3 percent).

Covering more uninsured children would go a long way toward combating racial disparities in health care. With health coverage, these children would be more likely to visit a doctor regularly and would have fewer unmet health care needs.

Being Uninsured Increases the Likelihood of Having an Unmet Health Care Need

Our second data source, the 2005 National Health Interview Survey, provides important insight into *why it matters* that more than 9 million children are uninsured. It identifies clear deficiencies in the health care experiences of uninsured children compared to children who are insured. These results, shown in Table 7 and in Figure 1, support previous research that

has found that children with insurance are more likely to have a usual source of health care and access to preventive care and less likely to have unmet health care needs.¹⁶

Having a usual source of care—a medical provider one routinely visits for primary care—is very important for children and parents. It ensures that children are seen by someone familiar with their medical history. It also allows families to develop a comfort level with their particular provider so that they can consult the provider with any questions they may have and catch problems early. Children with a usual source of care are more likely to be up-to-date with their immunizations.¹⁷ Having a usual source of care has also been associated with better health and reduced health disparities.¹⁸ This is why it is especially troubling that children who were *uninsured* for a year or more were 13 times more likely to be without a usual source of care than children who were *insured* for a year or more (Table 7 and Figure 1).

Without coverage, many children make it to the doctor only when something urgent is needed (for example, if the child has a fever or an injury that demands immediate attention) and miss out on the benefits of ongoing well-child care. This is supported by the finding that more than half of children who were uninsured for a year or more had not had a well-child visit in the past year, compared to only about one-quarter of children who were insured for a year or more. Well-child care includes basic services such as immunizations, hearing and vision screenings, and monitoring growth and development. Without adequate preventive care, a child's health is at risk. Problems that could be prevented, or detected early and corrected, can escalate into serious health problems that affect whether the child can attend school regularly, participate in physical recreation activities with other children, or develop appropriate social and emotional skills for his or her age.

Another consequence of being uninsured is delaying seeking care for medical needs—or never getting these needs met at all. Our analysis found significant differences between insured and long-term 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. More than 34 percent of children who were uninsured for a year or more had at least one delayed or unmet medical need in the past year, compared to only 7 percent of children who were insured for a year or more. While having health insurance does not guarantee access to health care services, these findings certainly show that having insurance makes a significant difference in families' abilities to overcome cost barriers and meet basic health care needs.

How Does Being Uninsured Affect Children?

In the past year...

- 1.91 million uninsured children didn't have a doctor's visit.
- 3.29 million uninsured children didn't get a well-child visit.
- 610,000 uninsured children had an unmet dental need.
- 1.43 million uninsured children had an unmet vision care need.
- 340,000 uninsured children had an unmet need for prescription drugs.
- 110,000 uninsured children had an unmet need for mental health care.

Source: This analysis was conducted by the Urban Institute for Families USA based on the 2005 National Health Interview Survey. The numbers are weighted averages for children ages 2-17 who have been uninsured for a year or more. See Appendix Table 1 on page 25.

The Longer a Child Is Uninsured, the Greater the Negative Impact

The middle column in Appendix Table 1 on page 25 refers to children who had a gap in health insurance coverage in the past 12 months. These children were uninsured for part, but not all, of the year. Comparing these children to those who were insured a year or more demonstrates clearly the difference that even a small gap in coverage can make. When it comes to delayed care and unmet needs, these children did as poorly as, or worse than, children who were uninsured for a year or more. Compared to children who were insured a year or more, children who were uninsured part of the year:

- nearly nine times as likely to have a delayed or unmet medical need;
- nearly six times as likely to have an unmet dental need;
- nearly five times as likely to have an unmet vision need;
- more than five times as likely to have an unmet need for prescription drugs; and
- eight-and-a-half times as likely to have an unmet mental health need.

Having even brief periods of being uninsured—likely due to a parent's job change, a change in income that affects public program eligibility, or cycling on and off public coverage due to problems surrounding the renewal process—has a measurable effect on children. In some cases, children who were uninsured for brief periods had an even greater likelihood of delaying care or having unmet needs than children who were uninsured for a year or more. Parents may delay care while they are looking for other coverage for

their child, or families with newly uninsured children might not be as familiar with the safety net providers or clinics in their community that will treat their children. When children are uninsured for longer periods of time, some families may adapt and find these types of providers. It is essential that renewal policies for public programs be as simple as possible and that children be permitted to retain their eligibility status as long as possible. Twelve months of continuous eligibility for a program can clearly make a big difference in whether or not the child's health care needs are met.

Differences between Insured and Uninsured Children Are Exacerbated for Children in the Three Lowest Health Status Categories

The National Health Interview Survey asks interviewees (a parent or guardian in the case of children) to rank the child's health status according to the following five categories: excellent, very good, good, fair, or poor. The sample of children with health status in the fair and poor categories was too small to permit statistically reliable comparisons between these children by insurance status. However, it is important to note that parents may hesitate to rank their child's health as fair or poor, even though the child may have some chronic health problems (such as asthma or allergies) that need consistent health care. In view of this fact and of the sample size limitations, we opted to look at children in the lowest three health status categories: good, fair, and poor (Table 8). Although differences would have been even more pronounced if we could have isolated just those children in fair and poor health, there were significant disparities between insured and uninsured children even when looking at children in the three lowest health status categories.

Compared to *insured* children in the lowest three health status categories, these *uninsured* children were:

- more than 11 times as likely to lack a usual source of care;
- more than twice as likely not to have had a well-child visit in the last year;
- nearly eight times as likely to have a delayed or unmet medical need;
- three-and-a-half times as likely to have an unmet dental need;
- more than four times as likely to have an unmet vision care need;
- more than three times as likely to have an unmet need for prescription drugs; and
- two-and-a-half times as likely to have an unmet need for mental health services.

As a whole, children in the lowest health status categories have greater unmet health care needs than the sample of all children. These uninsured children would benefit even more from having insurance, and conversely, are harmed even more due to their lack of it.

Table 8

Access to Health Care and Unmet Health Care Needs among Children in Good, Fair, and Poor Health, 2005*

	Children Insured A Year Or More	Children Uninsured A Year Or More
Doctor Visits in the Past Year		
0 visits	8.6%	31.4%
1 or more visits	91.4%	68.6%
Had at Least One Well-Child Visit in the Past Year		
Yes	73.6%	40.7%
No	26.4%	59.3%
Have a Usual Source of Care		
Yes	96.6%	63.3%
No	2.9%	33.5%
Delayed or Unmet Needs in the Past Year Due to Cost**	12.4%	45.4%
Unmet Dental Need	4.5%	16.1%
Unmet Vision Need	7.3%	30.1%
Unmet Prescription Need	2.8%	9.1%
Unmet Mental Health Need	1.2%	3.1%
Any Other Delayed or Unmet Medical Need	3.7%	29.1%

Source: Analysis conducted by the Urban Institute for Families USA based on the 2005 National Health Interview Survey.

* Sample includes children ages 2-17 only.

** Delayed or unmet needs include medical, dental, vision, prescription, mental health, and any other medical needs.

CONCLUSION

This report shows that a large number of children in the United States remain uninsured, and these children are paying a steep price—they are going without the health care they need. These children's chances of succeeding in school, in the workforce, and in life are jeopardized by the delayed care and unmet needs they experience during their developmental years. Fortunately, Medicaid and SCHIP provide affordable coverage with benefit packages that meet the needs of low-income children, and approximately two-thirds of uninsured children are eligible for these programs. Ensuring that Medicaid and SCHIP can continue to meet the needs of the millions of children who rely on them, and enrolling children who are eligible but not enrolled, will require additional financial support for outreach and enrollment efforts and for the coverage itself.

Failure to ensure that all children in this country have health coverage is shortsighted and harmful. Children are the future of this country, and the policy choices the nation makes now can have long-term effects on who today's children grow up to be. At the very least, we must ensure that each child gets the best possible start, which includes high-quality, affordable health coverage.

ENDNOTES

¹ Carmen DeNavas-Walt, Bernadette Proctor, and Cheryl Hill Lee, "Income, Poverty, and Health Insurance Coverage in the United States: 2005," *Current Population Reports*, P60-231 (Washington: U.S. Census Bureau, August 2006).

² Current Population Survey data analyzed by the U.S. Census Bureau are cited for the child uninsurance rate trends (see endnote 1). These data are for single years only and include children ages 0-17. Families USA's analysis of the Current Population Survey uses a three-year merge (2003, 2004, and 2005) to generate accurate state-level estimates, and 2005 data only for national estimates. Our analysis also includes children ages 0-18. For these reasons, Families USA's estimates regarding uninsured children differ somewhat from those produced by the U.S. Census Bureau.

³ In the comparisons of children by family composition, as well as the comparisons by both family composition and working status (Tables 2 and 4), the universe of uninsured children excludes those uninsured children who did not live with a parent. These children may live with a grandparent or other relative, an unrelated caregiver, or on their own. Although the majority of uninsured children (86 percent) live with a parent, a relatively large group (14 percent) does not. Children who do not live with a parent are more likely to be uninsured for a variety of reasons—when children are living with a grandparent or other relative, they are not eligible to enroll in the relative's employment-based coverage, and older children who live on their own are unlikely to be employed in positions that offer employer-based coverage.

⁴ Detailed tables are available upon request from Families USA.

⁵ Detailed tables are available upon request from Families USA.

⁶ The poverty level income for a family of three in 2006 is \$16,600 for the 48 contiguous states and the District of Columbia, \$19,090 for Hawaii, and \$20,750 for Alaska. Currency figures represent annual income for a family of three in 2006. "U.S. Department of Health and Human Services: 2006 Federal Poverty Guidelines," *Federal Register*, Vol. 71, No. 15, January 24, 2006, pp. 3,848-3,849.

⁷ Detailed tables are available upon request from Families USA.

⁸ The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2005 Annual Survey* (Menlo Park, CA: The Kaiser Family Foundation, 2005).

⁹ Arinjadrit Dube, Ken Jacobs, Sara Muller, Bob Brownstein, and Phaedra Ellis-Lamkins, *Kids at Risk: Declining Employer-Based Health Coverage in California and the United States: A Crisis for Working Families* (Berkeley: UC Berkeley Center for Labor Research and Education and Working Partnerships USA, August 2005).

¹⁰ Ibid.

¹¹ Eligibility levels are from Donna Cohen Ross and Laura Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Washington: Kaiser Commission on Medicaid and the Uninsured, October 2005), available online at <http://www.kff.org/medicaid/7393.cfm>.

¹² Lisa Dubay and Genevieve Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid," *Health Services Research*, Vol. 38, No. 5, October 2003.

¹³ Unpublished data presented by Lisa Dubay of the Urban Institute at the Georgetown Center for Children and Families conference "Too Close to Turn Back: Strategies for Moving Forward on Children's Coverage," July 20-21, 2006. Data are based on economic modeling using the March 2005 Current Population Survey and July 2004 eligibility rules.

¹⁴ See endnote 3.

¹⁵ Families USA, *Why Health Insurance Matters for Children* (Washington: Campaign for Children's Health Care, July 2006), available online at <http://www.childrenshealthcampaign.org/assets/pdf/Kids-Why-Insurance-Matters.pdf>.

¹⁶ Ibid.

¹⁷ Philip J. Smith, Jeanne M. Santoli, Susan Y. Chu, Dianne Q. Ochoa, and Lance E. Rodewald, "The Association Between Having a Medical Home and Vaccination Coverage Among Children Eligible for the Vaccines for Children Program," *Pediatrics*, Vol. 116, No. 1, July 2005.

¹⁸ Barbara Starfield and Leiyu Shuh, "The Medical Home, Access to Care, and Insurance: A Review of the Evidence," *Pediatrics*, Vol. 113, No. 5, May 2004.

TECHNICAL APPENDIX: METHODOLGY AND TABLES

Current Population Survey Methodology prepared by:

Mark Merlis, Consultant

National Health Interview Survey Methodology prepared by:

The Urban Institute

TECHNICAL APPENDIX:

METHODOLOGY AND TABLES

Current Population Survey

Estimates in this report are based on data collected in the Annual Social and Economic (ASEC) Supplement to the Current Population Survey (CPS) for 2003 through 2005. (The ASEC was previously known as the March supplement.) The CPS is a monthly survey of a household sample of the civilian noninstitutionalized population conducted by the Census Bureau. Questions asked in the ASEC about income, health insurance coverage, and employment reflect experiences during the preceding calendar year. Thus, the estimates in this report are for calendar years 2003 through 2005. For state-level estimates, three-year averages were used in order to improve reliability. The national estimates reflect data for 2005 only.

■ Insurance

For each household member, the ASEC asks whether the person had any of several forms of health coverage at any time during the year. Some people report multiple sources of coverage during the year, either because they had two sources at the same time, or because they changed sources over time. These people are assigned to a single source using the following hierarchy: Medicaid or SCHIP, employer-sponsored insurance, other public coverage (such as Medicare or TRICARE), and other private coverage. This report follows the Census Bureau in not counting reported coverage by the Indian Health Service as insurance.

■ Defining Families

ASEC defines a family as a single person living alone or two or more people living together and related by marriage, birth, or adoption. This report reconstructs families into “insurance units” consisting of spouses and children under age 19 who are living with them. (Unmarried partners of identified parents are not treated as part of the same unit.) This grouping of family members is closer to the grouping under Medicaid and SCHIP rules than it is to the grouping used by private insurers (who would exclude 18-year-olds but include children up to age 23 if they were full-time students). Note that a substantial number of uninsured children do not live with a parent; these include

children living with another relative or guardian, foster children, and older children no longer living at home. (However, college students temporarily living away from home are counted as living with their parents.) These children are excluded from the tables reflecting characteristics of parents.

■ **Poverty**

To establish family income as a percent of poverty, income for all members of the insurance unit was totalled and compared to the federal poverty guidelines established by the Department of Health and Human Services (HHS) for each year. These guidelines are not identical to the poverty thresholds used by the Census Bureau, and the estimates here therefore differ slightly from published CPS figures.

■ **Employment**

“Full-time” workers are full-time, full-year workers, defined by the Census Bureau as working at least 35 hours per week for at least 50 weeks during the year. “Part-time” workers worked fewer hours, fewer weeks, or both.

National Health Interview Survey

■ **Data Source and Sample**

This analysis uses the 2005 National Health Interview Survey (NHIS). The NHIS is a continuous, in-person, household survey sponsored by the National Center for Health Statistics (NCHS). The 2005 sample included 38,509 households, which yielded responses from 98,649 people in 39,284 families. After weighting, the sample is nationally representative of the civilian, noninstitutionalized U.S. population. The NHIS collects information on demographic characteristics, family income, insurance coverage, health status, access to care, and use of health care services. More detailed questions about access to care, use of services, and the presence of acute and chronic health conditions are asked about a sample child in each family. A knowledgeable adult serves as the respondent for minor children.* The sample size of the 2005 NHIS is 12,523 children. Data were analyzed for children ages 2 to 17 years on the 2005 NHIS sample child file.

■ **Identifying Children with and without Health Insurance**

The NHIS collects information on a person’s health insurance at the time of the survey, asking whether he or she had any of a variety of public or private insurance plans or were without insurance other than plans that covered only a single service.

Children without any general medical insurance coverage at the time of the interview were considered uninsured. Any general medical insurance included private health insurance (from an employer or workplace, purchased directly, or through a state, local government, or community program), Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), a state-sponsored health plan, other government programs, or military health plan (including VA, TRICARE, CHAMPUS, and CHAMP-VA). As indicated below, three insurance variables were created based on information about the child's insurance status at the time of the survey and about their coverage during the prior 12-month period.

■ Access Measures

The analysis focuses on several measures of access to and use of health care. These measures, which are described below, are based on responses to questions on the NHIS.

- Number of doctor visits in the past year: The NHIS collects information on how many times a child has visited a doctor or other health care professional in the past year.
- Child visited a hospital emergency room: The NHIS asks whether a child has gone to a hospital emergency room about his/her health in the past year.
- Child did not receive a well-child visit in the past year: The NHIS collects information on whether the child had a checkup in the past year.
- Child lacks a usual source of care (USOC), or the USOC is an emergency department: The NHIS captures whether a child is reported to have a usual source of health care when he or she is sick, as well as the type of provider. The various types of USOC providers reported on the NHIS were grouped to create indicators for private (physician office, HMO), public (clinic or hospital outpatient department), and other settings (hospital emergency department, other).
- Reported delay in receiving care or unmet need for care in the past year due to cost: The NHIS collects information on whether medical care was delayed due to cost and whether needed medical care, prescription drugs, mental health care, vision care, or dental care were forgone entirely due to cost.** An unmet medical care need is defined broadly, encompassing both delays in seeking care and needed medical care forgone.

■ Analysis

Limiting the analytic sample to children ages 2-17 was done for two reasons. The first reason is that insurance status in this analysis is based on a child's previous year's insurance coverage. The second reason is that unmet need questions pertaining to unmet dental, vision, and mental health needs are asked only of children aged 2 and older. Therefore, the analytic sample is limited to children ages 2-17 to ensure that the analysis is conducted over a set of data that includes complete information on all its observations.

The access measures discussed above are presented in Appendix Table 1 according to the child's health insurance coverage. Appendix Table 2 presents these same measures for children in good, fair, or poor health according to the child's health insurance coverage status. Children are categorized in one of the three following mutually exclusive insurance categories: 1) insured for a full year up to the time of the survey; 2) uninsured for some, but not all, of the 12-month period before the survey; and 3) uninsured for the entire year prior to the survey up to the time of the survey. In addition to presenting access to health care by health insurance coverage for all children, we analyzed a subset of children who were reported to be in fair, poor, or good health.

Estimates are based on sample proportions that are weighted to national totals. The comparisons are made using Stata software and conventional t-tests, taking into account the complex sample design of the NHIS. While the estimates presented here do not control for observed and unobserved differences in the characteristics of the children in the three insurance status categories, which could also affect the access and use measures, other research indicates that access differentials persist when such adjustments are made.

* As with any household survey, the information captured in the NHIS is self-reported and may be subject to reporting errors.

** NHIS questions pertaining to unmet dental, vision, and mental health needs are asked only for children ages 2 and older, which is why the analysis focuses on children ages 2-17.

Appendix Table 1

Access to Health Care among Children Ages 2-17 with and without Health Insurance, 2005

Indicator	Children Insured A Year Or More		Children Uninsured Part of The Year		Children Uninsured A Year Or More	
Number (in millions) Sample Size	54.16 8,954		2.42 411		6.14 1,203	
	Percent	Weighted Number (millions)	Percent	Weighted Number (millions)	Percent	Weighted Number (millions)
Doctor Visits in the Past Year						
0 visits	9.9%	5.36	9.3%	0.22	31.1%*	1.91
1 or more visits	90.1%	48.80	90.7%	2.20	68.9%*	4.23
Among children with 1 or more visits						
1 visit	25.8%	12.60	23.3%	0.51	41.1%*	1.74
2-3 visits	41.6%	20.32	42.7%	0.94	38.1%	1.61
4-5 visits	16.6%	8.11	17.8%	0.39	11.0%*	0.47
6 or more visits	15.9%	7.77	16.2%	0.36	9.7%*	0.41
Emergency Room Visit in the Past Year	19.6%	10.61	25.6%*	0.62	17.3%	1.06
Had at Least One Well-Child Visit in the Past Year						
Yes	74.0%	40.07	68.8%*	1.66	46.4%*	2.85
No	26.0%	14.09	31.2%*	0.76	53.6%*	3.29
Have a Usual Source of Care						
Yes	97.5%	52.80	92.7%*	2.24	67.0%*	4.12
No	2.3%	1.23	6.6%*	0.16	30.3%*	1.86
Among children with a usual source of care						
Type of usual source of care:						
Private	80.2%	42.33	77.0%	1.73	59.2%*	2.44
Clinic/hospital outpatient department	19.5%	10.32	23.0%	.52	40.1%*	1.65
Delayed or Unmet Need in the Past Year Due to Cost						
Delayed or Unmet Medical Need						
Yes	2.1%	0.99	18.0%*	0.37	20.0%*	1.09
No	97.9%	53.18	82.0%*	2.05	80.0%*	5.05
Unmet Dental Need						
Yes	1.9%	1.00	11.0%*	0.27	10.0%*	0.61
No	98.1%	53.16	89.0%*	2.15	90.0%*	5.53
Unmet Vision Need						
Yes	4.6%	2.52	22.9%*	0.55	23.3%*	1.43
No	95.4%	51.64	77.1%*	1.87	76.7%*	4.71
Unmet Prescription Need						
Yes	1.5%	0.83	7.8%*	0.19	5.6%*	0.34
No	98.5%	53.33	92.2%*	2.23	94.4%*	5.80
Unmet Mental Health Need						
Yes	0.6%	0.32	5.1%*	0.12	1.9%*	0.11
No	99.4%	53.84	94.9%*	2.30	98.1%*	6.03
Any Delayed or Unmet Need**						
Yes	7.2%	3.89	35.8%*	0.87	34.7%*	2.13
No	92.8%	50.27	64.2%*	1.55	65.3%*	4.01

Source: Analysis conducted by the Urban Institute for Families USA based on the 2005 National Health Interview Survey.

* Estimates are significantly different from children insured throughout the past year at $p \leq .05$.

** Any delayed or unmet need includes medical, dental, vision, prescription, mental health, and any other medical needs.

Appendix Table 2

Access to Health Care among Children Ages 2-17 in Good, Fair, or Poor Health by Insurance Status, 2005

Indicator	Children Insured A Year Or More		Children Uninsured Part of The Year		Children Uninsured A Year Or More	
Number (in millions) Sample Size	9.25 1,904		0.56 119		1.45 340	
	Percent	Weighted Number (millions)	Percent	Weighted Number (millions)	Percent	Weighted Number (millions)
Doctor Visits in the Past Year						
0 visits	8.6%	0.79	8.5%	0.05	31.4% *	0.45
1 or more visits	91.4%	8.46	91.5%	0.51	68.6% *	0.99
Among children with 1 or more visits						
1 visit	22.2%	1.88	12.5% *	0.06	36.1% *	0.36
2-3 visits	33.4%	2.82	32.1%	0.16	38.4%	0.38
4-5 visits	17.0%	1.43	21.0%	0.11	11.9%	0.12
6 or more visits	27.4%	2.32	34.4%	0.18	13.6%	0.13
Emergency Room Visit in the Past Year	26.9%	2.49	37.4%	0.21	19.8% *	0.29
Had at Least One Well-Child Visit in the Past Year						
Yes	73.6%	6.81	75.7%	0.42	40.7% *	0.59
No	26.4%	2.44	24.3%	0.14	59.3% *	0.86
Have a Usual Source of Care						
Yes	96.6%	8.94	94.1%	0.53	63.3% *	0.92
No	2.9%	0.27	4.7%	0.03	33.5% *	0.48
Among children with a usual source of care						
Type of usual source of care:						
Private	72.8%	6.50	71.6%	0.38	49.1% *	0.45
Clinic/hospital outpatient department	26.8%	2.40	28.4%	0.15	50.8% *	0.46
Delayed or Unmet Need in the Past Year Due to Cost						
Delayed or Unmet Medical Need						
Yes	3.7%	0.34	18.4% *	0.10	29.1% *	0.42
No	96.3%	8.91	81.6% *	0.46	70.9% *	1.03
Unmet Dental Need						
Yes	4.5%	0.42	17.4% *	0.10	16.1% *	0.23
No	95.5%	8.83	82.6% *	0.46	83.9% *	1.21
Unmet Vision Need						
Yes	7.3%	0.68	23.0% *	0.13	30.1% *	0.44
No	92.7%	8.57	77.0% *	0.43	69.9% *	1.01
Unmet Prescription Need						
Yes	2.8%	0.26	10.5% *	0.06	9.1% *	0.13
No	97.2%	8.99	89.5% *	0.50	90.9% *	1.32
Unmet Mental Health Need						
Yes	1.2%	0.12	4.1%	0.02	3.1% *	0.04
No	98.8%	9.13	95.9%	0.54	96.9% *	1.40
Any Delayed or Unmet Need**						
Yes	12.4%	1.15	36.9% *	0.21	45.4% *	0.66
No	87.6%	8.10	63.1% *	0.35	54.6% *	0.79

Source: Analysis conducted by the Urban Institute for Families USA based on the 2005 National Health Interview Survey.

* Estimates are significantly different from children insured throughout the past year at $p \leq .05$.

** Any delayed or unmet need includes medical, dental, vision, prescription, mental health, and any other medical needs.

CREDITS

This report was written by:

Jennifer Sullivan, Health Policy Analyst

Families USA

*The following Families USA staff contributed to the
preparation of this report:*

Ron Pollack, Executive Director

Kathleen Stoll, Director of Health Policy

Peggy Denker, Director of Publications

Ingrid VanTuinen, Writer-Editor

Jenelle Partelow, Editorial Associate

Nancy Magill, Design/Production Coordinator



The Campaign for Children's Health Care is dedicated to making high-quality, affordable health insurance coverage for all of America's children a top national priority. We are a diverse group of organizations who represent health care providers, educators, parents, advocates, and others, all of whom share a commitment to our nation's children. The Campaign coordinates public education efforts across the country to demonstrate the importance of health insurance for children and families and to show why national action is needed to expand coverage for children.

More than 9 million children lack health insurance in the United States, the wealthiest nation in the world, and millions more are underinsured. Investing in children's health returns innumerable benefits, including improved development and health outcomes for children, improved school performance, and long-term savings in health care costs. We believe it is time for our leaders to take action.

For more information about the campaign, go to
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