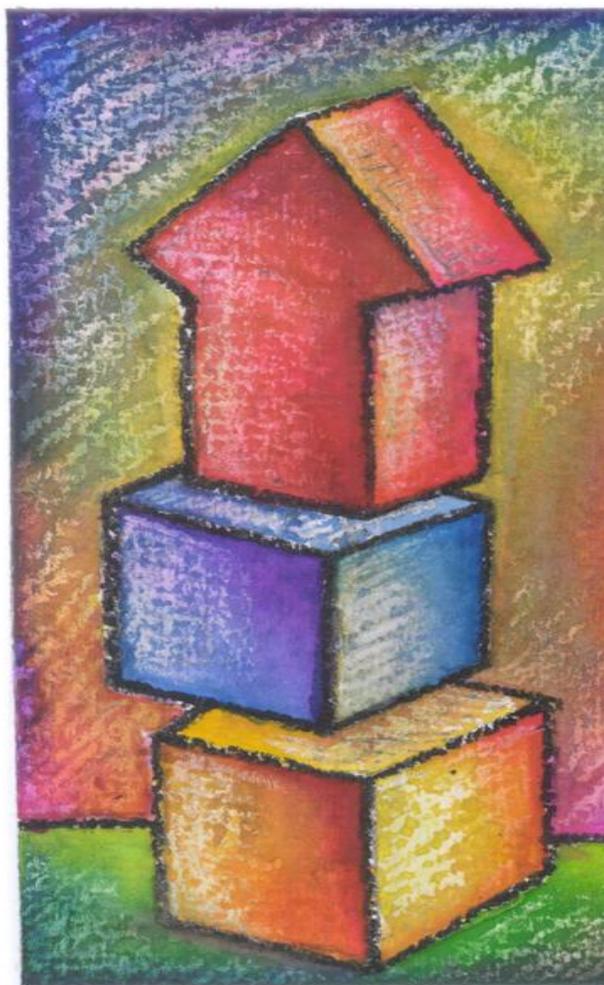


BUILDING ON OUR SUCCESS:

Moving from Health Care Coverage to
Improved Access and Comprehensive Well-Being
for Illinois Children and Youth



September 2007



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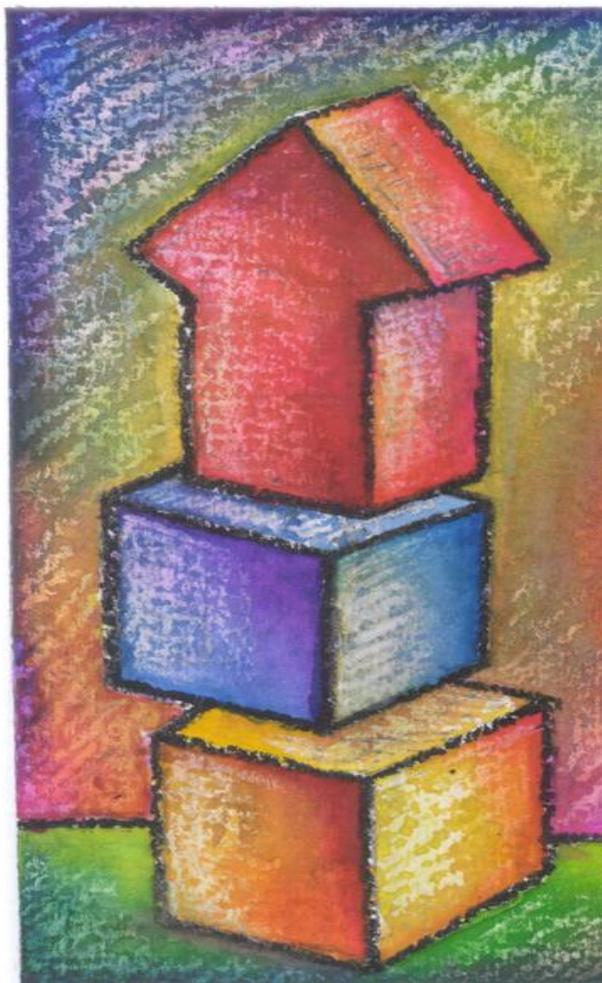
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The Poverty Measure

Income poverty is defined by the federal government using food cost as a basis. Each year, a monetary threshold - commonly called the **federal poverty line (FPL)** - is set, and families as well as the individuals who comprise those families are considered poor if their family income falls below the threshold for their family size. In 2007, a family of four is considered poor if their gross annual income falls below **\$20,650**. Income poverty is also discussed in terms of percentage of the FPL. Extreme poverty is defined as half the poverty line, or 50% FPL; low-income is defined as twice the poverty line, or 200% FPL.



REALIZING A VISION OF CHILD AND YOUTH WELL-BEING IN ILLINOIS

Childhood is an important time of emotional, physical, cognitive, and social development, and each plays an important role in helping children grow into healthy, productive adults. **Illinois has made initial investments in the health and development of children.** Most notably, Illinois has taken important steps to ensure public health insurance coverage for all children regardless of income and status.

As recently as 2003, Illinois' state children's health insurance program, KidCare, ranked 39th in the nation with only 18 percent of eligible children enrolled. Due to concerted outreach efforts, Illinois' rank improved to 18th by the following year with 35 percent of eligible children enrolled - the second largest increase of all states.¹ In July of 2006, Illinois implemented the All Kids program, which absorbed children's Medicaid and KidCare and offers health insurance coverage on a sliding fee scale for every child in Illinois. All Kids established Illinois as a leader in extending coverage to children, and as of April 2007, 50,000 previously ineligible, uninsured children had coverage through the program, with a total of 1.3 million Illinois children covered.²

Additionally, Illinois was the first state in the nation to offer health insurance coverage to the parents of children who are eligible for the state's child health insurance program. Through the creation of FamilyCare, parental coverage increased by 227 percent.³ This coverage increase is significant in light of research that shows that low-income uninsured parents are three times as likely to have uninsured children as insured parents.⁴ Research also shows that parent enrollment in Medicaid increases enrollment of children, and that when parents are insured their children gain better access to care.⁵

Along with these expansions of public health insurance coverage are efforts to move toward a "medical home" model of care that emphasizes primary and preventive care for both children and adults with public health insurance coverage.⁶ This model, called Illinois Health Connect, aims to achieve better patient outcomes and increase the cost-effectiveness of health care services.

While these efforts are vital first steps in helping children and youth realize healthy lives, they are indeed only first steps. **The effects of poverty experienced by many Illinois families translate into a higher risk for negative child health outcomes and more difficulty accessing the health care children need to thrive.** Children from poor families are still less likely to be insured, and Black and Hispanic Illinois children are 2.5 times less likely to have public health insurance coverage as White children.⁷ Lack of health insurance coverage greatly contributes to unfavorable health outcomes for many poor and minority children and youth and diminishes the ability of poor families to adequately respond to their children's health needs. Illinois must continue with efforts to enroll poor and minority children in the All Kids program as a first step in helping improve health outcomes.

For those with coverage, many poor and low-income families face a gap between having insurance and accessing the care their children need to become and stay healthy. The number of doctors, dentists, and mental health professionals who accept patients with public insurance falls far short of meeting the demand, and in many places in the state there is a severe lack of providers who accept public insurance within a reasonable distance from where families live. Filling this gap requires concerted efforts to expand the number and geographic dispersion of health care professionals across the health spectrum who accept public insurance and is a critical step in ensuring children and youth can lead healthy lives.

Families in Illinois not only experience difficulty finding health care professionals that accept public insurance for their children, but they also have trouble obtaining regular and preventive physical health care, getting mental health needs met, accessing oral health services, obtaining nutritious food, and for older youth, acquiring insurance.

Helping children and youth become and stay healthy requires a holistic approach in which all the components of health are addressed. Health is more than the absence of disease; it encompasses complete physical, mental, and social well-being. In order to realize comprehensive child and youth well-being, the following components need to be in place:

- Affordable health insurance coverage for those who need it that covers prevention, early diagnosis, and treatment
- A coordinated and streamlined health system that minimizes barriers to accessing coverage and care
- Health care professionals who accept public insurance with offices in close proximity to where people with that insurance live
- Medical homes for all children in which the doctor knows the child’s medical history and where parents know they can take their children for needed checkups and treatment
- Preventive care and treatment for physical, mental, and oral health
- Nutritional support to promote healthy development
- Appropriate insurance coverage and care for parents so they can maintain healthy lives to care for their children

What follows in this report is a description of access challenges in the areas of physical health, mental health, oral health, proper nutrition, and insurance coverage for older youth. **In addition to the critical step of enrolling additional doctors, dentists, and mental health professionals in Medicaid, Illinois can implement the following concrete recommendations in order to achieve the components of comprehensive child and youth well-being outlined above.** These recommendations are realistic next steps that can be implemented in the near future to help Illinois enhance its status as a leader in the field of child health.

Building on our Success: Where to go from Here

- Expand existing **school health centers**, and establish new centers in communities of need.
- Engage in outreach efforts to enroll **Licensed Clinical Social Workers as Medicaid providers** and education efforts aimed toward families with Medicaid-enrolled children.
- Expand **dental sealant programs** to reach more low-income children and **increase Medicaid reimbursement rates for restorative procedures.**
- Implement **universal school breakfast** in districts with high percentages of low-income students.
- Extend eligibility of **All Kids** to include youth through age 24.

THE RELATIONSHIP BETWEEN CHILD POVERTY AND HEALTH

Alone, poverty or health problems can have serious consequences for a child. But the reality is that poverty and health intersect in a child's life; poverty is exacerbated by health problems and health problems are intensified by poverty. The effects of poverty experienced by many Illinois families translate into a higher risk for negative child health outcomes and more difficulty accessing the health care children need to thrive.

Growing up in poverty has adverse effects on children's physical, cognitive, and emotional health. Compared to their non-poor counterparts, poor children are:

- More likely to be low birth weight and have a greater risk of infant mortality.⁸
- Twice as likely to be in poor health.⁹
- Three to four times as likely to suffer lead poisoning.¹⁰
- More likely to have unmet medical and dental needs.¹¹
- More likely to experience injuries from accidents.¹²
- More likely to experience developmental delays and learning disabilities.¹³
- At greater risk for suffering from behavioral or emotional problems.¹⁴

The intersection of poverty and health in a child's life is further compounded by the fact that poverty often limits options and opportunities for adequately addressing health issues. Poor families are less likely to have emergency funds available to respond to health crises, and poor children are less likely to have a medical home, more likely to rely on emergency rooms for routine care, and despite recent investments, are less likely to have health insurance coverage.¹⁵

Child and Youth Poverty in Illinois

- Over half a million children live in poverty.¹⁶
- 1 in 5 children live in low-income working families.¹⁷
- Children are disproportionately affected by poverty, making up 25% of Illinois' population, but 35% of those in poverty.¹⁸
- 1 in 5 youth ages 18 to 24 live in poverty.¹⁹
- 15% of youth ages 18 to 24 are not enrolled in school, are not working, and have no degree beyond high school.²⁰

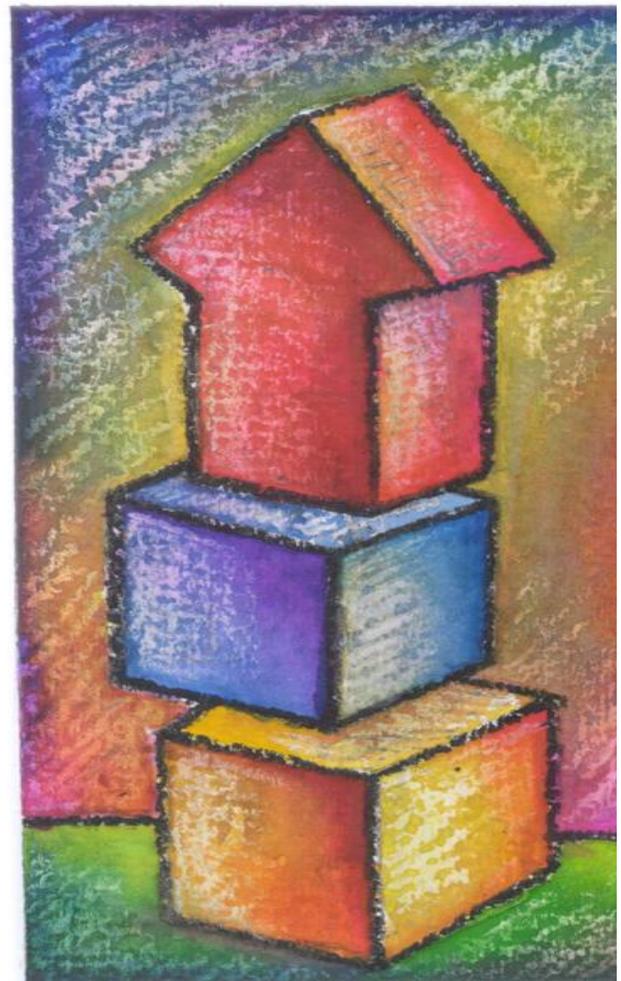
EXISTING GAPS AND TARGETED SOLUTIONS

The following pages look at children’s physical, mental, and oral health, as well as nutrition issues and insurance coverage. In each of the following sections, these two questions are posed:

“What are the barriers to achieving a healthy life for poor and low-income children and youth in this area?”

“What can we do to ensure all children and youth have access to the care they need to become healthy, productive adults?”

The answers to the first question illuminate gaps in care and access problems for many children and youth in Illinois. The second question elicits recommendations for targeted solutions that can be effective in building upon Illinois’ successful insurance expansions in order to realize a vision of expanded access to care and complete well-being for all children and youth.



PHYSICAL HEALTH

Q: What are the barriers to achieving a healthy life for poor and low-income children and youth in the area of *physical health*?

A: The physical health of poor Illinois children and youth is compromised by limited access to regular care, lack of preventive care, and disparities among racial and ethnic groups.

Many Illinois children and youth lack preventive care, personal doctors, and medical homes in which the doctor knows the child's medical history and where parents know they can take their children for needed checkups and treatment.

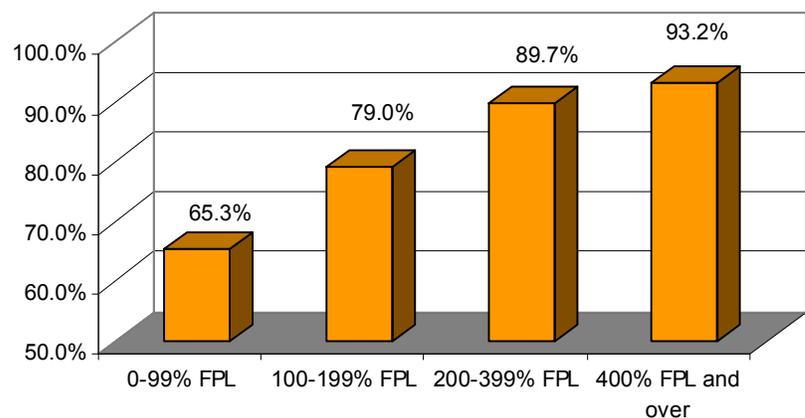
- 20% of Illinois children did not have a preventive medical care visit in the previous year.²¹
- 52% of Illinois children do not have a personal doctor or nurse who knows the child, and to whom parents take their children to when they need checkups and treatment.²²

Lower income Illinois children are less likely to be in excellent or very good health than their higher income counterparts.²³

There are a number of health outcomes and risk behaviors that emerge as children get older that highlight the importance of prevention:

- 31% of Illinois children and teens from age 10 to 17 are obese.²⁴
- 52% of Illinois children and teens do not exercise regularly.²⁵
- Youth ages 10 to 19 constitute nearly 40% of Illinois' Chlamydia and Gonorrhea cases.²⁶
- In the past month, of all Illinois youth ages 12 to 17: 141,000 have used tobacco, 190,000 have used alcohol, 147,000 have used marijuana, and 50,000 have used other illicit drugs.²⁷

Parents Reporting their Child's Health to Be Excellent or Very Good, by Income



Minority children and youth in Illinois often have worse health outcomes and more difficulty accessing needed health services.

- 67% of Hispanic children and 59% of Black children do not have a medical home compared to 46% of White children.²⁸
- 26% of Hispanic children did not receive preventive medical care visits in the previous 12 months compared to 19% of both White and Black children.²⁹
- 66% of Hispanic parents and 79% of Black parents describe their child's health excellent or very good, compared to 91% of White parents.³⁰

Q: What can we do to ensure all children and youth have access to the care they need to become healthy, productive adults?

A: **Expand existing school health centers, and establish new centers in communities of need.**

School health centers (SHCs) provide primary care, mental health, oral health, and preventive health care services to students and are located on school grounds or nearby. These centers offer affordable, comprehensive, and age-appropriate health services to children and youth and significantly increase students' access to care, particularly among low-income students who may otherwise have a difficult time accessing comprehensive medical treatment. Research shows many health benefits of SHCs:

- SHCs have demonstrated that they *attract harder-to-reach populations*, especially minorities and males, and that they do a better job than community health centers or HMOs at getting them crucial services such as mental health care and high-risk behavior screens.^{31,32}
- There can be *significant increases in health care use by students who use school health centers* compared to those who do not have access to a SHC.³³
- SHC medical services can help *decrease absences by 50%* among students with three or more absences in a 6-week period.³⁴
- Students who receive mental health services from SHCs can experience *dramatic declines in school discipline referrals*.³⁵
- School health centers can *reduce inappropriate emergency room use* among regular users of school health centers.^{36,37}
- Elementary school health centers have shown a *reduction in hospitalization and an increase in school attendance* among inner-city school children with asthma.^{38,39}
- SHCs can reduce *Medicaid expenditures* related to inpatient, drug, and emergency room use.⁴⁰

Fifty-two school health centers operate in Illinois, and there are 10 more centers in the planning stage. In the 2004-2005 school year,* 38 SHCs reported enrolling over 82,000 students and providing over 102,600 health care visits. The cost is less than \$39.00 per student each year.

Each year in Illinois SHCs save an estimated:⁴¹

- \$233,000 to \$342,000 by reducing asthma hospitalizations
- \$1.77 million by providing immunizations
- \$2.50 million by reducing emergency room visits

School health centers are a viable strategy for ensuring children and youth have a regular place of care for both treatment and preventive care, and for addressing risk behaviors.

*This is the most recent year for which data are available.

Q: What can we do to ensure all children and youth have access to the care they need to become healthy, productive adults?

A: **Engage in outreach efforts to enroll Licensed Clinical Social Workers as Medicaid providers and education efforts aimed toward families with Medicaid-enrolled children.**

Children and youth need broader access to mental health services in order to succeed in school and have healthy relationships with their families and peers. Half of all lifetime cases of mental illness begin by the age of 14.⁴⁸ Delays in diagnosing and treating mental illness can lead to a more severe, more difficult to treat illness, and to the development of additional mental illnesses. Investing additional resources in the mental health of Illinois children and youth today will substantially reduce future spending on more complex problems when they become adults.

There are nearly 9,000 Licensed Clinical Social Workers (LCSWs) in Illinois who are licensed to provide mental health services.⁴⁹ Mental health is the specialty of approximately 37 percent of LCSWs.⁵⁰ LCSWs hold master degrees, are professionally trained to operate under a code of ethics, are licensed and regulated by the state of Illinois, and have a professional commitment to serving underserved populations. Under federal law and recently under Illinois state law, LCSWs can be directly reimbursed by Medicaid for their services.

The recent change in Illinois to allow LCSWs to be directly reimbursed for the services they are licensed to provide will significantly increase the number of mental health professionals available to children and youth with public insurance and will expand the service provider and service setting options for their families. Implementing this policy change holds particular promise in areas where there are shortages of mental health providers who accept public insurance.

However, a change in law is simply the first step in expanding access to mental health care. This effort's success depends on the extent to which LCSWs are aware of their expanded options for billing and families are aware that they can access mental health services for their children in additional settings. **Increasing access to mental health services for children and youth must include outreach efforts to enroll LCSWs as Medicaid providers and education efforts aimed toward families with Medicaid-enrolled children.** Such efforts will facilitate greater access to the mental health care low-income children and youth need to develop into healthy adults.

ORAL HEALTH

Q: What are the barriers to achieving a healthy life for poor and low-income children and youth in the area of *oral health*?

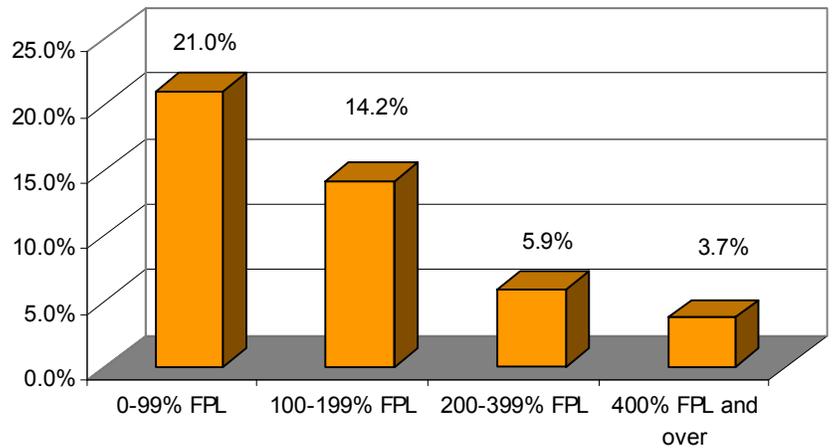
A: Many Illinois children have untreated oral health needs and lack preventive care.

A child cannot be completely healthy without having sound oral health.

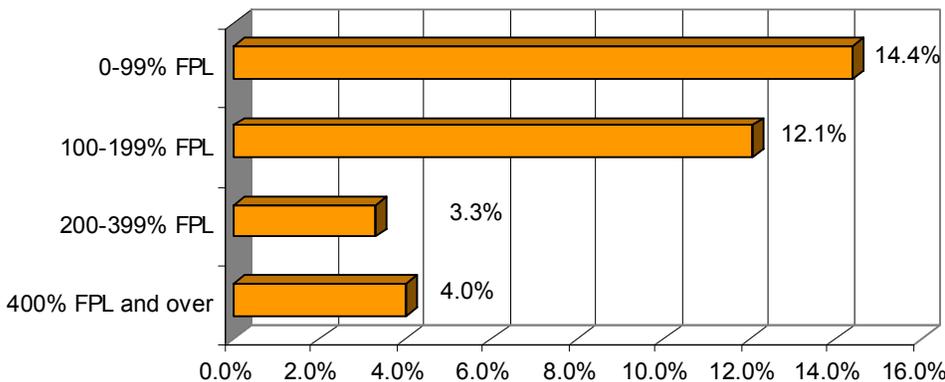
Untreated oral diseases and conditions can have a significant impact on a child's quality of life. The pain associated with many oral diseases and conditions can render concentration difficult, leading to diminished school performance and increased days absent. Additionally, oral disease can present barriers to speaking, chewing, swallowing, can contribute to loss of self-esteem, and can ultimately lead to worse oral health problems as adults.⁵¹

- Cavities are the most common chronic childhood disease, occurring five to eight times as frequently as asthma, the next most common chronic childhood disease.⁵²
- 55% of Illinois third graders have suffered from the damaging effects of tooth decay.⁵³
- 30% of Illinois third graders have untreated cavities.⁵⁴

Percent of Illinois Children with Teeth in Fair or Poor Condition, by Income



Percent of Illinois Children Not Receiving all Needed Dental Care, by Income



Prevention is the surest measure in the fight against childhood oral disease, yet 28 percent of Illinois children did not see a dentist for routine preventive care in the past 12 months. Research has shown that children who are poor and minority children are more likely to have teeth that are in fair or poor condition and are less able to access the care they need to maintain healthy teeth and mouths.⁵⁵

Q: What can we do to ensure all children and youth have access to the care they need to become healthy, productive adults?

A: **Expand dental sealant programs to reach more low-income children and increase Medicaid reimbursement rates for restorative procedures.**

Tooth decay, an infective and sometimes painful condition, can largely be prevented by providing all children and youth with access to timely exams and direct interventions that include education to prevent decay, appropriate amounts of fluoride supplementation, and dental sealants. Dental sealants consist of a thin plastic coating applied to the chewing surfaces of molars to prevent tooth decay and are a proven cavity-prevention effort. Furthermore, dental sealants are cost-effective: on average, a dental sealant costs over three times less than a filling.⁵⁶

- The rate of school-age children receiving dental sealants has risen over the past several decades; however, there has been no increase for children from low-income families.⁵⁷
- Only 27% of Illinois third graders have dental sealants.⁵⁸

The Illinois Department of Public Health operates a Dental Sealant Grant Program, which provides grants to local communities to implement dental sealant programs to serve low-income children. The dental sealant program operated in 44 of Illinois' 102 counties in the fiscal year 2007, reaching 50,953 children and applying 53,019 sealants. Increasing available funds to support the dental sealant program will help maintain and build needed infrastructure to reach more children.

Many children have oral health needs that are well beyond that of dental sealants. Children with existing decay need restorative therapies, such as fillings and other more complex procedures. The current low rate of Medicaid reimbursement does not come close to the cost of providing such care and discourages dentists from accepting patients with public health insurance. Consequently, children and youth who need these procedures often face a large gap in ongoing oral health care.

Expanding the Dental Sealant Grant Program and increasing the Medicaid reimbursement rate for restorative procedures, coupled with efforts to increase the number of dentists in all areas of the state who accept public insurance, will result in more low-income children receiving the proper oral health assessment, treatment, and preventive oral health care they need.

PROPER NUTRITION

Q: What are the barriers to achieving a healthy life for poor and low-income children and youth in the area of *proper nutrition*?

A: Providing proper nutrition is difficult for low-income families on limited budgets.

Proper nutrition is a vital component of healthy living for children and youth. Yet when families have low incomes, it can be a struggle to purchase enough food for the family, let alone the more costly nutritious food that children and youth need for proper development and robust immune systems. Over 12 percent of Illinois households experience food insecurity or hunger.⁵⁹

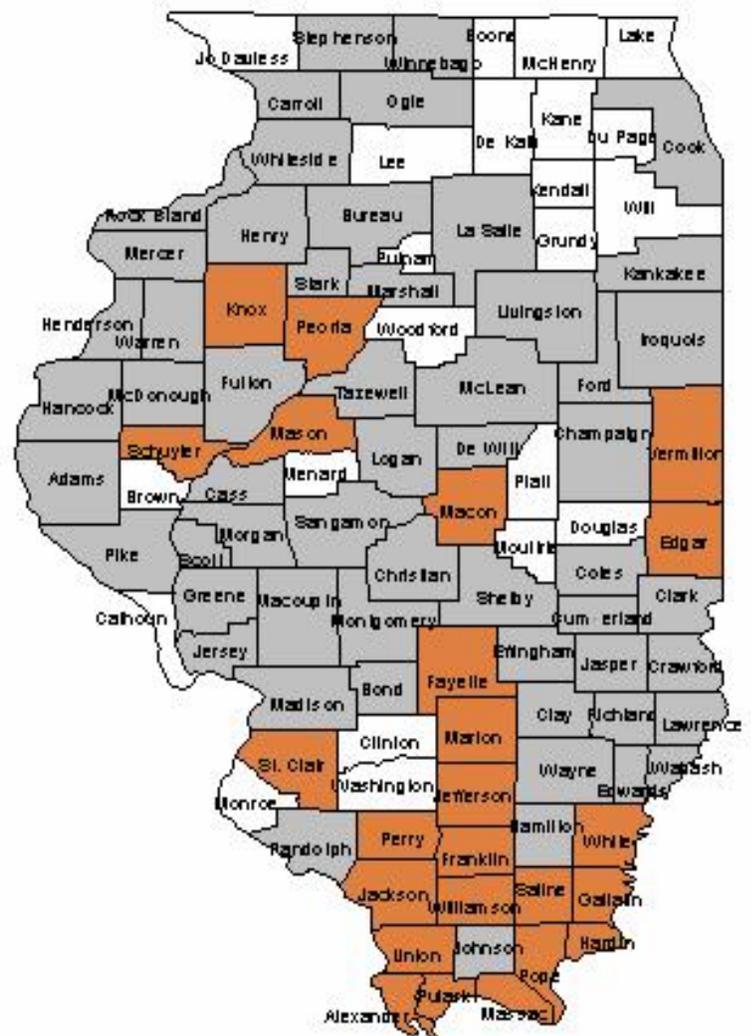
Families are increasingly relying on supports to ensure that their children do not go hungry:

- Nearly 820,000 Illinois children received Food Stamps in 2006 – making up nearly half of all Illinois Food Stamp recipients.⁶⁰
- 46% of Illinois students received school lunches in 2006 through the National School Lunch Program, a federally-assisted meal program operating in schools for low-income children – up from 42% in 2001.⁶¹

Families who are struggling to get by are often forced to take measures to make food last longer. This may mean skipping breakfast before school or only eating breakfast sporadically. **Missing breakfast and experiencing hunger lead to a variety of negative health and educational outcomes:**

- Children experiencing hunger have lower math scores and are more likely to have to repeat a grade.⁶²
- Behavioral, emotional, and academic problems are more prevalent among children experiencing hunger.⁶³
- Youth who do not eat breakfast tend to have a higher body mass index, an indication of being overweight or obese.⁶⁴

Percent of Children Receiving Food Stamps, 2006



- 6.0%-19.9% of children receiving Food Stamps
- 20.0%-34.9% of children receiving Food Stamps
- 35.0% or more children receiving Food Stamps

Q: What can we do to ensure all children and youth have access to the care they need to become healthy, productive adults?

A: Implement universal school breakfast in districts with high percentages of low-income students.

The School Breakfast Program reduces hunger among low-income children while improving their health and nutrition. Children and youth who eat breakfast have increased school attendance, are more attentive, have higher academic achievement, fewer school nurse visits, fewer classroom discipline problems, and are far less likely to be overweight since skipping breakfast is associated with obesity.⁶⁵

The National School Lunch Program and the School Breakfast Program are important tools in guaranteeing that low-income children have nutritious food in their stomachs to get them through the school day and maximize their learning potential. In Illinois, the Childhood Hunger Relief Act mandates that schools with over 40 percent of students eligible for the Lunch Program also offer eligible students the option of breakfast. Despite this mandate and the well documented benefits of a healthy breakfast to start a child's day off right:

- Less than one third of Illinois low-income (i.e. free and reduced-price eligible) students who receive School Lunch on an average day also participate in the School Breakfast Program.⁶⁶
- Between the 2004-2005 and the 2005-2006 school year, the number of Illinois low-income students in the School Breakfast Program grew by over 13%, yet Illinois still has the second lowest percentage of low-income students participating in the program in the country.⁶⁷
- In the Chicago Public School system, only 29% of low-income School Lunch students participate in the Breakfast Program.⁶⁸

Implementing a universal breakfast program, rather than an optional program, in Illinois districts with a high percentage of low-income students can significantly increase low-income student participation in the program since it reduces stigma and eliminates fee barriers for many low-income families. School districts that offer breakfast free to all students are more successful in enrolling low-income children who are most likely to need breakfast. Low-income student participation rises even more in districts that make breakfast part of the school day by serving breakfast in the classroom.⁶⁹

Raising participation in the School Breakfast Program will also increase federal dollars going into school districts. For example, if the Chicago Public School district raised participation in the School Breakfast Program to 70 percent of the Lunch Program – a realistic achievement if universal breakfast were implemented – the district would receive an additional \$25.3 million in federal funding and would serve a needed nutritional breakfast to 116,080 additional low-income students.⁷⁰

INSURANCE

Q: What can we do to ensure all children and youth have access to the care they need to become healthy, productive adults?

A: Many older youth in Illinois lack health insurance coverage which limits their ability to access health care.

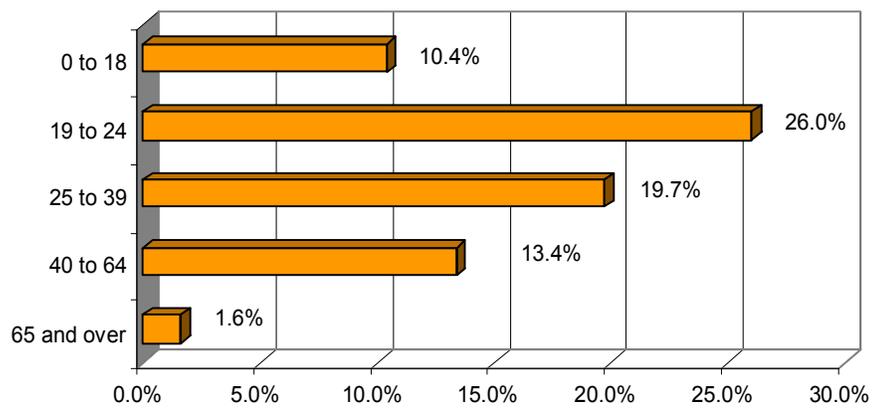
In recent years, Illinois has prioritized insuring children ages 0 through 18, **yet youth through the age of 24 are not eligible for public health insurance coverage.** Many of these youth do not have access to health insurance because if they are not enrolled in school, they cannot typically be on their parent's insurance. Additionally, youth who do not have children of their own or do not have a disability, are typically not eligible for public insurance. Many of these youth are working in low-wage or entry-level jobs that do not offer health benefits or that require them to pay substantial portions of the costs – which they cannot afford to do.

19 to 24 year old Illinoisans have the highest rate of uninsurance of any age group. While these youth comprise only 9 percent of the Illinois population, they represent 17 percent of Illinois' uninsured population. Youth with low incomes are significantly more likely to be uninsured than higher-income youth.⁷¹

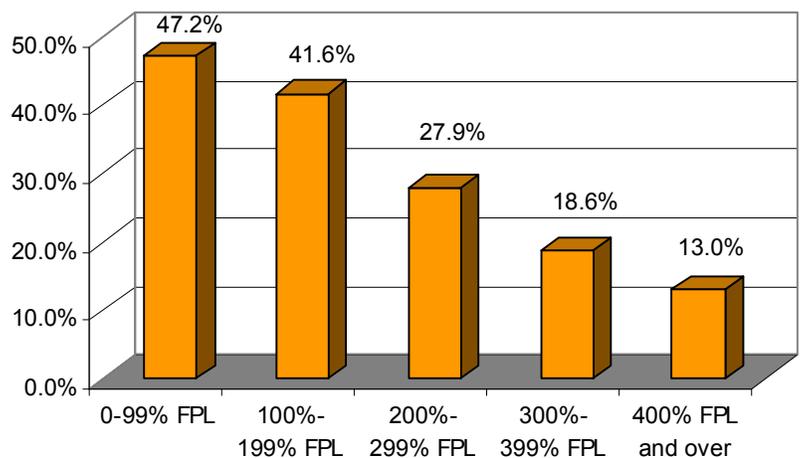
While constituting a relatively healthy group:

- The rate of injury for 18 to 24 year olds is 19% higher than that of 0 to 17 year olds, 32% higher than that of 25 to 44 year olds, and 102% higher than that of 45 to 64 year olds.⁷²
- Uninsured people who experience accidental injury are less likely to receive any medical care and if they do, they are twice as likely to not receive needed follow-up care.⁷³
- 18 to 24 year olds are the least likely of any age group to have a usual place to go for medical care.⁷⁴

Rates of Uninsured Illinoisans by Age, 2006



Uninsured Illinois Youth Ages 19 to 24, 2006, by Income



Q: What can we do to ensure all children and youth have access to the care they need to become healthy, productive adults?

A: **Extend eligibility of All Kids to include youth through age 24.**

The age range of 19 to 24 years is a critical time in the lives of many youth that includes a transition from school to work with new independence and freedom. Not having health insurance during this juncture presents a serious threat to the safety and stability of Illinois youth and can result in serious health and financial costs that follow them well into the future.

Having health insurance can lead to improved health outcomes and better access to care.⁷⁵ Expanding the full package of All Kids coverage to youth through age 24 will help low-income Illinois youth receive preventive care, address problems before they grow into more serious issues, and ensure they do not incur devastating financial consequences that force them to start adulthood with significant medical debt. Moreover, having access to medical care at this age can help youth form a relationship with health care professionals that carries well into adulthood. Research has established a link between poor health and decreased annual earnings, which is problematic not only for an individual, but also for the state, which feels the effects of reduced labor force participation and work effort through fewer tax revenues.⁷⁶

Illinois cannot afford to *not* insure these youth who are the future backbone of the state's workforce. In fact, young adults are the least expensive age group to insure.⁷⁷ **By launching youth into adulthood with this necessary safeguard to address health issues as they arise rather than letting them manifest into more difficult problems, and to head off the physical, emotional, and financial consequences of unexpected accidents or health events, the state can make an investment that will reap solid health and economic returns.**

BUILDING ON OUR SUCCESS: WHERE TO GO FROM HERE

Illinois has been a groundbreaking leader in offering health care coverage for all children, and we must build upon this foundation to improve health care access and availability and address all of the components of health and well-being for Illinois children and youth. This requires concerted efforts to expand the number and geographic dispersion of health care professionals across the health spectrum who accept public insurance and continued work to enroll poor and minority children in the All Kids program. In addition, the highlighted suggestions in this report offer concrete ideas on how to further promote health and well-being so all Illinois children and youth can thrive:

- Expand existing **school health centers**, and establish new centers in communities of need.
- Engage in outreach efforts to enroll **Licensed Clinical Social Workers as Medicaid providers** and education efforts aimed toward families with Medicaid-enrolled children.
- Expand **dental sealant programs** to reach more low-income children and **increase Medicaid reimbursement rates for restorative procedures**.
- Implement **universal school breakfast** in districts with high percentages of low-income students.
- Extend eligibility of **All Kids** to include youth through age 24.

Incorporating these suggestions are important steps in building on Illinois' investments in health care coverage to become the national leader in ensuring comprehensive child and youth well-being.

THE MID-AMERICA INSTITUTE ON POVERTY (MAIP) is the policy and research arm of Heartland Alliance for Human Needs & Human Rights. MAIP provides a source of reliable information and data to elected officials, government agencies, media, nonprofits, community groups, and other advocates to promote effective policies, programs, and systems change.

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ENDNOTES

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