

Utah Health Status Update:

Uninsured Utah Children on the Rise

August 2007

Utah Department of Health

It is estimated that more than 9 million children in the U.S. are currently without health insurance. In 2006, despite a strong economy, one in five low income children in Utah were without health insurance. These statistics continue to raise concern because children without health insurance are less likely to get appropriate preventive care, putting them at risk for poor health and missed days of school.

Rising Number of Uninsured Children

According to the 2006 Health Status Survey, 89,500 Utah children between the ages of 0 and 18 were not covered by health insurance during 2006. This represents a 57% increase from 2003 and a 26% increase from the previous year. In 2003, 7.2% of all Utah children were uninsured, and by 2006, this rate had risen to 10.6%.

A recent internal study by Utah Department of Health (UDOH) staff examined this increase in uninsured children. The most salient result of their study was that the majority of increase in the number of uninsured Utah children is attributable to a rise in the number of uninsured children in families with incomes between 100%–200% of the federal poverty level (FPL) - \$20,000–\$40,000 annual income for a family of four. In 2006, 51% of Utah's uninsured children were in families within that income range, an increase from 47% in 2004, and 36% in 2005.

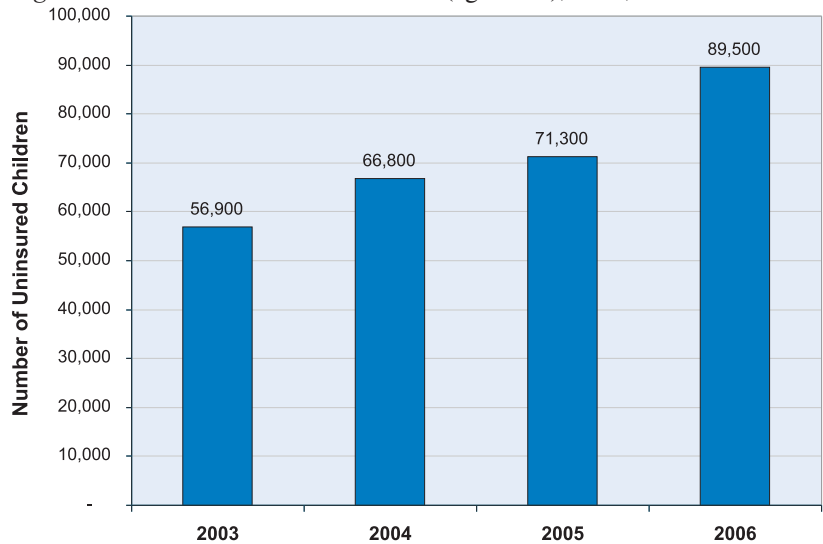
Potential Explanatory Factors

This income range is of particular interest because most of the children within the 100%–200% FPL income range would qualify for public programs, specifically Utah's Children's Health Insurance Program (CHIP). UDOH staff looked at potential explanations as to why this income group experienced such a dramatic rise, including:

- **Employers no longer offer coverage.** For this income group, this does not appear to be the cause for the increase. Twenty-four percent of children in this range were reported to be uninsured because of employers not offering coverage, which is actually at its lowest level since a high of 57% in 2004.
- **Affordability.** Typically, well over half of uninsured children's families reported being uninsured due to associated costs. While the rate is particularly high for this income range at 69%, this is lower than the 78%–80% figures that were observed in 2003 and 2004. Affordability is clearly an issue regarding the underlying level of uninsured children; however, it does not explain the recent increase for this group.

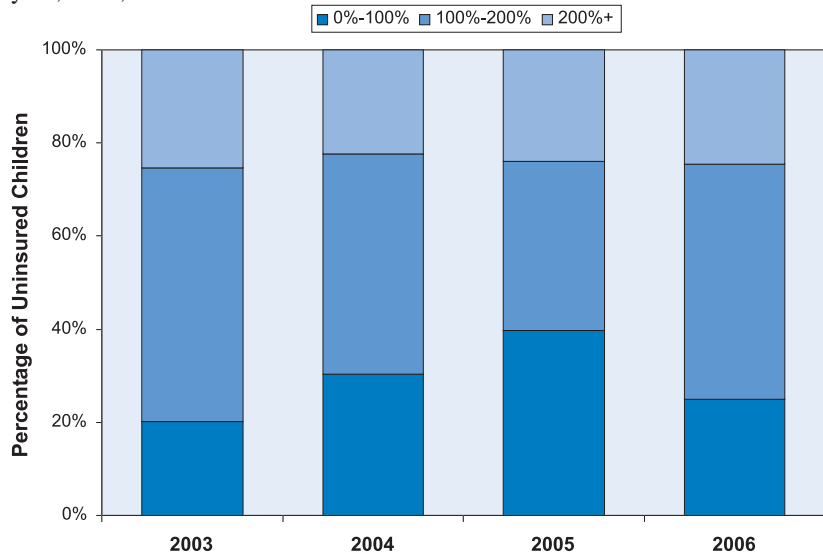
Total Number of Uninsured Children

Figure 1. Number of uninsured children (age 0–18), Utah, 2003–2006



Uninsured Children by Poverty Level

Figure 2. Percentage distribution of uninsured children by poverty level and year, Utah, 2003–2006



- **Lost eligibility for Medicaid or CHIP.**

One factor that seems to have some degree of correlation with the rise of uninsured children is the fraction of uninsured children who are reported to have lost eligibility, namely 36% in 2006. This is the highest rate in the past four years; however, the increase from previous years is not big enough to entirely explain the significant rise of uninsured children in 2006. Lost eligibility represents a portion of the answer and deserves further evaluation.

- **CHIP closing enrollment.** Another factor that may have contributed to the rise of uninsured children in this FPL income range is CHIP closed enrollment on September 1, 2006. Although there is not any specific data, this is a possible contributing factor.

- **Growth in uninsured Hispanic children.**

As seen in Figure 3, there has been a steady rise in the fraction of uninsured children in this income range that are Hispanic over the past four years, doubling from 22% in 2003 to 45% in 2006. While it is known that Hispanic children are generally less likely than non-Hispanic children to be insured, it is not known why there has been such a marked rise in the fraction of low-income uninsured children who were Hispanic since 2003.

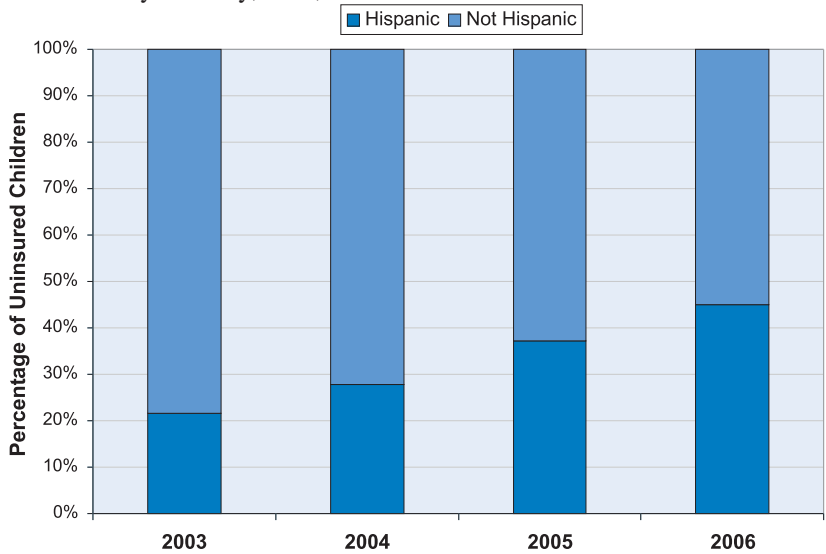
CHIP Open Enrollment and Increased Funding May Be the Solution

Because so many of the uninsured children fall between 100%–200% of the FPL, CHIP is a key element in addressing the increased number of uninsured children. In the 2007 Utah Legislative Session, lawmakers appropriated \$4 million to increase the number of children enrolled in CHIP to approximately 45,000. As of July 1, 2007, 25,095 Utah children are enrolled in CHIP. On July 2, 2007, CHIP reopened enrollment for new families.

In addition to understanding more about the reasons why this increase has happened, it is also important to look at the success of past efforts. Figure 4 depicts the number of Utah children who have been enrolled in CHIP over time, as well as the CHIP open enrollment periods. It is clear that CHIP open enrollment periods have been effective at increasing the number of insured children, a trend that UDOH anticipates to continue during the current open enrollment period.

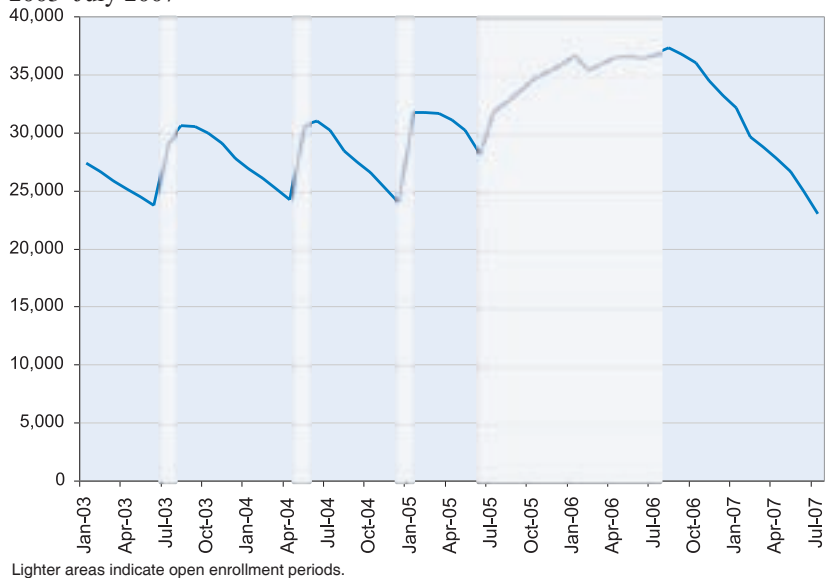
Hispanic Status (Uninsured and Poverty 100%–200%)

Figure 3. Percentage of uninsured children who were between 100%–200% of the FPL by ethnicity, Utah, 2003–2006



CHIP Enrollment

Figure 4. Number of children enrolled in CHIP by month, Utah, January 2003–July 2007



Lighter areas indicate open enrollment periods.

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Breaking News, July 2007

Poisonings Surpass Motor Vehicle Crashes as Utah's Leading Cause of Injury Death

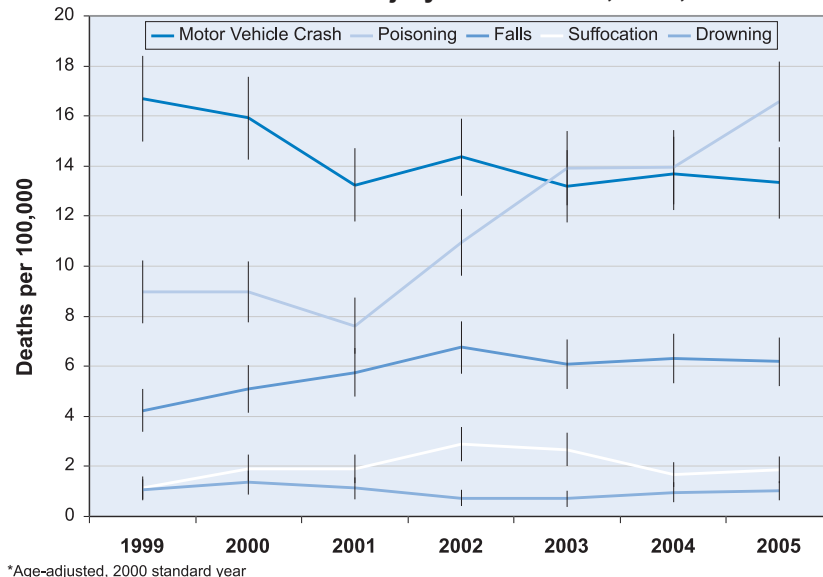
In 2003 the rate of unintentional and undetermined poisoning deaths (13.9 per 100,000) surpassed the rate of motor vehicle crash deaths (13.2 per 100,000) in Utah. Until this time, motor vehicle crashes have been responsible for more lives lost than any other cause of injury.

This change is due largely to the increase in poisoning deaths among adults caused by medications that can be legally prescribed. Although prescription pain medications underlie many recent Utah poisoning deaths, it is uncertain to what extent the drugs were prescribed for pain or attained illegally.¹ There has been an increase in poisoning deaths of *unintentional* intent (i.e., accidental), as well as *undetermined* intent (cases where intent could not be determined by the medical examiner). Sixty percent of Utah poisoning deaths are of undetermined intent.

The rate of unintentional and undetermined poisoning deaths in the U.S. has increased in recent years as well (from 5.3 per 100,000 in 1999 to 8.3 per 100,000 in 2004), however not as rapidly as in Utah (from 9.0 per 100,000 in 1999 to 16.6 per 100,000 in 2005).

¹ CDC. Increase in Poisoning Deaths Caused by Non-Illicit Drugs—Utah, 1991-2003. *Morbidity and Mortality Weekly Report*, 200; 54:33-36

Unintentional & Undetermined Injury Death Rates*, Utah, 1999-2005



Community Health Indicators Spotlight, July 2007

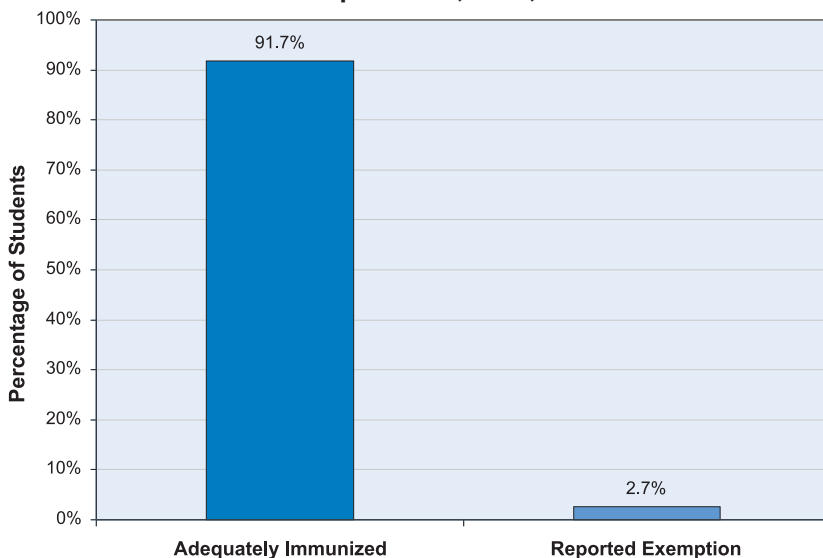
7th Grade Immunization Requirement

Immunization requirements were added for students entering the 7th grade beginning in the 2006–2007 school year. In order to attend the 7th grade for the 2007–2008 school year, students must receive the following immunizations: three Hepatitis B, one Tetanus/Diphtheria/Pertussis (Tdap) booster, and one varicella (chickenpox). These immunizations are required in addition to immunization series that should already have been completed. A child may be allowed to attend school “conditionally” if they have received at least one dose of the required vaccines and are on schedule to complete each series. Parents may report an exemption for medical, religious, or philosophical reasons.

Each year public and charter schools are required to report the immunization status of their students in November and to submit a follow-up report in June for students who were conditional or not in compliance on the November report.

In November, 91.7% of students entering the 7th grade were adequately immunized and 2.7% reported exemptions. Because this requirement is new, the 2006–2007 data will establish a baseline measurement and comparisons will be made in subsequent years.

7th Grade Immunization Requirement, Utah, 2006–2007



Monthly Health Indicators Report

(Data Through June 2007)

Monthly Report of Notifiable Diseases, June 2007	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (Campylobacter)	50	33	184	119	1.6
Enterotoxigenic Escherichia coli (E. coli)	9	11	37	25	1.5
Hepatitis A (infectious hepatitis)	0	3	2	17	0.1
Hepatitis B (serum hepatitis)	2	3	10	19	0.5
Measles (Rubeola, Hard Measles)	0	0	0	0	--
Meningococcal Diseases	0	0	7	3	2.1
Norovirus	1	0*	15	7*	2.1
Pertussis (Whooping Cough)	22	28	212	164	1.3
Salmonellosis (Salmonella)	31	23	132	122	1.1
Shigellosis (Shigella)	5	3	14	21	0.7
Varicella (Chickenpox)	8	29*	567	411*	1.4
Viral Meningitis	8	9	29	37	0.8
West Nile (Human cases/Equine cases)†	1 / 0	0 / 0	1 / 0	0 / 0	-- / --
Notifiable Diseases Reported Quarterly, 2nd Qtr 2007	Current Quarter # Cases	Current Quarter # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
HIV	26	24	45	41	1.1
AIDS	8	11	20	22	0.9
Chlamydia	1,471	1,049	2,652	1,844	1.4
Gonorrhea	229	150	403	261	1.5
Tuberculosis	9	9	23	16	1.5
Program Enrollment for the Month of June 2007	Current Month	Previous Month	% Change^s From Previous Month	1 Year Ago	% Change^s From 1 Year Ago
Medicaid	159,849	161,368	-0.9%	174,800	-8.6%
PCN (Primary Care Network)	17,795	18,066	-1.5%	16,043	+10.9%
CHIP (Children's Health Ins. Plan)	24,747	26,285	-5.9%	35,248	-29.8%

Medicaid Expenditures (in Millions) for the Month of June 2007	Current Month	Expected/Budgeted for Month	Fiscal YTD	Budgeted Fiscal YTD	Variance - over (under) budget
Capitated Mental Health	\$ 7.7	\$ 8.4	\$ 94.3	\$ 105.3	(\$ 10.9)
Inpatient Hospital	\$ 20.6	\$ 17.2	\$ 181.6	\$ 184.2	(\$ 2.6)
Outpatient Hospital	\$ 8.4	\$ 6.7	\$ 76.6	\$ 73.0	\$ 3.6
Long Term Care	\$ 14.5	\$ 14.5	\$ 182.4	\$ 180.1	\$ 2.3
Pharmacy	\$ 13.2	\$ 10.7	\$ 127.8	\$ 131.6	(\$ 3.7)
Physician/Osteo Services	\$ 5.2	\$ 5.9	\$ 60.0	\$ 63.9	(\$ 3.9)
TOTAL HCF MEDICAID	\$ 122.0	\$ 123.3	\$ 1,406.7	\$ 1,441.2	(\$ 34.4)
Health Care System Measures	Number of Events	Rate per 100 Population	% Change^s From Previous Year	Total Charges in Millions	% Change^s From Previous Year
Overall Hospitalizations (2005)	268,652	10.0%	-1.3%	\$ 3,501.7	+8.6%
Non-maternity Hospitalizations (2005)	161,474	5.8%	-1.6%	\$ 2,914.5	+8.2%
Emergency Department Encounters (2005)	664,523	25.0%	+3.5%	\$ 553.2	+21.2%
Outpatient Surgery (2005)	308,300	11.7%	-0.5%	\$ 947.7	+12.1%
Annual Community Health Measures	Current Data Year	Population at Risk	Number Affected	Percent/Rate	% Change^s From Previous Year
Overweight and Obesity (Adults 18+)	2006	1,777,802	976,000	54.9%	+1.3%
Cigarette Smoking (Adults 18+)	2006	1,777,802	174,200	9.8%	-15.0%
Influenza Immunization (Adults 65+)	2006	217,313	156,700	72.1%	+3.4%
Health Insurance Coverage (Uninsured)	2006	2,582,371	306,500	11.9%	+2.5%
Motor Vehicle Crash Injury Deaths	2005	2,528,926	292	11.6 / 100,000	-4.5%
Suicide Deaths	2005	2,528,926	344	13.6 / 100,000	-11.1%
Diabetes Prevalence	2006	2,582,371	105,600	4.1%	-0.7%
Coronary Heart Disease Deaths	2005	2,528,926	1,567	62.0 / 100,000	-4.6%
All Cancer Deaths	2005	2,528,926	2,512	99.3 / 100,000	+0.4%
Births to Adolescents (Ages 15-17)	2005	58,374	917	15.7 / 1,000	+5.8%
Early Prenatal Care	2005	51,517	40,587	78.8%	+1.0%
Infant Mortality	2005	51,517	231	4.5 / 1,000	-13.3%
Childhood Immunization (4:3:1:3:3)	2005	50,043	37,100	74.1%	+3.9%

* Due to limited historical data, the average is based upon 3 years of data for norovirus, varicella, and 4 years of data for West Nile virus infections.

† West Nile virus surveillance has begun for the 2007 season.

§ % Change could be due to random variation.

Note: Active surveillance has ended for influenza until the 2007 season.