HEALTH INEQUITIES AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The importance of coverage for children with special health care needs

Children with special health care needs (CSHCN), by definition, require more health care services than their typically developing peers. While having health insurance does not guarantee that a child will receive needed care, it is a first step towards accessing it. Because CSHCN require more health care services and may be more vulnerable when they cannot access them, the consequences of uninsurance can be dire. Empirical evidence suggests that uninsured CSHCN are **less likely** than those who are privately insured to have a usual source of care and receive all needed routine and specialty care. Uninsured CSHCN are **more likely** than their privately insured counterparts to have an unmet health or dental care need, report difficulty receiving referrals for and accessing specialists, therapy services, and prescription medications, delay or forgo care, live in families reporting financial problems or where family members reduce or stop working because of the child's health care needs, and report ease of use problems with care.

Some groups of CSHCN are at greater risk for uninsurance

While uninsurance among CSHCN generally is low, several subgroups are less likely to be insured and may be at the greatest risk for adverse health effects associated with uninsurance. Uninsured Hispanic CSHCN are more likely than uninsured white CSHCN to have an unmet need for specialty care. Uninsured black CSHCN are more likely than uninsured white CSHCN to have an unmet need for mental health care. In addition to race/ethnicity, inequities are also observed by socioeconomic status, functional status, age, language, and immigration or documentation status.

Barriers to coverage among eligible but unenrolled children include: stigma and privacy concerns, the complexity of the application/re-enrollment process, distrust in the government and concerns about enrolling in government programs, language barriers, and health literacy issues. Particular barriers exist for immigrant families including: fear of being deemed a "public charge," fear due to undocumented status of parents/other family members, an inability to produce required documentation, multi-state residence of children of migrant workers, the 5-year waiting period for documented immigrants (which some states have lifted for children and/or pregnant women), experiences of bias and discrimination, and lack of eligibility for undocumented children.

Household Income

- CSHCN whose household income is below 200% of the federal poverty level (FPL) (~$47,000 for a family of four) are more likely to have one or more gaps in insurance and are less likely to have coverage.[1]

Race/ethnicity

- Black and Hispanic CSHCN are **more likely** than white CSHCN to be uninsured and **less likely** to have adequate insurance.[2, 3]
- Hispanic CSHCN have seen the most gains in meeting the health insurance core outcome (see insert) between 2001 and 2010, but are still the least likely of any racial/ethnic group to meet the outcome.[4, 5]

Functional Status

- CSHCN with more functional difficulties are **more likely** than those with fewer difficulties to have 1 or more periods without insurance during the year and are **less likely** to have adequate insurance.[2, 5]

What is the health insurance core outcome?

The Maternal and Child Health Bureau (MCHB) outlines six core outcomes to improve the system of care for CSHCN. The Catalyst Center is charged with making progress toward the health insurance core outcome, which states that, "families of CSHCN have adequate private and/or public insurance to pay for the services they need."

For more information:
http://www.childhealthdata.org/docs/cshcn/outcome-3.pdf

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Age

- Older CSHCN are **less likely** than younger CSHCN to meet the health insurance core outcome, with children aged 12-17 being least likely to meet the outcome.[5]
- Between 2001 and 2010, there was an **increase** among children aged 0-5 in meeting the insurance core outcome, but **no change** in meeting the outcome for CSHCN aged 6-11 or 12-17 during this time period.[4, 5]

Primary Household Language

- CSHCN with non-English speaking parents are **more likely** to be uninsured and to lack adequate insurance.[6, 7]
- Hispanic CSHCN living in Spanish-speaking households are less likely to meet the core outcome than Hispanic CSHCN living in English-speaking households.[5]

Immigration Status

- CSHCN in immigrant families are **more likely** than those in non-immigrant families to be uninsured or to have lacked continuous insurance in the last year.[8]

Researching innovative strategies to address health inequities

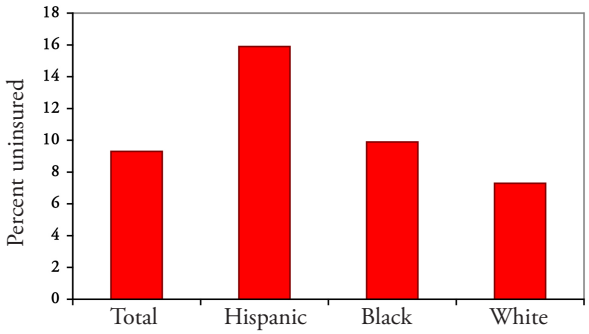
One of our priorities at the Catalyst Center is to address inequities in health insurance coverage among CSHCN by highlighting this issue in all of our work. We will identify the problems associated with insurance inequities and how they impact families of CSHCN by sharing materials that highlight the scope of this issue. We will analyze innovative strategies and best practices used by states to address health inequities, write publications, and assess our own cultural awareness.

Please share innovative strategies your state is employing to promote health equity. E-mail Kasey Wilson, Catalyst Center Research Assistant, at wilsonka@bu.edu

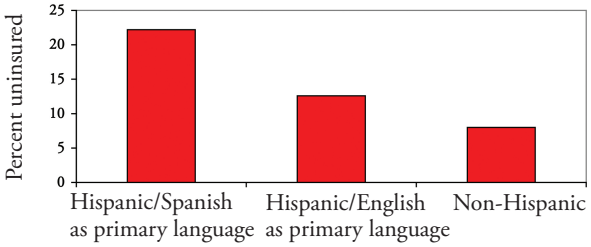
This fact sheet can be found on the Web at http://hdwg.org/catalyst/publications/factsheet-inequities

Findings from the National Survey of Children with Special Health Care Needs

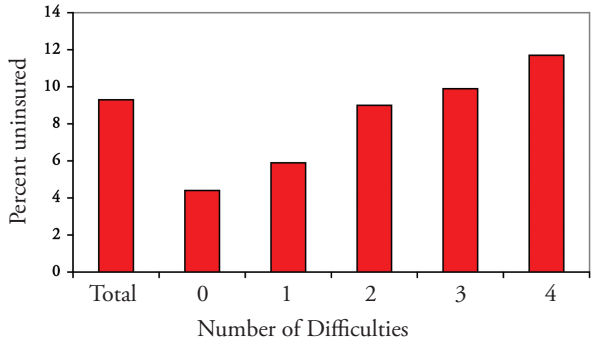
Uninsured CSHCN* by Race



Uninsured CSHCN* by Primary Household Language



Uninsured CSHCN* by Functional Difficulties



*CSHCN who have experienced one or more periods without insurance during the past year; National Survey of Children with Special Health Care Needs

[1]National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 12/18/13 from http://www.childhealthdata.org

[2]Kogan, M. D., Newacheck, P. W., Honberg, L., & Strickland, B. (2005). Association between underinsurance and access to care among children with special health care needs in the United States. *Pediatrics,* 116(5), 1162-1169.

[3]Newacheck, P. W., Hung, Y., & Wright, K. K. (2002). Racial and ethnic disparities in access to care for children with special health care needs. *Ambulatory Pediatrics,* 2(4), 247-254.

[4]Honberg, L., McPherson, M., Strickland, B., Gage, J. C., & Newacheck, P. W. (2005). Assuring adequate health insurance: Results of the national survey of children with special health care needs. *Pediatrics,* 115(5), 1233-1239.

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[6]Yu, S. M., Nyman, R. M., Kogan, M. D., Huang, Z. J., & Schwalberg, R. H. (2004). Parent's language of interview and access to care for children with special health care needs. *Ambulatory Pediatrics*, 4(2), 181-187.

[7]Yu, S. M., & Singh, G. K. (2009). Household language use and health care access, unmet need, and family impact among CSHCN. *Pediatrics*, 124, S414-S419.

[8]Javier, J. R., Huffman, L. C., Mendoza, F. S., & Wise, P. H. (2009). Children with special healthcare needs: How immigrant status is related to health care access, health care utilization, and health status. *Maternal and Child Health Journal,* 14, 567-579.

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