

# State Policies That Work

# PROMOTING BETTER FAMILY HEALTH



A Series of Policy Briefs from the Policy Matters Project

Brief No. 4

## INTRODUCTION

The physical and mental well-being of every family member is an important factor affecting a family's economic success, the readiness and success of children in school, and the engagement of youth in positive and productive roles. Likewise, family health is crucial to a family's capacity to provide, nurture, and care for its members. In short, the health status of low-income families is highly correlated with their prospects for better lives.

“Healthy Families” refers to the physical and mental well-being of families and examines the behavioral, environmental, and clinical determinants of health for low-income families. Using this three-part framework, we recommend here a set of state policies intended to help low- to moderate-income families address a range of financial, systemic, and personal barriers<sup>1</sup> to:

- Receipt of timely, appropriate, and coordinated diagnostic, prevention, and treatment services;
- Lifestyles that enhance their physical and mental well-being; and
- Health-supporting environments.

This brief is a companion to a complete policy and research paper that provides an overview of current health trends and offers a beginning framework for state health policy. The complete paper is one in a series of papers available from CSSP at [www.cssp.org](http://www.cssp.org). Policy and research papers and companion “Policies That Work” briefs are available for six core outcomes: family economic success, school readiness, healthy families, educational success, youth engagement, and strong family relationships. Interested readers may obtain these publications from the CSSP website ([www.cssp.org](http://www.cssp.org)) or by calling the Center at 202-371-1565.

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# HEALTH CARE SERVICES

## Affordability

Insurance is a major key to whether families receive health care in the United States.<sup>2</sup> The proportion of low- and moderate-income families who lack either publicly or privately financed insurance remains very high. Consequently, general health status and vulnerability to chronic diseases and disabilities often reflects an inability to purchase care. States can significantly enhance the ability of families to purchase health care through a range of policies designed to make health services more affordable.

## POLICY 1

### Health Insurance Eligibility

Good insurance coverage provides enrolled individuals or families with financial access to a comprehensive range of preventive and treatment services, including: primary and specialty care, dental health, mental health, and substance abuse services. Whatever the mix of federal, state, and private programs, families up to approximately 250 percent of the federal poverty level (FPL) need this coverage. The objective of state health insurance eligibility policies should be to secure continuous health insurance coverage for children and families facing financial hardship and disparate access to quality health care. To meet this aim, states should consider the following health insurance eligibility options.

**1.1 Child Age Eligibility.** Older children are more likely than younger children to be uninsured. With most adolescents becoming ineligible for public health insurance coverage around age 19, public programs tend to be more inclusive of younger children even when their family's income is higher. Moreover, it is around age 19 that young people are least likely to earn enough to purchase private coverage or attain a job that includes health benefits, but most likely to face higher risks of serious injuries, need screening and treatment services for mental and reproductive health, and initiate risky behaviors.<sup>3</sup> This results in insurance coverage and health service gaps at precisely the time young people need these supports to successfully transition into adulthood. Given this, state health insurance policy should extend eligibility to all children and youth up to age 23.

**1.2 Child Income Eligibility.** As of January 2002, ten states expanded their Medicaid or S-CHIP income eligibility levels for children to 250 percent or more of FPL.<sup>4</sup> States should ensure that children in families with incomes up to at least 250 percent of the federal poverty level are eligible for health insurance coverage.

**1.3 Parent Income Eligibility.** Research indicates that parental insurance coverage and use of health services are strong predictors of a child's use of health services. Two parent eligibility issues are important: covering parents at appropriate eligibility levels and covering two-parent families

at the same level as one-parent families. When a parent is not covered by health insurance, children are less likely to get timely health care services, and their health and development is compromised.<sup>5</sup> While some states meet or exceed child income eligibility levels at 250 percent of the federal poverty level, very few do so for either single or two-parent families. For example, the median state Medicaid eligibility policy for single-parent families with children was 66 percent of the 2001 FPL. While eighteen states made these families eligible at 100 percent or more of the FPL, only the District of Columbia, Minnesota, New Jersey, and Washington included single-parent families at 200 percent or more of the FPL. Regarding equality between one-parent and two-parent households, thirty-six states passed laws covering two-parent families at the same level as single-parent families.<sup>6</sup> Given that adult participation in health care coverage and services often affects rates of child participation and well-being, state policy should make parents or guardians and pregnant women with family incomes up to 250 percent of the federal poverty level eligible for health insurance coverage.

#### **1.4 State Financed Health Insurance Coverage for Legal Immigrants.**

Immigrants who are not eligible for federal assistance with health insurance lack access to quality health care services. Immigrant children and parents account for only about six percent of the entire population of uninsured persons. However, recent immigrants are nearly three times more likely to be uninsured than the general population, and poor immigrants have uninsured rates of 53 percent.<sup>7</sup> The impact of increasingly large immigrant populations, some immigrating with pressing health care needs, warrants attention to ensuring health care coverage for immigrant families. Despite the fact that the 1996 welfare reform law made many legal immigrants ineligible for federal sources of insurance coverage, states can enact state funded programs to cover legal immigrants who would otherwise be uninsured and ineligible for health care coverage. State policy should make immigrant families eligible for health insurance coverage up to 250 percent of the FPL.

## **POLICY 2 Caps on Out-of-pocket Expenses**

The financial protection of an insurance plan can be negated by high deductibles or catastrophic circumstances that leave even middle-income families facing bankruptcy because of extensive treatment expenses. Over one-quarter of families with incomes below 200 percent of the poverty level and with serious health problems face out-of-pocket expenses of over five percent of family income, not including premium costs. In addition, research reveals that families facing high out-of-pocket expenses will forgo necessary health care. Out-of-pocket caps in employer-sponsored health insurance plans range from less than \$500 per year to no limit. However, the largest number of employer-sponsored plans had caps that fell between \$1,000 and \$1,500.<sup>8</sup> With the exception of

Medicare, public insurance programs (including Medicaid and S-CHIP) already limit co-payments and deductibles. State insurance commissions can greatly support the need for extending the affordability of health care coverage to families living near the poverty level by regulating family deductibles and co-pays required by private health care plans.

**2.1 Caps on Out-of-pocket Expenses.** Studies indicate that even low co-pays and deductibles have the effect of keeping low-income families from getting necessary care.<sup>9</sup> States should limit out-of-pocket expenses like co-pays, deductibles, and other patient-borne costs to a range of \$500-\$1,000 per year. Out-of-pocket expenses totaling \$1,000 is one full month's salary or approximately eight percent of a family's yearly salary at the poverty level. Limiting these costs to less than \$1,000 helps to protect low-income families from financial devastation.

## Availability

Insurance coverage has little utility without the actual availability of health care services. Availability refers to both the presence of individual providers and the overall service capacity of the health care system. In addition, the range of benefits covered in a health insurance plan also affects availability.

## POLICY 3

### Health Care Provider Availability

While having a broad range of benefits is ideal for families with diverse needs, simply including a benefit in a health plan does not ensure that a professional actually exists to provide such services. In 2002, the federal government designated 3,216 geographic areas as “shortage areas” for primary care health providers; 1,953 are so designated for dental health providers; and 963 are designated as having mental health provider shortages. The need to recruit and place health care professionals for direct-care positions and under-served areas is especially acute for rural communities.<sup>10</sup> To improve the availability of health care providers, states should consider a number of policy options designed to train, recruit, and compensate professionals for working in underserved areas and professions.

**3.1 Loan Forgiveness and Scholarships.** States should provide loan forgiveness and scholarships for professionals willing to serve in medically underserved areas or in professional specialties experiencing workforce shortages. Targeting incentives to areas of greatest need is important for making health care services available where they are needed most.

**3.2 Minority Recruitment and Training.** The percentage of minority enrollees in medical schools remained essentially unchanged between 1970 and 1996, and continued at a rate lower than minority representation in the general population.<sup>11</sup> Addressing this trend is important because minority physicians are more likely to serve in minority communities and underserved areas.<sup>12</sup> State policy should establish goals to encourage

the recruitment and training of health care providers whose race, ethnicity, and language reflect the composition of the state and communities of need.

**3.3 Telemedicine for Remote Areas.** An approach with growing support is the use of telemedicine technology for linking underserved areas to remote sources of medical expertise.<sup>13</sup> Telemedicine approaches enable the transfer of medical information - including medical images, two-way audio and videoconferences, patient records, and data from medical devices - for diagnosis, therapy and education. Extensive telemedicine operations have been deployed in many countries, including Norway, France, the United Kingdom, Japan, Australia, and Canada.<sup>14</sup> In the United States, health providers in a number of medical specialties use telemedicine practices.<sup>15</sup> The Kansas University Center for Telemedicine and Telehealth, in its brief summary of the small body of telemedicine research, reports that telemedicine practices appear to be at least comparable in cost to services offered using traditional methods, and may be substantially less expensive if telemedicine networks are more fully developed and utilized.<sup>16</sup> As of 2001, 19 states used Medicaid options to cover telemedicine services, and in some states private providers also provide limited telemedicine coverage.<sup>17</sup> In addition, 21 states require full licensure of medical practitioners providing telemedicine services across state borders and five states use a variety of approaches including registrations or permits for out-of-state physicians. Rather than taking a restrictive approach to licensing, 12 states have adopted the Interstate Nurses Licensing Compact, an agreement that provides mutual recognition between states and is administered by each state's head of nursing licensing board.<sup>18</sup> Given the early but promising research on telemedicine practices, states should make use of currently available technology to develop and support telemedicine systems that provide medical expertise to underserved geographic areas of the state. Specifically, states should exercise Medicaid options for reimbursing telemedicine services and protect patients by requiring out-of-state physicians to be licensed to provide telemedicine services.

**3.4 Provider Reimbursement Rates.** Medicaid reimbursement rates have been associated with child and family access to services as diverse as dental treatment, cochlear implants, and nursing home quality.<sup>19</sup> Between 1993 and 1998, Medicaid reimbursement rates grew slower than inflation and fell 14.3 percent when compared to Medicare rates. During that same period, only 11 states maintained Medicaid rates of 75 percent or more of Medicare rates for primary care, obstetric care, and other services.<sup>20</sup> Medicaid reimbursement rates vary widely among the states.<sup>21</sup> To improve the availability of quality care, states should set provider reimbursement rates for Medicaid and other state-funded health care services at 75 percent or more of current Medicare reimbursement rates.

## Accessibility

“Accessibility” is defined as the ability of families and children to reach or secure needed, appropriate health care services. Accessibility involves the relative difficulty or ease of enrollment in public health care insurance programs, culturally and linguistically responsive service delivery, and use of alternative delivery strategies.

## POLICY 4

### Enrollment in Publicly Funded Insurance Programs

Complex and difficult enrollment procedures tend to stand as barriers to insurance coverage and, therefore, as barriers to receipt of health care services. While states have made strides in expanding coverage for children during the 1990s, protecting those gains and making enrollment more “user-friendly” are important policy issues.

**4.1 Streamlined Procedures for Enrollment in Medicaid and S-CHIP.** States should adopt enrollment procedures that reduce complexity and increase the ease of enrollment by low-income families. Several enrollment procedure policies have proven effective at improving access. They include use of joint application forms for Medicaid and S-CHIP (28 states), dropping asset tests for eligibility determination (42 states), eliminating face-to-face interviews (40 states), and extending re-determination intervals to 12 months (39 states). Less frequently used are adoption of temporary presumptive eligibility determination (8 states), self-declaration of income (10 states), and 12-month continuous eligibility regardless of income changes (13 states).<sup>22</sup> Based on state experience with these options, states should adopt a mix of at least four of the above procedures.

## POLICY 5

### Culturally and Linguistically Appropriate Services

The increase in immigrant groups in most states argues strongly for health care services that can adequately serve linguistically and ethnically diverse families. A 1996 survey found that 15 percent of American Indian and Hispanic families, and 14 percent of Asian and Pacific Islander families, experienced difficulty or delays in receiving health care or received no health care when needed.<sup>23</sup> To improve the cultural and linguistic responsiveness of the health care system, states should adopt the following policy features:

**5.1 Cultural and Linguistic Competence.** Concern for the cultural and linguistic appropriateness of health services prompted the federal Office of Minority Health to lead a national effort to produce consensus-backed standards for cultural and linguistic competence in health care.<sup>24</sup> These standards are endorsed by more than 20 national health-related organizations.<sup>25</sup> Other research indicates that some states were unprepared for significant growth in Hispanic and Asian populations and the health care access challenges such growth created.<sup>26</sup> To better serve the health needs of their diverse communities, states should require and fund training for

health care providers to ensure culturally and linguistically competent health care services as defined by federal Cultural and Linguistic Appropriate Services (CLAS) standards.

**5.2 Translation and Outreach Materials.** Several studies indicate that patients for whom English is a second language experience a range of serious difficulties when attempting to access medical care. For instance, one national survey of Hispanic adults found that those who primarily speak Spanish reported significantly greater communication problems than those who primarily speak English.<sup>27</sup> Other studies reveal that patients with language barriers are more often less satisfied with their care, often do not understand medical instructions, are less willing to return to hospital emergency rooms, less likely to receive a follow-up appointment, and less likely to have a medical home or receive preventive care.<sup>28</sup> To provide better access to health care and prevent unnecessary complications due to language and cultural barriers, states should provide translation, outreach, and educational materials in the languages of patient populations.

## **POLICY 6** **Mental Health Services**

The need for mental health supports and treatments is pervasive. Prior to 1996, however, it was commonplace for health insurance providers and plans to either refuse coverage of mental illness and substance abuse treatment or provide significantly lower levels of coverage for such services. This policy approach left many families without necessary mental health care or resulted in extraordinary out-of-pocket costs when compared to physical health care and surgery costs. In addition, other mental health policies, often in an effort to make mental health treatment accessible and affordable, actually do harm to families needing help. To better meet the pervasive mental health needs of significant numbers of Americans, states should adopt policies that make mental health care affordable, accessible, and more family-friendly.

**6.1 Parity for Mental Health and Substance Abuse Treatment.** The practice of limiting mental health benefits in private insurance plans is widespread. Some research indicates that 94 percent of health maintenance plans and 96 percent of other plans significantly limit mental health benefits, such as the number of outpatient sessions and inpatient days covered.<sup>29</sup> This state of affairs prompted the federal Mental Health Parity Act of 1996 (MHPA), which requires that annual or lifetime dollar limits on mental health benefits be no lower than such limits for medical and surgical benefits offered by a group health plan. The Act gives employers discretion over the extent and scope of mental health benefits covered in the plan and does not apply to substance abuse or chemical dependency.<sup>30</sup> As of 2002, 34 states enacted mental health parity laws. The statutes varied in terms of benefits covered and eligible partici-

pants.<sup>31</sup> States should enact parity laws requiring insurers to cover treatment costs for both biological and non-biological disorders and for substance abuse or chemical dependency. In addition, states should require eligibility for all employees at businesses (public and private) with 51 or more employees, which is the federal standard set in MHPA.

**6.2 Parental Custody and Treatment Rights.** In a survey of child welfare directors in 19 states and juvenile justice officials in 30 counties, the General Accounting Office (GAO) found that the parents of over 12,700 children relinquished custody to either the child welfare or the juvenile justice system so that their children could receive necessary mental health services. The report estimates that the actual number of children and families in such situations is likely higher. Officials responding to the survey indicated that limitations in public and private health insurance coverage, limited service availability, and difficult eligibility rules all contribute to the practice of relinquishing custody to child welfare and juvenile justice agencies as a prerequisite to state payment for such treatment.<sup>32</sup> Nearly half of the states now require that families unable to afford, but in need of, mental health treatment relinquish custody of their children to child welfare or juvenile justice systems.<sup>33</sup> This policy is clearly harmful to the maintenance and stability of long-term family bonds. Consequently, states should enact voluntary placement statutes that allow parents to place their children in child welfare or juvenile justice residential treatment settings for emotional and mental health treatment without relinquishing parental rights. Eleven states have adopted such laws and three others have empowered courts to order treatment from an appropriate agency without terminating parental rights.<sup>34</sup>

**6.3 Range of Mental Health Services and Supports.** In order to meet the various mental health needs of its citizens, states must fund a range of services and supports to eligible children. Typically, the range of needed services covered by Medicaid include: day treatment (42 states), case management for serious emotional illness (43 states), intensive home-based services (35 states), independent living skills training (30 states), therapeutic foster care (20 states), and child respite care (11 states). States also provide summer camps and programs (5 states), after school activities (8 states), family support and wraparound services (19 states), therapeutic nurseries (7 states), therapeutic preschools (3 states), and other psychosocial rehabilitation programs (14 states).<sup>35</sup> In addition to these supports, more aggressive use of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are another way for states to provide necessary mental health supports to children and youth up to age 21. State Medicaid programs and qualified Medicaid providers must provide mental health treatment services to children screened through EPSDT and found to have a diagnosed disease or condition.

In states where SCHIP is not an expansion of Medicaid or a Medicaid look-alike program, state policy should ensure that children eligible for SCHIP have access to the same range of services as Medicaid-eligible children. In most states, separate SCHIP programs are more restrictive than its Medicaid counterpart. And in order to ensure a sufficient range of services, state policy should make available 6-8 of the above listed community-based service options for children with mental health needs. Sixteen states meet this benchmark, and another 6 offer between 9 and 11 of the recommended services.<sup>36</sup>

**6.4 Community-based Mental Health Options.** The widespread demand for mental health supports and treatment services creates a strain on already thin mental health resources. To meet the need for community-based treatment options, state lawmakers should consider two Medicaid options for making mental health services available to children - the Tax Equity and Financial Responsibility Act of 1998 (TEFRA) option and the Home- and Community-based Services Waiver (HCBW). The Medicaid TEFRA option - more commonly known as Katie Beckett waivers - permits states to enroll children with a federally defined disability needing extensive medical care, which could appropriately be provided at home less expensively than institutional care. While 20 states have enacted a TEFRA option for children with disabilities, only 10 of these states include children with mental and emotional health needs.<sup>37</sup>

The HCBW option provides states flexibility to furnish children or adults, without regard to family income and as an alternative to more costly institutional care, an expanded range of community-based services. Services include: family respite care, family support services, skill building and independent living services, home supports, adaptive equipment and environmental modification, individualized care coordination, crisis-response, and one-time start up expenses for the child's transition from an institution to home. To date, 49 states have elected the HCBW option to support people with disabilities, but only Kansas, Vermont, and New York use this waiver to cover home- and community-based treatments for mental or emotional health disorders.<sup>38</sup>

Both the TEFRA and HCBW options require the state to utilize treatment options that are less expensive than institutions, creating cost savings. In 2001, Kansas, Vermont, and New York reported that average annual per child costs using the HCBW were less than half the projected institutional costs. In addition, both the TEFRA and HCBW options are effective at reducing the likelihood that parents will relinquish custody to secure care for their children.<sup>39</sup> Given this evidence, states should seek TEFRA and HCBW options that include both children and adults with developmental disabilities and those with mental or emotional disorders.

## HEALTH-RELATED BEHAVIORS

Health-related behaviors include some of the leading contributors to premature death and disability in the United States.<sup>40</sup> Healthy lifestyles and individual behaviors affect the levels of risk associated with chronic illnesses, traumas, and some transmittable infectious diseases. While healthy behaviors cannot always prevent the onset of specific illnesses, chronic conditions, or injuries, a person's health-related decisions and habits can make such conditions more manageable and reduce the risk of serious illness resulting from them. Moreover, state policy is a useful tool for encouraging healthy and discouraging risky behaviors.

### **POLICY 7** Tobacco Tax and Enforcement

Tobacco leads the list of behavioral contributors to preventable death and chronic disease in the United States.<sup>41</sup> However, studies indicate that state taxes levied on tobacco products significantly lower product use, especially among youth, pregnant women, and low-income people.<sup>42</sup> To reduce health risks associated with tobacco use, state tobacco tax policy should include:

**7.1 Cigarette Tax.** A state excise tax of \$1.00 per pack of cigarettes or more appears to be an effective rate for influencing harmful tobacco consumption, and this is recommended as the policy benchmark. Two states - New York and California - have raised cigarette taxes to over \$1.00 per pack with resulting reductions in consumption for teenagers.<sup>43</sup> The average state tax per pack of cigarettes is set to increase from 42 cents in 2001 to over 62 cents in July 2003.<sup>44</sup> Research indicates that higher cigarette prices are an effective tool for lowering consumption for all young smokers, with highest reductions seen among those young smokers previously smoking as much as one-half a pack of cigarettes per day.<sup>45</sup> In addition to curbing unhealthy smoking behaviors, cigarette taxes are a revenue source for state governments.

**7.2 Enforcement of Tobacco-related Age Restrictions.** Provisions of the Substance Abuse Prevention and Treatment Partnership Block Grant (the Synar Amendment) require that states take action to enforce age restrictions on access to tobacco products. The most recent report indicates that sales to minors have dropped from 40.1 percent of cigarette sales in 1996 to 16.3 percent in 2001.<sup>46</sup> Educating cigarette retailers, aggressive compliance checks, along with fines and other punitive measures are among the approaches used to reduce youth access to tobacco products.<sup>47</sup> According to one survey of experts administering youth access enforcement programs, implementing these measures at high levels is needed and effective where present.<sup>48</sup> The Synar Amendment also requires states to achieve an overall 20 percent violation rate goal. In 2001, 38 states achieved this goal and 13 others achieved negotiated target rates for 2001.<sup>49</sup>

## **POLICY 8** Alcohol Tax and Enforcement

Alcohol competes with tobacco as a major risk to the health of Americans. Its threat extends beyond the health of the user and is a principal contributor to injuries from drunk driving, community and domestic violence, and other preventable tragedies.<sup>50</sup> However, state tax policy can influence alcohol consumption levels, again particularly among youth and low-income people.<sup>51</sup> And, like cigarette taxes, taxes on alcoholic beverages are a revenue source for state governments. To curb unhealthy alcohol consumption, state alcohol taxation policy should include:

**8.1 Alcohol Taxes.** Since 1951, only the increase in federal wine tax rates has kept pace with inflation. To offset inflation over this period, taxes on beer and distilled spirits would have required a fourfold and eightfold increase, respectively. In other words, the real value of taxes on most forms of alcohol is well below the real value of these taxes in 1951.<sup>52</sup> Earlier recommendations from the Bush Administration suggested a tax rate of 25 cents per ounce of pure alcohol in any beverage, a rate substantially above the existing tax rate of the time.<sup>53</sup> In short, most states have significant room to raise alcohol taxes both as a strategy for reducing negative child and family outcomes and increasing state revenue. States should establish an excise tax of more than \$.30 per gallon to control beer consumption. Fifteen states now have rates exceeding \$.30, the U.S. median tax rate on beer is 18.5 cents and the average is 26 cents.<sup>54</sup> States should establish an excise tax of more than \$4.00 per gallon to control liquor consumption. Twelve states now have rates exceeding \$4.00.<sup>55</sup> To control wine consumption, state policy should set an excise tax of more than \$.75 per gallon. Nineteen states now have rates exceeding \$.75, with eleven of those states enacting wine taxes exceeding \$1.00 per gallon.<sup>56</sup>

**8.2 Enforcement of Alcohol-related Age Restrictions.** States should establish procedures to ensure that the prohibition of alcohol sales to minors is enforced. Some states have adopted use of improved technology for on-site verification of drivers' licenses, use of "cop-in-shop" approaches to monitoring sales, and employment of youth to perform compliance checks of retail establishments.<sup>57</sup> Several studies have found that programs monitoring retailer compliance with age restrictions lowered sales to minors from a range of 60 to 80 percent to a range of 25 to 30 percent.<sup>58</sup>

## **POLICY 9** School Health Education and School Nutrition Standards

Rising obesity among children and youth make diet and physical exercise important policy concerns for state governments. For example, in 2000 and 2001, the Centers for Disease Control (CDC) provided funding to twelve states to initiate social marketing strategies to prevent obesity and other chronic

diseases.<sup>59</sup> Specifically, state policies affecting health education, school breakfast, lunch and nutrition programs, and physical exercise are important.

Schools in over 80 percent of states and 85 percent of school districts require classes in health education. However, requirements do not extend throughout all grade levels. Full, statewide provision of comprehensive health education ranges from a high of 44 percent of schools at the 5th grade level to a low of two percent at the 12th grade level.

In addition to health education, school breakfast and lunch programs are especially crucial services for children of low-income families. The nutritional content of these meals is a significant aspect of preventive health. Similarly important is the availability of regular physical exercise and physical education for establishment of life-long patterns of physical activity.<sup>60</sup> Both diet and physical activity are especially significant for children and youth, given the increasing prevalence of obesity.

**9.1 Comprehensive School Health Education.** Comprehensive school health education generally includes the prevention of accidents and injury, alcohol and other drug use, HIV/AIDS, pregnancy, sexually transmitted diseases, suicide, tobacco use, and violence. It also includes a focus on nutrition, diet, and physical fitness.<sup>61</sup> Evaluations indicate that children and teenagers who received comprehensive school health education were both more knowledgeable about the consequences of health risks and less likely to be engaged in them.<sup>62</sup> Given this evidence, states should fund age-appropriate comprehensive school health education for grades kindergarten through 12. Moreover, as an effort to keep parents informed and involved in their children's health education, states should require parental consent for children participating in such programs.

**9.2 Physical Education.** Obesity among young people is estimated at 14 percent of children ages 6 to 11 years and 12 percent of all adolescents. In addition, the trends appear to be worsening as young people move into adulthood. Obesity rates among adults were nearly 21 percent in 2001, increasing more than 60 percent since 1991.<sup>63</sup> Nationally, an estimated 300,000 deaths annually are attributable to obesity.<sup>64</sup> Given the growing concern for the physical fitness of young people, states should require and fund school-based physical education as part of elementary and secondary school curricula.

**9.3 Nutrition Standards for School Meals.** The most recent School Health Policies and Programs Study conducted by the Centers for Disease Control and Prevention found that 28.6 percent of schools and 20.5 percent of school districts required use of the Nutrient Standard Menu Planning Guidelines for planning school meals.<sup>65</sup> States should adopt and enforce national standards (or equivalent standards) for the nutritional content of meals served as part of school food service programs. Such

standards help ensure that students receive a nutritionally balanced diet, and consequently, reduce the risk of diet related problems like obesity.

## HEALTH SUPPORTING ENVIRONMENTS

Policies of particular relevance to low-income families that help shape health-supporting environments include addressing lead poisoning and prevention of firearm hazards.

### **POLICY 10** **Lead Poison Abatement**

Ingested lead paint particles are linked to serious physical and mental impairments in young children. Exposure to lead-based paint is almost exclusively a danger experienced by children living in old, usually inner-city housing. An early 1990s study found that 22 percent of non-Hispanic African American children living in homes built before 1946 had elevated blood lead levels.<sup>66</sup> To address risks of lead poisoning, states should adopt:

**10.1 Lead-based Paint Inspection and Abatement.** Requiring inspections and abatement is a significant environmental health intervention. Such policies should be coupled with measures to ensure that housing stock is not taken off the market rather than undergoing the relatively expensive process of abatement. States should fully fund lead-based paint inspections and subsidize abatement in housing found to have lead-based paint.

### **POLICY 11** **Firearm Hazards**

Violence continues to be a disproportionately greater threat to the health of low-income individuals than to the general population. However, the costs of gun violence affect the entire country at the rate of approximately \$100 billion per year - \$15 billion of which is attributable to gun violence against youth.<sup>67</sup> Another \$4 - 5 billion is spent annually on strengthening law enforcement, prosecution, and incarceration associated with gun crime.<sup>68</sup>

Using education as a proxy for income status, the rate of firearm-related deaths in 1998 was 21 percent higher for people ages 25 to 64 with less than a high school diploma than for those with a high school diploma, and over three times higher than for people with some college education.<sup>69</sup> The rate of firearm-related deaths among African Americans in 2000 was three times the rate for the general population in the same year.<sup>70</sup>

Annually, more than 20,000 children and youth under age 20 are killed or injured by firearms in the United States, making firearms second only to motor vehicle accidents as the leading cause of death among 10 to 19 year olds. In 1998, for example, 3,792 young people below age 20 died as a result of firearm-related injuries - down from the 1994 peak of 5,833 deaths and representing 7 percent of all deaths in this age group.<sup>71</sup>

Conventional wisdom holds that states enacting firearm safety measures, including laws governing procedures for safe storage, ownership, and purchasing, have better chances of preventing gun-related deaths and injuries than those with no or less comprehensive measures. For example, 68 percent of Americans—and 64 percent of gun owners—support government safety regulations for the design of guns. Seventy-one percent (71%) of Americans polled—and 59 percent of gun owners—support legislation requiring manufacturers to personalize all handguns sold in the U.S.<sup>72</sup> Some research evidence, briefly reviewed below, support these widely held positions.

**11.1 Safety Devices on Handguns.** Safety devices, including trigger locks, gun safes, grip safety, and magazine disconnect devices, are generally thought to reduce accidental injury involving firearms and gun theft. For instance, nearly three-quarters of Americans support a requirement that trigger locks be used for all handguns.<sup>73</sup> While some safety products are not tamper proof, even with children, products meeting more exacting standards show promise. For example, California adopted a law, effective January 2002, requiring locks that meet exacting standards on guns sold in the state.<sup>74</sup> Massachusetts' law requires childproofing features on all commercially sold handguns. New Jersey also requires new handguns sold in the state to be childproof and Maryland law requires all handguns sold after December 31, 2002 to have an “integrated mechanical safety device that disables or locks the gun.”<sup>75</sup> States should require trigger locks or other safety devices on all handguns manufactured or sold in their jurisdictions.

**11.2 Gun Storage.** Four states - California, Connecticut, Hawaii, and Massachusetts - have adopted gun storage laws.<sup>76</sup> Some research indicates that the eighteen states with safe storage laws have firearm thefts 26 percent lower than states that do not, and these states show a sharper decline in overall theft rates over the last ten years.<sup>77</sup> This is an important finding, given that firearm theft is a major supplier to the illegal firearm market. To help protect children from accidental injury and death, states should enact laws that require firearms be locked when stored and laws that hold gun owners liable for failure to comply.

**11.3 Licensing of Gun Owners.** With over 4,000 gun shows in the U. S. each year, averaging 2,000 to 5,000 attendees, firearms are easily accessible to young people and high-risk buyers. In one national study involving male high school sophomores, 50 percent of participants reported that obtaining a gun would be “little” or “no” trouble.<sup>78</sup> This same ease of accessibility is also true for would-be gun purchasers who would be prohibited from purchasing weapons under the Gun Control Act of 1968 and the Brady Act of 1994. However, in 1999, only Maryland and California had statutes regulating purchases at gun shows.<sup>79</sup> States

should require licenses for purchasing guns from retailers, individuals and gun shows. Fifteen states have such licensing or registration laws.<sup>80</sup>

**11.4 Waiting Periods.** Proponents of waiting period policy argue that waiting periods provide a “cooling off” period and potentially reduce impulsive crimes and suicide. In some public opinion research, 81 percent of respondents say they want both a five-day waiting period and background checks.<sup>81</sup> Twenty-two states have waiting periods for handguns and six states require waiting periods for rifles and shotguns. States should require waiting periods be enforced for purchasing handguns, rifles and shotguns from both retailers and private sellers.

**11.5 Background Checks.** Six years following passage of the Brady Act of 1994 requiring background checks, approximately 700,000 illegal purchases were prevented.<sup>82</sup> Even more illegal purchases could be prevented if the 40 percent of all firearm sales made through non-retail outlets (individual sale, gun shows, classified ads, internet) also were subject to background checks.<sup>83</sup> Twenty-three states require only federal background checks when handguns are bought from a dealer; the other 27 states require state police record checks as well. Thirty-two states require no background checks when handguns are purchased privately.<sup>84</sup> Given the benefits of keeping firearms out of the hands of illegal purchasers and the effectiveness of background check policies, states should require federal and state background checks for both the retail and private purchase of firearms. In 95 percent of cases, these checks can be completed within two hours, with most completed in a couple of minutes.<sup>85</sup>

## CONCLUSION

Health care services to meet the preventive, diagnostic, treatment, and medical management needs of low-income families claim a large and growing portion of public resources. Acute and chronic illness and disease create major burdens on individuals, families and society at large. For this reason, policymakers at the federal and state levels are constantly challenged to craft laws and to appropriate sufficient funds to maintain or reform complicated health care delivery systems that meet the needs of vulnerable children and their families.

This brief provides an outcome-focused framework for assessing the adequacy of state policies that address health issues. Health care services, health-related behaviors, and health-supporting environments are the three major components of this framework. Because of their significant impact on public resources, health care services receive the most attention here, with emphasis on policies aimed at affecting the affordability, availability, and accessibility of appropriate services.

This framework and the policy options presented are not exhaustive. Their focus is on poor and near-poor families whose circumstances make them most vulnerable to the crises and burdens of traumatic injury and acute or chronic illness. The policies are limited to a selection holding the most promise for achieving the outcomes that support health for these families.

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## ENDNOTES

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## About the Policy Matters Project

The *Policy Matters* project is an attempt to offer coherent, comprehensive information regarding the strength and adequacy of state policies affecting children, families, and communities. The project seeks to establish consensus among policy experts and state leaders regarding the mix of policies believed to offer the best opportunity for improving key child and family results.

The project focuses on six core results: school readiness, educational success, family economic success, healthy families, youth development, and family maintenance. In each of these areas, a series of briefs, overview publications, self-assessments, and 50-state reports are envisioned.

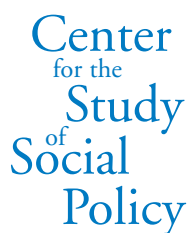
## About the Partners

The Center for the Study of Social Policy is a non-profit, non-partisan policy organization located in Washington, D.C. The Center's mission is to promote policies and practices that improve the living conditions and opportunities of low-income and other disadvantaged persons. The Center works in partnership with federal, state, and local governments and communities to shape new ideas for public policy, to provide technical assistance to states and communities, and to develop and lead networks of innovators.

The National Center for Children in Poverty (NCCP) is a non-profit, non-partisan policy and social science research organization out of Columbia University. NCCP identifies and promotes strategies that prevent child poverty in the United States and that improve the lives of low-income children and their families. The Center conducts and synthesizes research on the causes and consequences of poverty to develop policy solutions that will provide low-income families in the United States with the resources and tools they need to create better lives for themselves.

Child Trends is a non-profit, non-partisan research organization dedicated to improving the lives of children by conducting research and providing science-based information to improve the decisions, programs, and policies that affect children. In advancing this mission, Child Trends collects and analyzes data; conducts, synthesizes, and disseminates research; designs and evaluates programs; and develops and tests promising approaches to research in the field. Child Trends has achieved a reputation as one of the nation's leading sources of credible data and high-quality research on children.

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