BRIEF

NPM 15

MCH EVIDENCE

Strengthen the Evidence for Maternal and Child Health Programs

Continuous and Adequate Insurance

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Continuous and adequate insurance is one of fifteen Maternal and Child Health (MCH) National Performance Measures (NPMs) for the State Title V MCH Services Block Grant to States program.[1] NPM 15 is the percentage of children, ages 0-17, who were continuously insured in the past year with adequate coverage, based on 3 criteria: whether their children's insurance covers needed services and providers, and reasonably covers costs.[2]

This evidence review will focus on strategies, programs, and policies that Title V programs can support and/or implement to ensure comprehensive health insurance coverage and continual access to affordable care for children and adolescents.

The full report and supplemental implementation resources can be found at: https://www.mchevidence.org/tools/npm/15-adequate-insurance-coverage.php.

This review was conducted as part of Strengthen the Evidence Base for MCH Programs, a Health Resources and Services Administration (HRSA)-funded initiative that aims to support states in their development of strategies to promote the health and well-being of MCH populations in the United States (U.S.).

Overview

In the U.S., the number of uninsured children rose from a historic low of 3.6 million (4.7%) in 2016 to 4.4 million (5.7%) in 2019 (Alker & Corcoran, 2020).[3] Over that same period, underinsurance among all U.S. children rose from 30.6% to 34% (+ 3.4%), a relative increase of 11.1%, representing an additional 2.4 million children (Yu et al., 2022). This means millions of children and families lacked adequate and continuous health insurance coverage even before the rapid spread of the COVID-19 pandemic and the beginning of the economic crisis when many parents became unemployed and lost access to job-based health insurance.

Children with inadequate insurance are more likely to delay or forego care and are less likely to have access to a medical home model of care, receive needed referrals, receive care coordination, and receive family-centered care than children with adequate insurance coverage (Kogan et al., 2010).

Comprehensive health care coverage can help children receive the health care they need when they need it, especially primary preventive care, including finding and treating preventable delays or diseases; protect families' financial stability; and improve children's long-term health, economic, and educational outcomes (Lu et al., 2015; Zhang, 2012; Murphey, 2017).

[1] https://mchb.tvisdata.hrsa.gov/Home/Resources
[2] https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NPMDistribution
[3] https://www.childrensdefense.org/state-of-americas-children/soac-2021-child-health

Evidence-based or informed Strategy Measures (ESMs)

Across the states and jurisdictions that chose adequate insurance as one of the NPMs, there are 7 ESMs that have been chosen by Title V agencies to monitor progress in advancing NPM 15. These ESMs fall into three categories:

- 0 represent activities directed to professionals (e.g., training activities, technical assistance),
- 1 is directed to families and their children (e.g., outreach materials to families, family-to-family support, development of care coordination plans), and
- 6 represent activities related to systems-building (e.g., engagement of stakeholder groups, quality improvement initiatives, collaboration between systems of care).

Findings from this report – specifically the evidence-based and evidence-informed interventions identified – can be used by Title V programs as models to strengthen current ESMs or develop new measures to affect change for each of these categories. Seven ESMs currently focus on NPM 15. These can be organized by the levels of the "MCH Pyramid," the conceptual service framework for the Title V MCH Block Grant program:[4]

- 5 measure activities related to public health services and systems (foundational level of the pyramid),
- 2 measure strategies related to enabling services (middle level of the pyramid), and
- 0 Title V program is currently funding strategies related to direct services in regards to ensuring adequate and continuous insurance coverage (gap-filling level of the pyramid).

The MCH Evidence Center uses Results-Based Account (RBA)[5] as a conceptual framework to track how ESMs are measured. This framework consists of increasing levels of measurement across four quadrants (Quadrant 1 being the simplest measurement and Quadrant 4 being the most complex). States and jurisdictions should focus efforts in expanding how they measure programs by moving up the RBA quadrant scale.[6, 7]

- 6 current adequate insurance ESMs measure effort:
  - 5 ESMs fall within Quadrant 1 (measuring the quantity of agency effort) and answer the question "what did we do?" (e.g., counts and "yes/no" activities).
  - 1 ESM falls within Quadrant 2 (measuring the quality of effort) and answers the question "how well did we do it?" (e.g., reach, quality of materials, satisfaction of intervention).
- 1 current adequate insurance ESM measures effect (e.g., increases in skills/knowledge, change in behavior or circumstance):
  - 0 ESMs fall within Quadrant 3 (measuring the quantity of the effect) to answer the question "is anyone better off?" (e.g., numbers of providers with increased knowledge).
  - 1 ESM falls within Quadrant 4 (measuring the quality of the effect) and answer "how are they better off?" (e.g., percentages of families whose self-efficacy improved).

Methods and Results

This review highlights evidence from the last decade since the Patient Protection and Affordable Care Act of 2010 (ACA) was enacted that demonstrates effectiveness in increasing health coverage and strengthening care for children and youth. Peer-reviewed studies were identified by searching five online databases. Sixteen studies (n=16) met the inclusion criteria.[8] Interventions were categorized along a continuum from evidence against (least favorable) to scientifically rigorous (most favorable). Each included study was rated on its own merit, and also rated as an intervention type to speak to the public health impact.

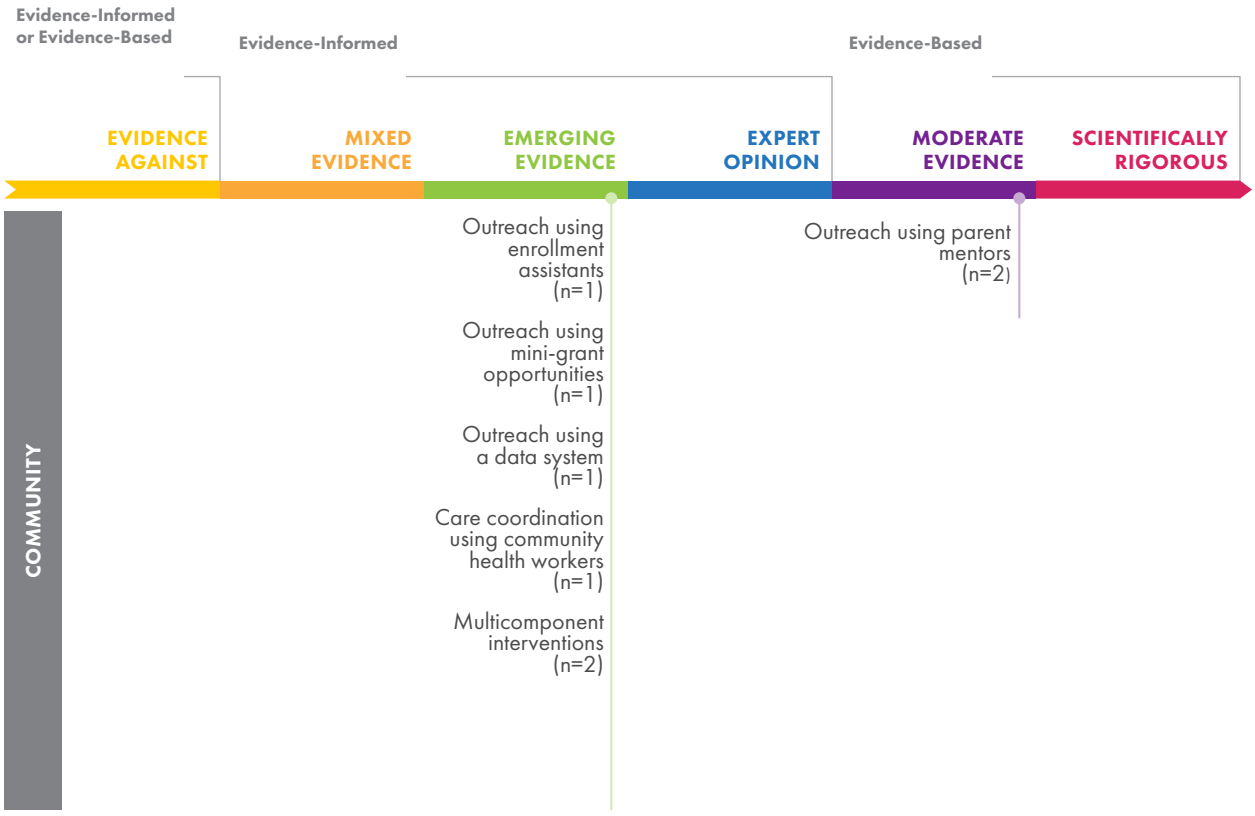
[4] The conceptual framework for the services of the State Title V MCH Block Grant is envisioned as a pyramid with three tiers of services and levels of funding that provide comprehensive services. A goal is to "move on down" the pyramid with more states and jurisdictions engaging in public health services and systems. See https://mchb.tvisdata.hrsa.gov/Glossary/Glossary for a graphical representation of the pyramid.

[5] RBA is described in the RBA Implementation Guide http://raguide.org/

[6] ESM Review & Resources: https://www.mchevidence.org/documents/ESM-Review-National-Summary.pdf

[7] To search the MCH Library to find state ESMs, visit: https://www.mchlibrary.org/evidence/state-esms.php

[8] Refer to the full report for the inclusion and exclusion criteria and a summary table of evidence-based and evidence-informed strategies to increase adequate insurance for children and youth..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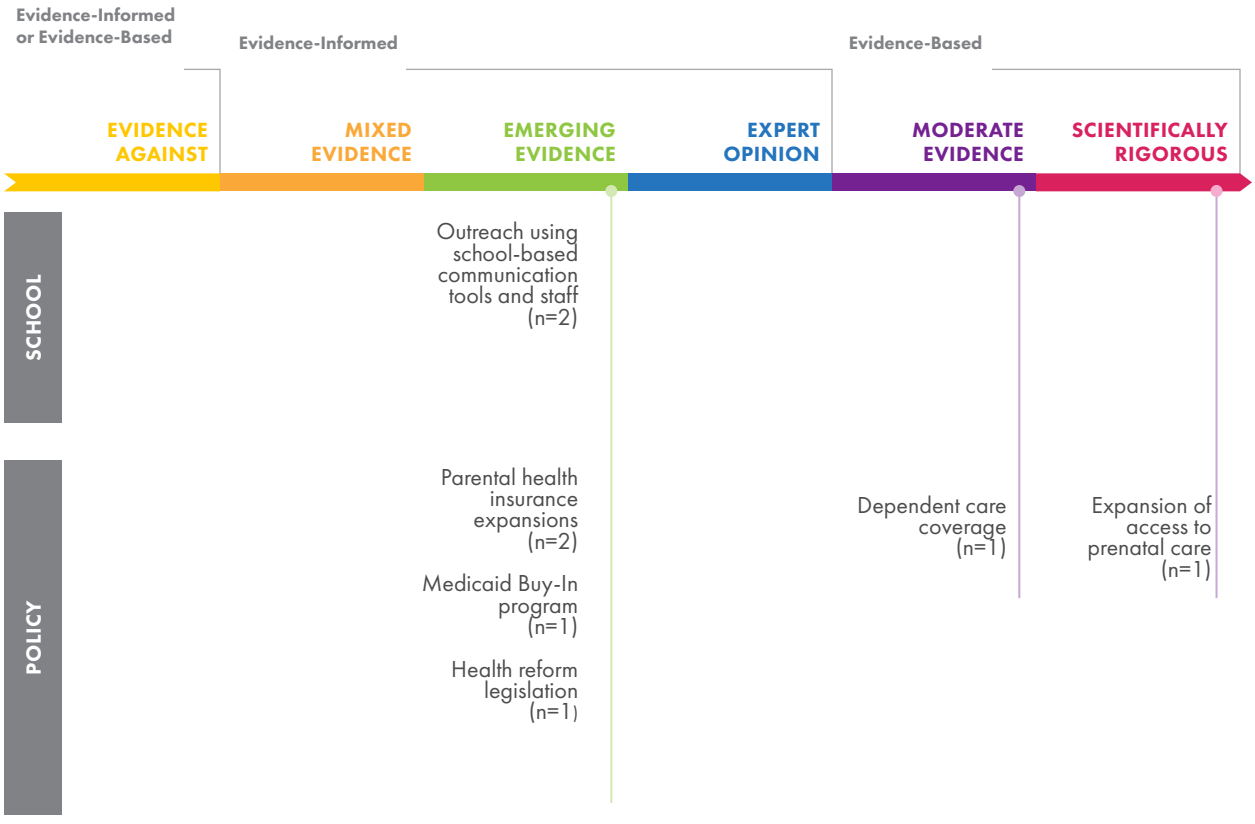
EMERGING EVIDENCE
EXPERT OPINION
MODERATE EVIDENCE
SCIENTIFICALLY RIGOROUS
COMMUNITY
Outreach using enrollment assistants (n=1)
Outreach using mini-grant opportunities (n=1)
Outreach using a data system (n=1)
Care coordination using community health workers (n=1)
Multicomponent interventions (n=2)
Outreach using parent mentors (n=2)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MODERATE EVIDENCE
SCIENTIFICALLY RIGOROUS
SCHOOL
Outreach using school-based communication tools and staff (n=2)
POLICY
Parental health insurance expansions (n=2)
Medicaid Buy-In program (n=1)
Health reform legislation (n=1)
Dependent care coverage (n=1)
Expansion of access to prenatal care (n=1)

Key Findings

Overall, 9 key findings emerged from the analysis:

1. In terms of setting, eight studies (50%) were community-based, six studies (37.5%) were policy focused, and two studies (12.5%) took place in schools.

2. In the community and school-based studies, outreach was the primary strategy used to insure uninsured and underinsured children and improve access to a comprehensive array of needed and affordable services, supports, and providers.
    a. Peers and professional staff, such as parent mentors, enrollment assistants, community health workers, child benefit advisors, and school nurses and administrative staff, were trained to outreach to parents to help them obtain and renew coverage for their children.
    b. Technology and tools, such as data systems and communication channels, assisted in the identification of uninsured children who were eligible for public insurance.
    c. A proactive approach was taken to identify and outreach to uninsured and underinsured children and facilitate their enrollment into public insurance.
    d. Community-health centers serving low-income populations are well-positioned to support families navigating the complexities of enrolling in public insurance.
    e. Medicaid/Children's Health Insurance Program (CHIP) outreach can be viewed as a continuum of activities from initial contact with a target population, to facilitating enrollment, to addressing access barriers, and, ultimately, ensuring appropriate utilization of care (Phillips, 2010).

3. The policy-focused studies examined the impact of expansion initiatives and health reform legislation on children's insurance coverage and service utilization.
    a. Parental coverage expansions increased the likelihood of children gaining coverage.
    b. Dependent coverage expansion for young adults prevented the loss of coverage in young adulthood.
    c. A Medicaid Buy-In program created a paway to Medicaid for children with disabilities whose family income is too high for Medicaid.
    d. The expansion of access to prenatal care for low-income immigrant women (Emergency Medicaid Plus) resulted in increased utilization and improved health outcomes for the women and their infants.
    e. Adult-oriented health reform legislation, such as an individual mandate, Medicaid expansion, and minimum essential benefits, can reduce uninsurance and positively affect children's access to care.
    f. The children's health insurance landscape is ever evolving with policy reforms being debated and considered with legislative reauthorizations, changes in administration, national trends, and advocacy efforts.

4. Thirteen studies and policy initiatives (81%) were focused on obtaining coverage, increasing access, and getting children into the health care system. One study (6%) examined underinsurance and measured whether children's insurance covered needed services and providers, and reasonably covered costs. Two studies (13%) were dually focused on both obtaining coverage and addressing underinsurance for children and youth.

5. Attention was given to overcoming enrollment barriers experienced by families and preventing gaps in coverage that result when parents are unable to renew their children's coverage.

6. Thirteen studies (81%) focused on extending insurance coverage to healthy children and adolescents. Three studies (19%) focused on getting coverage or increasing benefits for children and youth with special health care needs (CYSHCN), children with chronic diseases, and children with disabilities.

7. With states having the flexibility to implement different policies regarding expanding public insurance eligibility and subsidizing options for children and families, there are opportunities for states to learn from one another.

8. Of the 16 studies included in this evidence review:
    a. The rating of *scientifically rigorous* was given to one study (6%).
    b. The rating of *moderate evidence* was given to two studies (13%).
    c. The rating of *emerging evidence* was given to 13 studies (81%).
    d. The rating of *mixed evidence* was not given to any studies.
    e. The rating of *evidence against* was not given to any studies.

9. Overall, the evidence base for the included insurance interventions seems to be *emerging*. Most of the articles were published in the last five years and some were pilot studies. Read the discussion section to learn more about effective strategies and promising practices to ensure adequate and continuous health insurance coverage for more children and youth.

Discussion

A Title V-Medicaid partnership is especially important for improving quality and assuring access to public health coverage. This includes expanding and ensuring coverage for CYSHCN. One of Medicaid's critical roles is to provide financial coverage for important preventive and primary care services and specialty services for those eligible; Title V is essential to help translate those funds into a system of care that is accessible. A robust interagency agreement (IAA) can be a key factor in assuring coordination and mutual support between agencies to ensure coverage and care for more children, youth, and their families.

With the recent economic downturn and the sudden surge of children without employer-sponsored insurance due to the COVID-19 pandemic, Medicaid and CHIP will be tasked with filling a coverage gap to prevent a national crisis of pediatric uninsurance (Strane et al, 2020). As we set the policy agenda for a post-pandemic economic recovery, new, bolder approaches will be needed to prevent erosion of children's coverage gains and also lead us towards achieving universal and affordable coverage and care for all children and youth in the years to come (Strane et al., 2020).

From Evidence to Action

This review is part of a series of scholarly works focused on each NPM to identify and describe evidence-based and informed strategies from peer-reviewed and grey literature. The 16 studies analyzed in this review provide an overview of the scientific literature that can inform Title V program design, implementation, and measurement to support adequate and continuous insurance for children and youth. If you are looking to build or strengthen coverage efforts in your state or jurisdiction, moving "from evidence to action" can seem daunting. The MCH Evidence Center has developed a framework, tips, and resources to help you through the process. An NPM 15: Adequate Insurance Toolkit is also available at https://www.mchevidence.org/tools/npm/15-adequate-insurance-coverage.php. Email us with questions, comments, and requests for technical assistance at mchevidence@ncemch.org.

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