

Case:

You are caring for an 8 yo African-American female on the general pediatrics floor. She was transferred from the PICU, where she was admitted for respiratory failure and status asthmaticus. She has a history of “wheezing” but has never been diagnosed with asthma. She receives a majority of her care in the ER and Urgent Care centers. She has never been on controller asthma medications. She lives at home with her mother and 2 siblings. Her mother is employed as a clerk at a hospital and earns \$29,942 per year, placing her at approximately 145% of the FPL. Her mother’s employer provides health insurance, however, she cannot afford to add all three of her children to her health insurance plan.

Questions:

- 1) Lack of health insurance limits this patient’s access to quality asthma care. But barriers to quality care exist even for those who are insured, what are some of those barriers?

- 2) Are there differences in asthma prevalence by race and income? Are there differences in how children in minority groups access medical care? How do these differences affect asthma care?

- 3) How are most children in the United States insured? Do you think it is common for a person to have a job yet not have health insurance coverage for their children? What are other health insurance options available to this family? Does she qualify for public insurance?

- 4) How could you be an advocate for this child? How can you help ensure improved asthma care?

Facilitator’s Guide:

1) Lack of health insurance limits this patient’s access to quality asthma care. But barriers to quality care exist even for those who are insured, what are some of those barriers?

There has been significant research into this question. Flores et al (1998) assessed barriers to healthcare for Latino children, as reported by Latino parents. In this study, parents identified language problems, cultural differences, poverty, lack of health insurance, transportation difficulties, and long waiting times as major access barriers to health care for Latino children.

Another article by Mansour (2000) looked at barriers to asthma care in pediatrics. Parents were recruited from 4 schools in low income, urban areas. There were forty respondents. 15% had private insurance, 79% Medicaid, and 6% none. The factors identified by this group were divided into four categories: patient/family factors, health care system factors, health provider factors, and environmental factors. The top barriers as reported by parents are listed below in table form. The identified barriers indicate the diversity of barriers experienced by families. An exhaustive list of barriers would also include other stakeholder’s perspectives, including pediatricians and schools.

Figure 1: Barriers to Asthma Care as Reported by Families from an Urban Environment

<p><u>Patient/Family Factors – 43%</u></p> <ul style="list-style-type: none"> • Misperceptions of asthma, asthma medications and their use (20%) • Parental attitudes toward disease (70%) • Compliance of child with parent’s recommendations (6.5%) 	<p><u>Health Care Systems – 11%</u></p> <ul style="list-style-type: none"> • Type of insurance, if present (4.8%) • Presence/absence of insurance (2.5%) • Primary location for asthma care (2.5%)
<p><u>Health Care Provider – 18%</u></p> <ul style="list-style-type: none"> • Education regarding asthma, asthma care and medications (6.8%) • Relationship between provider and child (2.3%) • General satisfaction with and trust of the health care provider (2.3%) • Continuity/lack of continuity of provider (2.3%) 	<p><u>Environmental – 28%</u></p> <ul style="list-style-type: none"> • Lack of knowledge about environmental triggers of asthma (14.6%) • Available support from school (8.6%) • Financial constraints – for transportation and medications (2.1%) • Housing constraints – unable to move/change allergen exposure (1.3%)

Source: Mansour, Mona. Barriers to Asthma Care in Urban Children: Parent Perspectives. Pediatrics 2000; 106; 512-519

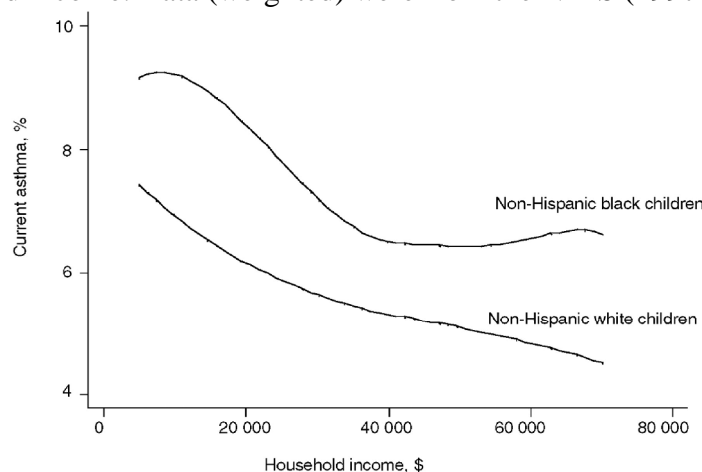
2) Are there differences in asthma prevalence by race and income? Are there differences in how children in minority groups access medical care? How do these differences affect asthma care?

2a) Are there differences in asthma prevalence by race and income?

While asthma affects children of all races, the prevalence of asthma is higher in both minority and low-income populations, see Figure 2 (McDaniel, 2006). In addition, minority children have the greatest morbidity from asthma, with low income, minority children having the greatest morbidity (Newacheck, 2000). Note in Figure 2 that for the same income, minority children have a higher prevalence of asthma.

Additional discussion question: What are the reasons for this difference?

Figure 2: Proportions of US children (age: 0–17 years) with current asthma, according to race and income. Data (weighted) were from the NHIS (1997–2003).



Source: McDaniel, Marla. Racial Disparities in Childhood Asthma in the United States: Evidence From the National Health Interview Survey, 1997 to 2003. Pediatrics. Vol. 117 No. 5 May 2006

2b) Are there differences in how children in minority groups access medical care?

Additional discussion questions: How do black children differ from white children in their ER utilization and follow-up with their primary care doctor? Can these differences be explained by differences in their insurance status?

Racial differences in emergency room utilization have been well documented even in insured individuals (Miller, 2000). In a study of Medicaid enrollees, black children saw their physicians 60% less often than white children. Black children visited ER's 3 times more often than their white counterpart (McDaniel, 2006). And in another study, Black and Hispanic children enrolled in Medicaid were 64% and 41%, respectively, less likely than white children enrolled in Medicaid to have received appropriate follow-up care after an ER visit (Shields, 2004).

2c) How do these differences affect asthma care?

Particularly in urban, racially diverse communities, asthma often goes undertreated (Jones, 2004), resulting in poorer outcomes for these populations. Studies have shown that black children are equally likely to be prescribed inhaled corticosteroids *despite an increase prevalence and severity of disease* (Boudreaux, 2003).

Primary care physicians are in a position to improve asthma outcomes and reduce disease burden. Asthma care delivered by a primary care physician who adheres to national asthma guidelines can result in a reduction in future ER visits and hospitalizations (Cloutier, 2005). Additionally, children without a primary care physician are more likely to have emergency room visits and are less likely to have effective asthma control (Kone, 2007).

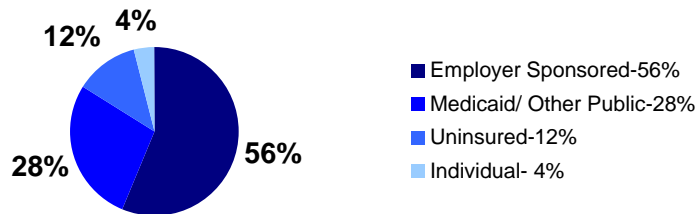
3) How are most children in the United States insured? Do you think it is common for a person to have a job yet not have health insurance coverage for their children? What are other health insurance options available to this family? Does she qualify for public insurance?

3a) How are most children in the United States insured?

Additional discussion questions: Do most people have private or public health insurance? To what degree do people have employee-sponsored health insurance?

In the United States, 12% of the children were uninsured in 2005 (N=77.9 million). Employer sponsored health insurance is the most common source of health insurance for children. Figure 3 provides a graphical representation of health insurance coverage for children.

Figure 3: Health Insurance Coverage of Children, January 2005

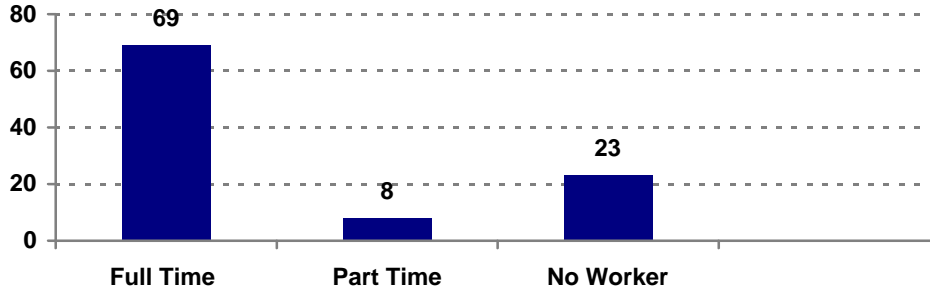


Source: Health Insurance Coverage of America's Children. Kaiser Family Foundation. January 2007

3b) Do you think it is common for a person to have a job yet not have health insurance coverage for their children?

While employer sponsored health insurance provides health insurance for more than half of children in this country, not all families have access to or can afford employer-sponsored insurance. Nearly 70% of uninsured children live in families where there is at least one full time worker.

Figure 4: Uninsured Children by Family Work Status, 2005, by percentage



Source: Health Insurance Coverage of America’s Children. Kaiser Family Foundation. January 2007.

3c) What are the health insurance options available to this family?

Medicaid and SCHIP programs are developed by each state under broad federal guidelines, therefore, programs can differ significantly between states. However, this child would likely qualify for SCHIP. To understand how this is determined, you first need to know what is “poor.” The federal poverty guidelines are listed below:

Figure 5: Federal Poverty Guidelines, 2007

Persons in Family	48 States and DC
1	\$10,210
2	\$13,690
3	\$17,170
4	\$20,650
5	\$24,130
6	\$27,610
7	\$31,090
8	\$34,570

Source: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148

Next, it is important to understand the main public insurance available to children: Medicaid and SCHIP.

Medicaid

Who receives Medicaid?

To be eligible for Medicaid, individuals must be poor AND meet a categorical requirement. While there are many details to eligibility, for most children, the categorical requirement is either their age or a disability. Below is an abbreviated list of mandatory income and categorical requirements that entitle children to Medicaid. All states must provide children Medicaid who meet these requirements.

Figure 6: Abbreviated List of Mandatory Medicaid Populations

Category	Income
Children less than 19	Below 100% FPL
Children less than 6	Below 133% FPL
Children with disabilities who receive SSI	Determined by SSI eligibility, which varies depending on circumstances, averaging 200% FPL

***Special treatment for children:** Through the Early, and Periodic, Screening, Diagnosis, and Treatment (EPSDT) requirement, states must provide children access to all Medicaid covered services (including optional services) when they are medically necessary, whether or not they cover such services for adult beneficiaries.*

Who Pays for Medicaid?

- Funding is shared between States and the Federal Government
- The Federal government share, known as the Federal Medical Assistance Percentage, is determined based on a State’s average per capita income level. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP must be between 50% - 83%.
- States pay the remainder.
- Medicaid is an entitlement program – all individuals who qualify for Medicaid in a State must receive Medicaid benefits and the Federal government is required to provide matching fund for these individuals.

State Child Health Insurance Program (SCHIP)

Who receives SCHIP?

Federal legislation sets broad eligibility criteria, which include:

- children not covered by Medicaid,
- under age 19 and
- at or below 200% of the FPL

What are the services provided under SCHIP?

- Services provided under SCHIP depend on the state. States have the option of 1) expanding their Medicaid program or 2) developing a new SCHIP program. For states that choose to expand their Medicaid program, they must offer the same services offered under Medicaid.

Who Pays for SCHIP?

- The federal government will match State funds at 30% higher than the State's Federal Medical Assistance Percentage (FMAP). The maximum Federal match is 85%.
- States pay the remainder.
- Enrollee cost-sharing:
 - At or below 150% of the FPL States can impose the following:
 - Premiums: \$15-19 per family per month
 - Deductible: \$2 per family per month
 - Co-insurance: 5% of non-institutional costs
 - Co-payments: ranging from \$0.50 to \$3.00 per services
 - Above 150% FPL, state can impose the following:
 - Sliding scale not to exceed 5% of the family's income.
- SCHIP is a block grant program, not an entitlement program. Therefore, States receive a set amount of federal funding and there is no guarantee that an individual who qualifies for a State's SCHIP program will receive benefits.

3d) Does she qualify for public insurance?

Based on the mother's income of \$29,942 per year (the average salary of a medical clerk in Washington, DC), for a family of four, this family's income is 145% of the FPL. While this family's income does not fall into a mandatory category for Medicaid, our patient would likely qualify for public insurance in most States under SCHIP.

4) How could you be an advocate for this child? How can you help ensure improved asthma care?

Linking our patient to health insurance and/or a primary care physician will likely be one of the primary goals identified by people participating in this case discussion. However, there are many avenues to advocate for this child and her family to improve her asthma care. Discussion should be sought to identify actions that can be taken on an individual, community and legislative level.

References:

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