Family and Youth Institute
Colorado State University Cooperative Extension
and College of Applied Human Sciences

I N S T I T U T E

Colorado State University
Knowledge to Go Places

b r i e f s

Insuring Our Families' Health

Volume III, Issue 4
October 2001

Inside this Issue

The Insured vs. the Uninsured

by Cheryl Asmus, Coordinator, Family and Youth Institute

More than 44 million Americans lack health insurance. Medical treatment for the uninsured often is more expensive than for the insured, because the uninsured are more likely to receive medical care in the emergency department than in a physician's office.

In 1997, Congress enacted a way to encourage health care for kids under age 19: S-CHIP–the State Children's Health Insurance Program. This issue begins with an article that describes Colorado's S-CHIP, CHP+, and (on the back page) FYI's role in this effort.

Many people who qualify for Medicaid do not apply for it. Usually this is because of bureaucratic barriers or because they are fearful of getting into the Medicaid system. Our second article is an interview with an expert on Medicaid and the elderly.

Elizabeth Garner then provides an overview of the status of how Colorado compares to the nation in health insurance coverage.

The last article introduces a topic quickly rising to the forefront of health care issues: dental coverage, with dental disease present in almost 60 percent of children ages 5 to 17.

Finally, we would like you to join us in welcoming the new editor of the *Institute Briefs*: Margaret Graham.

Health Insurance for Children

by Kimberley Imperiale, State Project Coordinator, Colorado Covering Kids Initiative, Family and Community Health Services

Covering Kids Colorado is a national health access initiative for low-income uninsured children. This program promotes access to health insurance for children through enrollment in the Child Health Plan Plus program (CHP+).

CHP+ provides over 35,000 Colorado children with affordable health coverage and access to an array of quality health care services. Families with children who do not qualify for Medicaid and who cannot afford health insurance are invited to inquire about eligibility criteria via our web site at http://www.cchp.org/WebSite/eligibility/EnrollFeeCalc.cfm or by calling 303-692-2426.

Applications are available at Colorado health department

Continued on page 5

Invitation to dialogue

What issues and concerns would you like to see addressed? Contact FYI at:

Family and Youth Institute
201 Gibbons Building
Colorado State University
Fort Collins, CO
80523-1501
Phone: 970-491-1936
Fax: 970-491-7859
E-mail: margaret.graham@cahs.colostate.edu
www.cahs.colostate.edu/fyi/

Coming next:
Healing from the Events of September 11th

Medicaid and the Elderly

An interview with Nancy Wallace, a Fort Collins attorney who frequently performs legal consultations regarding Medicaid through the Larimer County Office of Aging.

What information do you generally provide people regarding Medicaid?

I usually give them some basic information about Medicaid and long-term care. In Colorado, it's not required that the person needing care be institutionalized. We have a home-based program, an assisted-living program, and a nursing home program, but we still refer to "Community Spouse" (CS) and "Institutionalized Spouse" (IS) from the era when Medicaid only provided coverage for people in nursing homes.

I explain the financial framework. When someone needs long-term care and applies for Medicaid, the couple (or single person) has a certain number of exempt assets – those that they get to keep. The exempt assets can include a residence, personal property in the residence, an automobile (as long as it's used for medical services), and other limited assets.

In addition, the CS gets what is called the Community Spouse Resource Allotment (CSRA), which is their savings beyond the above assets. For 2001, the CSRA is $87,000. The IS is entitled to an additional exemption of $2,000. The CSRA is tied to a cost-of-living index. Some pension and other retirement accounts are exempt. There are exceptions to the CSRA, and there is an income allowance that goes to the CS that is based on the expenditures that the parties have had during the months before the application for Medicaid.

As long as the CS is alive, the Medicaid lien on the IS never *attaches to the CS's residence or assets, so the protection for the CS is absolute. It's not, however, absolute as to his or her ability to transfer the assets to heirs. For the most part, the policies are adequate.*

What is the response of most of the people you counsel upon hearing of these policies?

Women generally are concerned about how they are going to live if their husband is in a nursing home. When I talk to them about the Medicaid provisions, they feel a lot better. As recently as four years ago, if you had excess resources above a very small amount, a spouse needing long-term care had no choice but to go into a nursing home. Now, with a program called Home and Community Based Services (HCBS), Medicaid applies the CSRA rule, and a person needing medical care can get that care at home as well as in an assisted living facility. It makes a huge difference to people who need only assisted-living (rather than nursing home care), and their quality of life is much better. Before this change, the spouses just couldn't afford to do anything but put them into a nursing home. Medicaid's policies forced them to either impoverish themselves and spend down to nothing or use the nursing home route.

Do your clients comment on the quality of care available to them as long-term care Medicaid recipients?

In my experience, comments fall into two categories. One is the lack of available doctors. People have a hard time finding doctors who will visit nursing homes.

The other question that comes up is whether there's a difference in the quality of care for those paying out-of-pocket and for those receiving Medicaid. My opinion on institutional care is you get basically the same kind of medical care. In terms of facility surroundings, Medicaid patients are typically in a different ward that may not be as nice, and typically they share a room. For those in assisted-living, it makes a huge difference if you're on Medicaid because you can't use the nicest of the facilities. In addition, because the Medicaid reimbursement rates for assisted-living are set at a low rate, there are few assisted living Medicaid facilities.

What is the single greatest improvement legislators could make to Medicaid?

It would be nice if we had better and more trained eligibility technicians. The problem tends to be that the eligibility technicians are overworked and underpaid. A major difficulty for technicians is meeting the time limits on eligibility determinations.

How Do We Compare?

Health Insurance Coverage in Colorado and the Nation

by Elizabeth Garner, Coordinator, County Information Services, Colorado State University Cooperative Extension

As recently as 1997, the percentage of the Colorado population that did not have health care coverage was lower than the national average. However, since that time there has been an increase in the "uncovered" population in Colorado and a decrease in the percentage of people uncovered nationally, reversing a 12-year trend. The percent of people covered by employment-based health insurance rose significantly in 1999, driving the national increase in health insurance coverage; however, in Colorado this trend did not hold. By 1999, Colorado reported 16.8 percent of its residents as uncovered (up from 15.1 percent in 1997) while the United States reported 15.5 percent uncovered (down from 16.1 in 1997). This change is primarily due to the number of small businesses no longer offering coverage. In 1997, Colorado ranked 25th (out of the 50 states and the District of Columbia) in the country for having the most people *not* covered by health insurance. In 1999, Colorado had ranked 13th in comparison to the rest of the nation.

Twenty-nine percent of Colorado's 1,111,000 children (younger than age 19) are considered poor (based on 1997-99 average). Eighty-eight thousand of those children, or 7.8 percent of the total number of children in Colorado, were not covered by health insurance. This number has decreased since the mid-90s, when over 8.8 percent of the children were without coverage.

Key Employment, Income and Demographic Factors Affecting Health Insurance Coverage

(unless otherwise mentioned, these are national numbers)

- Employment-based insurance, the leading source of health insurance coverage, drove the recent national increase in insurance coverage rates. Colorado's employer-sponsored health insurance rate is much higher than the U.S. average (72.2 percent vs 62.8 percent).
- The poor and near poor are less likely to have health insurance than the total population (32.2 percent vs 15.5 percent).
- The percentage of children without health insurance has dropped, primarily due to the increase in employment-based insurance. Due to the increase in government health insurance coverage, rates of those not covered also fell among poor children. Older children (older than age 12) are less likely to have coverage than those under 12.
- Workers 18-64 were more likely to have health insurance (82.6 percent) than nonworkers (73.5 percent) but among the poor, workers were less likely to be covered (52 percent) than poor nonworkers (59.2 percent).

Future Challenges

Traditionally, policy debate about the uninsured has focused on expanding public insurance coverage of children. However, non-elderly adults are 40 percent more likely than children to be uninsured and less than half as likely to have public insurance coverage. Colorado's non-elderly population in Medicaid, 5.9 percent, is less than half the national average of 12.2 percent and the lowest of all the states (1994-1995). The non-elderly adult population without private insurance and without the likelihood of public coverage are most often men, married parents, healthy, and workers (those least associated with Medicaid eligibility). This trend is of some concern in Colorado due to the increase in businesses not offering insurance.

A challenge facing Colorado's health care system is how well it can weather changing economic conditions. State programs, including Medicaid (which includes federal funds, but is state-administered), offer only limited protection to Colorado's citizens. The current rate of uninsured is low due to a healthy economy and an above national average number of small firms offering insurance to their employees (which is decreasing). These factors could change suddenly, however, and the state's system of support is not well equipped to expand to meet greater needs. The constitutionally required spending limits and the lean nature of the current Medicaid program mean that there is little room to stretch resources further. In addition, Colorado's emphasis on moving its Medicaid recipients into managed care may place some strains on the relatively healthy system of safety net providers that currently serves the uninsured.

References

"Health Insurance Coverage 1999," US Census Bureau, http://www.census.gov/hhes/www/hlthin99.html. 9/2000.

"Low Income Uninsured Children by State: 1997, 1998, and 1999," US Census Bureau, November 3, 2000. http://www.census.gov/hhes/hlthins/lowinckid.html.

"State Profiles of Health Insurance, Access and Use," The Urban Institute, http://newfederalism.urban.org, 1997.

Deciphering Dental Insurance Needs

by Margaret Graham, Research Associate, Family and Youth Institute

Tooth decay is the most common chronic disease among children in the United States. Approximately 31 percent of Colorado children age 6 to 8 have untreated tooth decay, and 50 percent of teens from 15 to 18 remain untreated.

Colorado's insufficient dental care extends to Medicaid-covered children with only 23 percent receiving dental services in fiscal year 1998-99. Almost a third of Colorado counties had no dental services for low-income and at-risk populations as of April 2000. Nine Colorado counties had no licensed dentists and an additional ten counties had no dentists serving Medicaid-enrolled clients.

These statistics mirror those at the national level. Children from uninsured families are three times as likely to have dental needs compared to their insured peers.

While the need for dental insurance is strong, approximately 156 million Americans are covered by some dental insurance. The type and amount of coverage varies widely. Most dental plans emphasize preventative treatments, such as cleanings, checkups, and x-rays, covering them at a higher rate than treatment of dental disease and other major problems.

Employer-Based Coverage

While dental insurance coverage is more prevalent now as part of an employer-provided benefits package than it was 30 years ago, dental consumers who are not covered through their employer generally do not have dental insurance. Individual dental plans are unprofitable for providers because consumers typically seek coverage only when they have a dramatic need. They pay premiums for a short time to weather their dental crisis, and cancel coverage once the need is met.

Nationally, 50 percent of employers offer dental coverage, but they often view the plans as expendable. Compared to health insurance, dental insurance is often considered less vital, and as health care costs escalate, dental coverage erodes. With employers scrambling to contain benefits costs, they cut back on dental benefits despite the fact that dental claims are smaller than health insurance claims (dental claims average $150 per claim) and are more predictable than health care costs.

Types of Plans

Dental insurance plans fall into one of four categories. The categories are distinguished by the type of third party that funds and administers the plan, the ability to select a dentist without restriction or from a defined list, the type of reimbursement offered dentists, and the means by which benefits and payments are calculated.

- *Indemnity or Open Panel Plans*
  These plans have no restrictions on which dentist performs services. They reimburse only a percentage of fees, based on a fee schedule (usually a table/schedule of allowance).
- *HMO-Style Plans*
  Restricting coverage to only dentists within a predefined network, these plans require a co-payment, and they reimburse dentists for less than their usual and customary fees according to an agreement with their network of dentists.
- *PPO-Style Plans*
  These plans differ from the HMO model by covering services provided by dental offices that are out-of-network at a lower rate than dental offices within their network.
- *Self-Funded Insurance or Direct Reimbursement Plans (also called Fee-for-Service Plans)*
  These plans are funded by employers, which directly reimburse their employees according to a predetermined schedule regardless of services and service-providers.

Some employees have the benefit of a referral system, which is technically not an insurance plan. Referral systems are lists of dentists and specialists who have agreed to offer special rates to employees of particular companies.

Understanding Plan Benefits

Dental insurance plans can be easily categorized, but the details of each plan are different. The fee schedule that a dental plan uses has a great impact on the insured's purchasing power.

- *Capitation (or per capita) fee schedules* provide a predefined level of benefits and services, and the patient assumes responsibility for services that are not covered by the plan.
- *Schedule of allowances (or table)* fee schedules set a maximum dollar limit for each covered procedure regardless of the fee charged by the dentist. Patients are responsible for differences between dental fees and the amount covered by insurance.
- *Usual, customary and reasonable (UCR)* fee schedules pay benefits based on a fixed percentage of the insurance carrier's determination of the appropriate rate of a particular service. Insurance carriers take regional price differences into account when establishing UCR rates.
- Under *direct reimbursement plans,* the employer or plan sponsor reimburses the employee for a predetermined percentage of all costs. These plans are designed to create an incentive for the employee to select healthy and economical treatment plans.

Other variables in dental plans include: a ceiling on the amount of benefits allowed each patient annually, the exclusion of particular treatments or services, a minimum enrollment period (usually one year) before particular treatments are covered, and preauthorization of particular services.

The American Dental Association's (ADA) Council on Dental Benefit Programs offers free information to employers and benefits professionals researching dental plans. The ADA's Dental Benefit Information Service publishes a guide with plan terminology and general differences among plan types, and the ADA's Plan Analysis Service examines specific dental plans at no cost. Information is available at 312-440-2746 or http://www.ada.org/public/topics/dr/bg/index.html.

References

California Dental Association Online. (April 25, 2000). Selecting and Using Dental Benefits: A Consumer's Guide to Dental Insurance. http://dentistry.about.com/gi/dynamicoffsite.htm?site=http%3A%2F%2Fwww.cda.org%2Fpublic%2Fdentalcare%2Fconsumer.htm

California Dental Hygienists' Association. (1998). Prevention is Your Best Insurance: Choosing a Dental Insurance Plan. http://www.cdha.org/articles/d_plan.htm

Colorado Commission on Children's Dental Health. (2000, December). Addressing the Crisis of Oral Health Access for Colorado's Children. http://www.cdphe.state.co.us/pp/oralhealth/cccdhrpt.pdf

Satcher, D. (2000, May). Oral Health in America: A Report of the Surgeon General. http://www.surgeongeneral.gov/library/oralhealth/default.htm

Satcher, D. (2000, May 25). Remarks at the Release of *Oral Health in America: A Report of the Surgeon General.* http://www.surgeongeneral.gov/library/oralhealth/spchoral.htm

WebMD, Inc. (1999). Legal and Insurance. http://content.health.msn.com/content/article/1691.50042

Health Insurance for Children, *continued from page 1*

offices, social services offices, and many doctors' offices and schools. Additionally, satellite eligibility determination sites are located throughout Colorado for families to apply in person.

CHP+ is designed to help families take control of their health care, emphasizing prevention and allowing them to visit doctors when their children need care rather than when they can afford care.

Although CHP+ is only a few years old, it has succeeded in reaching many families in Colorado who would otherwise not have coverage for their children.

CHP+ offers eligible families a health insurance package that includes coverage of doctor's visits, well-child care, immunizations, prescriptions, mental health care, and other services. This coverage is offered at a cost of just $25 per child annually ($35 to cover two or more children).

Though CHP+ has certainly made great strides, there are still an estimated 30,000 Colorado families whose children are eligible for this program but who are not enrolled. On January 11, 2001, Governor Bill Owens delivered his State of the State address and remarked, "This [CHP+] is an important part of Colorado's safety net program."

Through the help of Covering Kids Colorado, enrollment of eligible children in CHP+ has increased by 22 percent in just two years. A nationwide project of the Robert Woods Johnson Foundation, Colorado's Covering Kids Initiative received $1,000,000 in January 1999 through the Colorado Department of Public Health and Environment to fund statewide outreach activities and local pilot programs to explore ways to break down barriers and enroll eligible families in available health insurance programs such as CHP+.

If you or anyone you know would like to get involved in a local coalition to help promote access to health coverage and care for children and families, contact Covering Kids Colorado at (303) 692-2426.

Collaborating for Children's Health Insurance

Cooperative Extension and Covering Kids Colorado link arms to reach low-income families for children's health insurance

by Rozi Horn, Research Assistant, Family and Youth Institute

In early spring 2001, Cooperative Extension received a Covering Kids Colorado grant to aid in enrolling families in the Colorado Health Plan Plus program (CHP+) in the four counties where CHP+ enrollment is low: Arapahoe, Boulder, El Paso and Jefferson.

Despite low enrollment, both organizations are committed to locating the families in these counties who meet the low-income requirement so that they can take advantage of the free to low-cost insurance program being offered. A primary goal of the program is to redirect families away from emergency health care to a preventative model (see "Health Insurance for Children" on page one for additional details).

The outreach methods used for other Front Range counties may not be the optimal way to reach the families in those counties where annual incomes often exceed eligibility requirements. Cooperative Extension has designed a specific outreach campaign to increase application submissions from these counties. We have launched a campaign that will reach churches, community college child care centers, and various youth organizations by sending a letter along with a poster. In addition, we are producing public service announcements.

Our web page includes an eligibility calculator, enrollment instructions, a list of health care providers, and more. Visit it at http://www.cchp.org/.