DATA SPOTLIGHT:

Insurance Rates

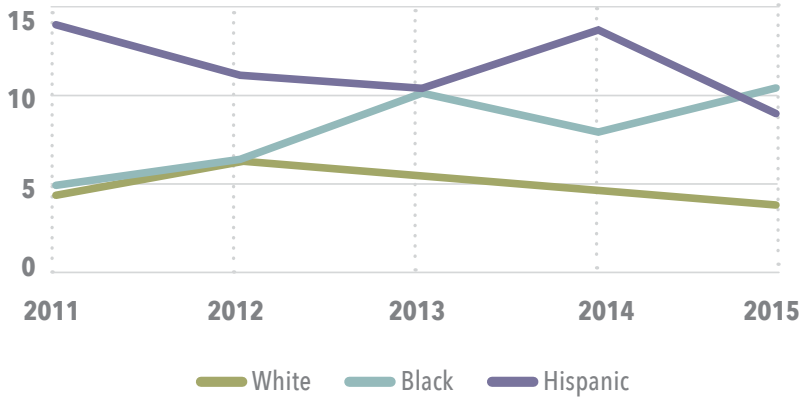
By looking deeply at data, we can shape the future of Kansas.

If we address the barriers facing children of color in our state, we can improve economic, health, education, and social outcomes across the board. Kansas Action for Children's Data Spotlight series examines how race and ethnicity shape the issues affecting Kansas children and identifies ways policymakers can help every Kansas child succeed.

We know children with health insurance are more likely to access preventive care, preparing them to succeed in school and be healthier into adulthood. In fact, longitudinal research shows when children are covered by public health insurance they are not only healthier but more likely to attain higher levels of education and higher earnings as adults.[i] However, more than 30,000 Kansas children went without health insurance in 2015, a number much too high for Kansans committed to healthy children and a healthy state. Although uninsured rates among children are declining, 5 percent of Kansas children remained without health insurance in 2015.

Despite the decline, racial disparities in health insurance rates remain, leaving Black and Latinx[ii] children more at risk of being without health insurance than their white counterparts.

BLACK AND LATINX KANSAS CHILDREN ARE TWICE AS LIKELY AS WHITE KANSAS CHILDREN TO BE UNINSURED



Source: US Census Bureau, American Community Survey 2011–2015 // 1-Year Public Use Microdata Samples.

Black and Latinx Kansas children are twice as likely as white Kansas children to be uninsured.

Despite the increase in insurance rates for Kansas children overall, Black and Latinx Kansas children remain twice as likely as their white counterparts to be without health insurance. Roughly one in 10 Black (10 percent) and Latinx (9 percent) Kansas children do not have health insurance, compared with white Kansas children (4 percent).[iii]

Compounding the effect of that ratio is the five-year trend showing a decrease in uninsurance rates for all racial and ethnic groups, except for Black Kansas children. Black Kansas children, despite the intent to broaden access through the Affordable Care Act (ACA), were less likely to be insured in 2015 than they were in 2011, likely due to federal and state changes related to Medicaid enrollment.

Black and Latinx children face barriers in accessing health insurance, regardless of insurance type.

Children are more likely to be insured when their parents are also insured. Most children who are insured have coverage through employer-sponsored insurance, the ACA marketplace, or Medicaid/CHIP.[iv] However, people of color face economic and access barriers to secure insurance regardless of type.

Employer-sponsored insurance:

Children insured under employer-sponsored insurance would be covered by their parent's employer. Insurance coverage is a benefit mandated for people working full-time jobs at companies with 50 or more employees. Race often dictates how parents enter the workforce, in terms of occupation, industry, and type of work. Research shows that Black parents are "more likely to have nonstandard employment or not to be employed," and Latinx parents are "more likely to have regular employment at a small firm,[v] have nonstandard employment, or to not be employed"[vi] than white parents. Nationally, Black and Latinx women are disproportionately represented in low-wage occupations such as the service industry. More than a quarter of Black women (27 percent) and Latinx women (30 percent) work in the service industry.[vii] In Kansas, 13 percent of Black adults and 8 percent of Latinx adults are unemployed, compared with 5 percent of white adults.[viii] These differences in employment result in Black and Latinx parents being less likely to have employer-sponsored insurance.

Black and Latinx parents who have access to health insurance through their employer still might not be able to afford the employee contribution. People who earn low incomes must spend disproportionate percentages of their earnings on basic necessities: food, housing, and transportation. On average, Black Kansans make $21,743 less and Latinx Kansans make $15,303 less than white Kansans.[ix]

Some income disparity can be explained by "differences in education, labor force experience, occupation or industry and other measurable factors." However, the income gap remains between workers in similar roles with similar work experience, a gap that can be attributed to discrimination.[x] For example, college-educated Black and Latinx men "earn roughly 80 percent the hourly wages of white college educated men."[xi]

New Affordable Care Act coverage pathways:

The Affordable Care Act (ACA) sought to give most Americans access to health coverage. Because most children already had access to coverage through Medicaid and CHIP, the ACA focused efforts on uninsured adults by expanding Medicaid and offering income-based subsidies to help middle-income adults purchase coverage on new marketplaces. A U.S. Supreme Court ruling made the Medicaid expansion to all low-income adults earning up to 138 percent of the poverty level (roughly $29,000 annually for a family of three) optional for states.

Kansas has not yet chosen to expand KanCare, leaving over 150,000 Kansans in the "coverage gap,"[xii] many of whom are uninsured and do not have access to affordable health care. The coverage gap is comprised of adults who do not currently qualify for Medicaid, which includes parents that fall between 38 percent of the federal poverty level (FPL) and 138 percent of the FPL, as well as childless adults that make less than 138 percent of the FPL. Because the ACA assumed they would have access to Medicaid, adults earning less than 100 percent of the federal poverty level (roughly $21,000 a year for a family of three) do not have access to financial support for marketplace plans.

Due to racial disparities in income[xiii] and wealth,[xiv] people of color are more likely to be in the coverage gap and less likely to afford the additional expense of health insurance premiums. In 2015, Black Americans' uninsured rate was at, or below, the national average of 12.1 percent in 25 of the 28 states that had expanded Medicaid at that time. Conversely, in the 23 states that did not expand Medicaid, only four states found uninsured rates among the Black population at or below the national average.[xv] This shows the expansion of Medicaid has a large effect on increasing insurance rates among Black Americans.

Medicaid/CHIP:

Because Medicaid was not expanded in Kansas, the only adults with access to Medicaid are very low-income parents (those below 38 percent of the FPL or less than $8,000 a year for a family of three). For those who qualify under Medicaid as it exists, barriers to enrolling remain as Kansas deals with an enrollment backlog and Kansans being "mistakenly denied coverage because of glitches in the system."[xvi] Most uninsured children — 23,000 — in the state are eligible for KanCare but not enrolled.[xvii] There have been problems with the state's eligibility system, resulting in loss of coverage or delays in enrollment.[xviii]

In addition to difficulty in enrolling in the state Medicaid program, there have been reports of increases in families with eligible children declining or unenrolling in social programs, such as Medicaid, due to concerns about anti-immigration policies.[xix, xx] In particular, undocumented parents, concerned about deportation, could fear interacting with government agencies, including Medicaid enrollment. Yet the majority of children in immigrant families are citizens.[xxi] With 16 percent of Kansas children coming from a family with at least one immigrant member,[xxii] declines in Medicaid enrollment due to fears about immigration policy could have a huge effect on children's health.

Policy Recommendations

If policymakers want to increase health coverage for Kansas children, it is imperative to think about closing health gaps through a race equity lens. Increasing health insurance rates for Kansas children of color will increase health insurance rates for all the state's children.

With race remaining a factor in health coverage rates, policy solutions must be responsive to the needs of communities of color. Policy solutions include:

» Encourage employers to provide quality health insurance for their employees, as access to health insurance can improve productivity of current workers and strengthen recruitment of future workers.

» Lawmakers should expand KanCare without barriers to enrollment. Expansion of Medicaid will improve the health and well-being of Kansas children and families by reducing the number of uninsured children and their parents. Many Kansas children currently without insurance are eligible for KanCare. By expanding coverage for their parents and other adults, we can help more children get the health care they need to stay healthy, active, and ready to succeed in school and in life.

» Lawmakers should reject proposed coverage barriers related to KanCare. Policies that limit eligibility would have the ultimate effect of discouraging or decreasing coverage for parents and undermine the opportunity to provide more parents and other adults with comprehensive health care coverage. A reduction in coverage for parents would pose a significant danger to the health and well-being of low-income Kansas children, as a child's health reflects the health of their parents. In addition, families without health insurance are financially vulnerable to unexpected medical emergencies.

» Agencies and lawmakers should continue to focus on improving the administration of KanCare by resolving eligibility processing challenges that discourage enrollment, avoiding eligibility application backlogs, and ensuring there are enough providers in the program. Increasing ease and accessibility to KanCare ensures the system works well and Kansas children can secure health insurance.

TO LEARN MORE:

- Learn more about how "Medicaid and CHIP Help Address Racial/Ethnic Disparities In Children's Health" from Georgetown University's Center for Children and Families.[xxiii]
- Read the Center on Budget and Policy Priorities' white paper.[xxiv]
- Examine other health indicators, by race and ethnicity, through the KIDS COUNT Data Center, a project of the Annie E. Casey Foundation.[xxv]

[i] Tricia Brooks, Karina Wagnerman. "Snapshot of Children's Coverage by Race and Ethnicity." Georgetown University Health Policy Institute, Center for Children and Families. https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf

[ii] With the exception of referring to data sources, when discussing people of Hispanic or Latin origin, KAC will use the term "Latinx" (pronounced "La-teen-ex") in order to be gender neutral.

[iii] US Census Bureau, American Community Survey 2011-2015 1-Year Public Use Microdata Samples.

[iv] Children's Defense Fund. "Children's Health" http://www.childrensdefense.org/policy/health/

[v] Small firms are defined as having less than 25 employees at all locations.

[vi] Clemans-Cope, Lisa, Genevieve Kenney, and Aaron Lucas. "Health Insurance in Nonstandard Jobs and Small Firms: Differences for Parents by Race and Ethnicity." The Urban Institute. April 2010. Brief 12. http://www.aecf.org/m/resourcedoc/urban-healthinsurancenonstandardjobs-2010.pdf

[vii] Kerby, Sophia. "The State of Women of Color in the United States." Center for American Progress. 2012. https://cdn.americanprogress.org/wp-content/uploads/issues/2012/07/pdf/women_of_color_brief.pdf

[viii] Panas, Lawrence John. "Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas." Kansas Health Institute. 2017. http://www.khi.org/policy/article/17-39

[ix] Panas, Lawrence John. "Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas." Kansas Health Institute. 2017. http://www.khi.org/policy/article/17-39

[x] Patten, Eileen. "Racial, gender wage gaps persist in U.S. despite some progress." Pew Research Center. 2016. http://www.pewresearch.org/fact-tank/2016/07/01/racial-gender-wage-gaps-persist-in-u-s-despite-some-progress/

[xi] Patten, Eileen. "Racial, gender wage gaps persist in U.S. despite some progress." Pew Research Center. 2016. http://www.pewresearch.org/fact-tank/2016/07/01/racial-gender-wage-gaps-persist-in-u-s-despite-some-progress/

[xii] Abby Goodnough and Mitch Smith. "Kansas House Narrowly Upholds Governor's Veto of Medicaid Expansion." The New York Times. April 3, 2017. https://www.nytimes.com/2017/04/03/health/kansas-brownback-veto-expand-medicaid.html

[xiii] Fetsch, Emily. "Closing racial disparity in income will bolster Kansas economy." Kansas Center for Economic Growth. 2018. https://realprosperityks.com/closing-racial-disparity-income-will-bolster-kansas-economy/

[xiv] Jones, Janelle. "The racial wealth gap: How African-Americans have been shortchanged out of the materials to build wealth." Economic Policy Institute. 2017. http://www.khi.org/policy/article/17-39

[xv] Bailey, Peggy, Matt Broaddus, Shelby Gonzales, and Kyle Hayes. "African American Uninsured Rate Dropped by More than a Third Under Affordable Care Act." Center on Budget and Policy Priorities. 2017. https://www.cbpp.org/research/health/african-american-uninsured-rate-dropped-by-more-than-a-third-under-affordable-care

[xvi] Marso, Andy. "Behind the backlog: The problem-plagued rollout of KEES." Kansas Health Institute. April 11, 2016. http://www.khi.org/news/%20article/behind-the-backlog-of-kees-applications

[xvii] Urban Institute. "Medicaid/CHIP Participation Rates Rose among Children and Parents in 2015." https://www.urban.org/sites/default/files/publication/90346/2001264-medicaid-chip-pariticipation-rates-rose-among-children-and-parents-in-2015_1.pdf

[xviii] Marso, Andy. "Problems with Medicaid eligibility system leave Kansans without care." Kansas Health Institute. February 1, 2016. http://www.khi.org/news/article/kancare-enrollment-glitches-have-actual-human-costs

[xix] Lowrey. Annie. "Trump's Anti-Immigrant Policies Are Scaring Eligible Families Away From the Safety Net." The Atlantic. March 24, 2017. https://www.theatlantic.com/business/archive/2017/03/trump-safety-net-latino-families/520779/

[xx] Cervantes, Wendy, Rebecca Ullrich, and Hannah Matthews. "Our Children's Fear: Immigration Policy's Effects on Young Children." Center for Law and Social Policy. 2018. https://www.clasp.org/sites/default/files/publications/2018/03/2018_ourchildrensfears.pdf

[xxi] Children in immigrant families who are U.S. citizens. KIDS Count Data Center. Anne E. Casey Foundation. https://datacenter.kidscount.org/data/tables/115-children-in-immigrant-families?loc=1&loct=1#detailed/2/18/false/870,573,869,36,868,867,133,38,35,18/any/445,446

[xxii] Immigrant family is defined as the child is foreign-born or resides with at least one foreign-born parent.

[xxii] Wagnerman, Karina and Tricia Brooks. "Medicaid and CHIP Help Address Racial/Ethnic Disparities In Children's Health." Georgetown University. Center for Children and Families. 2017. https://realprosperityks.com/closing-racial-disparity-income-will-bolster-kansas-economy/

[xxiv] Bailey, Peggy, Matt Broaddus, Shelby Gonzales, and Kyle Hayes. "African American Uninsured Rate Dropped by More than a Third Under Affordable Care Act." Center on Budget and Policy Priorities. 2017. https://www.cbpp.org/research/health/african-american-uninsured-rate-dropped-by-more-than-a-third-under-affordable-care

[xxv] KIDS Count Data Center. Annie E. Casey Foundation. http://datacenter.kidscount.org/data/tables/7757-children-without-health-insurance-by-race-and-ethnicity?loc=18&loct=2#detailed/2/18/false/870,573,869,36,35/10,11,9,12,1,185,13/14951,14952