DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: CHRISTY SCHMIDT **To:** CHRIS JENNINGS

Phone: (202) 690- _____ **Phone:** _____
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Number of Pages (Including Cover): _____

Comments:

Child Health Initiatives

Program	FY 97 Appropriation	FY 98 Proposed $1 billion	FY 98 Proposed $2 billion
Fulfill promise of Medicaid - Outreach to currently eligibles[1][2]			
- enroll at least 1/3 of eligible children by 2002		$144m	$144m
- enroll at least 2/3 of eligible children by 2002		$288m	$288m
Allow state option to accelerate phase-in of children under age 19 with family incomes below poverty[3]		$288m	$288m
Allow state option for 12-month Medicaid eligibility determination for children			
Enhance partnerships with States - 1115 Bully pulpit - Create new Title XIX demonstration authority - use workers between jobs capped entitlement authority	---	$100 m demo	$750 m to all states
Increase federal match for on-site eligibility workers from 50% to 75%			
Create performance match (similar to $500m welfare pot) to reward states that enroll more kids into Medicaid			
Expand access to community-based services through CHC/School Health	$802m	$200m	$200m

[1]Federal cost estimates are based on Medicaid federal share expense of $577 per child in FY 1998. Source: HCFA, OACT

[2]Assumes that at least one-third, up to two-thirds of eligible children could be enrolled in Medicaid by the year 2002 with enhanced outreach and other efforts targeted at enrolling eligible children. The estimated 5 year federal cost of this proposal would be $2.3 to $4.7 billion.

[3]Each year, approximately 250,000 additional children would receive Medicaid coverage through this phase-in. Assuming that states would include two age cohorts a year, the estimated 3 year federal cost of this proposal would be $603 million.

12/12/96 Draft

Demonstration Projects to Study the Effect of Allowing States to Extend Coverage to Children Not Otherwise Qualified to Receive Medicaid Benefits

I. Definition

The goal of this demonstration is to: (1) fulfill the promise of Medicaid by ensuring that eligible children are enrolled; and (2) extend benefits to other uninsured children who are not currently eligible for Medicaid.

In order to allow States to develop and carry out innovative programs to ensure that eligible children are enrolled in Medicaid and to extend health insurance coverage to children who lack insurance, the Department of Health and Human Services will enter into agreements with states for the purpose of conducting demonstration projects to study the effect on access to health care, private insurance coverage, and costs of health care when States are encouraged to improve enrollment of eligible children and to extend benefits to children not otherwise eligible for Medicaid.

II. Specific Provisions

The Federal government will provide support to States to continue and expand innovative programs to provide insurance for uninsured children. Under this program, States will be encouraged to enhance efforts to enroll eligible children in Medicaid and to expand coverage to other children by creating new opportunities for insurance coverage thereby creating a seamless system of care for children in their state.

For children not otherwise eligible for Medicaid, States will establish income guidelines, eligibility criteria including limits on access to employer-subsidized insurance, benefits, copayments and premiums up to the full cost of the program. States may limit coverage of items and services under the project, but will be required to assure the receipt of critical services including well-child care and other related services to reduce morbidity and mortality. Approval of the demonstration will be dependent upon the Secretary's determination that the project can reasonably be expected to improve children's access to health insurance coverage.

For each demonstration project, the Secretary shall assure that an evaluation is conducted on the effect of the project with respect to: (1) access to health care; (2) changes in health care insurance coverage; (3) costs with respect to health care; (4) benefits, premiums and cost sharing. The Secretary shall submit a report to Congress containing a summary of the evaluations documented under this demonstration.

III. Impact

States are showing an increasing interest in developing innovative ways to provide coverage to uninsured children. Under this proposal, the federal government would provide matching funds to expand the number of states participating in such programs and to increase the number of uninsured children who have access to such programs. States would be given latitude in designing the best program to meet the needs of their children.

Document No. _____

WHITE HOUSE STAFFING MEMORANDUM

DATE: 12.21 ACTION/CONCURRENCE/COMMENT DUE BY: 12-~~29~~ 23

SUBJECT: Children's Health Proposal – Shalala

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	☑	☐	McCURRY	☐	☐
PANETTA	☑	☐	McGINTY	☐	☐
McLARTY	☐	☐	NASH	☐	☐
ICKES	☐	☐	QUINN	☐	☐
LIEBERMAN	☐	☐	RASCO	☐	☐
RAINES	☑	☐	REED	☑	☐
BAER	☐	☐	SOSNIK	☐	☐
CURRY	☐	☐	STEPHANOPOULOS	☐	☐
EMANUEL	☑	☐	STIGLITZ	☐	☐
GIBBONS	☐	☐	STREETT	☐	☐
HALE	☐	☐	TYSON	☐	☐
HERMAN	☐	☐	HAWLEY	☐	☐
HIGGINS	☐	☐	WILLIAMS	☐	☐
HILLEY	☑	☐	BOWLES	☑	☐
KLAIN	☑	☐	RADD	☑	☐
LAKE	☐	☐	Spalding	☑	☐
LINDSEY	☐	☐	Jennings →	☑	☐

REMARKS:

Thx Bowles →

RESPONSE:

Staff Secretary
Ext. 6-2702

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

'96 DEC 20 PM7:14

MEMORANDUM FOR THE PRESIDENT

FROM: **Donna E. Shalala**

Today, 10 million--14 percent--of children are uninsured. Ninety percent of all uninsured children come from working families. Addressing the needs of these children requires a multi-dimensional approach:

- increase insurance coverage through Medicaid by reaching those eligible but not enrolled;
- guarantee twelve month eligibility for those children already enrolled in Medicaid;
- enhance partnerships with the states and private sector to help provide insurance for children; and
- expand access to community based care.

THE CHILDREN'S HEALTH INITIATIVE

Our goal ought to be to improve the insurance and access needs of half of the 10 million uninsured children. Because there is no single reason why these children are uninsured, no single solution effectively and efficiently addresses the problem. We also know that enrollment in insurance does not ensure access to quality care.

We must fulfill the promise of our existing programs and build upon innovative state programs for uninsured children. We must also allow states and communities to target efforts that best meet the needs of their children. Our initiative does not include federal subsidies to families with uninsured children because subsidies are generally costly, may require very high subsidy levels to attract the currently uninsured into a program, and may inadvertently substitute for employer subsidized insurance. The overall investment is almost $12 billion over five years, of which $4.7 billion has no scoring implications. The specific provisions and costs for the initiative to address the important health care needs of our nation's children are discussed below (see attached chart).

I. Medicaid Initiatives

A. Work with states to fulfill the promise of Medicaid for children who are already eligible under current law. An estimated 3 million children are currently eligible for Medicaid but not

enrolled. Our proposal assumes that up to two-thirds of these children could be enrolled into Medicaid with enhanced outreach and other efforts targeted at enrolling eligible children. Full enrollment of all Medicaid eligible individuals has been a challenge since the enactment of Medicaid, and this challenge will continue as the new welfare reform bill is implemented. We must:

- eliminate barriers to effective enrollment of eligible children through managed care and other Medicaid state programs;
- streamline eligibility by enhancing the federal/state partnership and providing best-practice models and other technical assistance to states;
- increase coordination with other federal programs (day care, Head Start, school health, community health centers, food stamps, WIC) to improve outreach and enrollment;
- increase collaboration with foundations and insurers/managed care organizations to identify innovative ways to improve enrollment;
- develop public information campaigns to inform the public about opportunities to enroll in Medicaid; and
- encourage state use of 1115 authority to expand Medicaid coverage and enrollment.

This initiative will cover an additional two million children. This off-budget proposal will increase the cost of the Medicaid baseline by $4.7 billion for FY 1998-2002.

B. Extend continuous coverage for children age 1 year and older. In 1990, Congress required continuous eligibility for pregnant women throughout their pregnancy and for three months postpartum, and for infants through the first 12 months of life. This proposal will provide states with the option to allow continuous coverage to children for one year after eligibility is determined. Doing so will guarantee more stable coverage for children and better continuity of health care services. In addition, it will reduce the administrative burden on Medicaid officials, health care providers, social service providers, and families who are required to refile paperwork for children's eligibility determination.

This initiative will cover an additional 1.25 million children. This proposal is estimated to cost $3.5 billion for FY 1998-2002.

II. State Demonstrations

Provide funding for states to support innovative partnerships to insure children not otherwise qualified to receive Medicaid or employer sponsored benefits. Numerous states have joined forces with insurers, providers, employers, schools, corporations and others to develop innovative ways to provide coverage to uninsured children. We ought to provide matching funds to expand the number of states participating in such programs and to increase the number of uninsured children who have access to such programs. States will be given wide latitude in program design but will be required to assure the receipt of critical services including well-child care and other related services to reduce childhood morbidity and mortality. To manage costs, programs may include cost-sharing, managed care, and competitive bidding.

- Under this program, States will be encouraged to enhance efforts to enroll eligible children in Medicaid and to expand coverage to other children by creating new opportunities for insurance coverage thereby creating a seamless system of care for children in their state.

- For children not otherwise eligible for Medicaid, States will establish income guidelines, eligibility criteria including limits on access to employer-subsidized insurance, benefits, copayments and premiums up to the full cost of the program. States may limit coverage of items and services under the project, but will be required to assure the receipt of critical services including well-child care and other related services to reduce morbidity and mortality.

- Evaluations will be conducted on the effect of these efforts to learn about: (1) access to health care; (2) changes in health care insurance coverage; (3) costs with respect to health care; (4) benefits, premiums and cost sharing.

This initiative will cover an additional 1.5 million children per year. It is estimated to cost $750 million per year, for a total of $3.75 billion for FY 1998-2002.

III. Safety Net Initiatives

Enhance access to care through school health centers and consolidated health centers (CHCs). We will provide increased targeted funding for CHCs to enhance and expand services to working families and their children, including children enrolled in day care, Head Start programs, and schools. To strengthen the safety net of community-based providers in urban and rural areas, these funds will be directed to communities with high levels of uninsured children, including EZ/EC communities. Funds will be used to increase CHCs capacity to serve uninsured children and their families and to better meet the needs of those in their community whose insurance coverage is fragmented or incomplete. In addition to increasing their own capacity, CHCs will serve as a focal point for marshaling public and private community resources directed

at child health and, with their partners, taking steps to mesh child health and related services into local integrated systems that serve children and their families.

We will also provide communities with the option of serving their children through school health centers. This effort will provide children with comprehensive primary care services including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services, health education and preventive dental care. School health centers will also be encouraged to link to other appropriate programs, including Healthy Start, state Maternal and Child Health, Head Start, Community Schools, and Empowerment Zones/Enterprise Communities. We will encourage programs to develop billing systems to collect third party payment and participate in a community-wide health care delivery system.

This initiative will serve an additional 250,000 children per year. The cost of these programs to the discretionary budget will be $25 million per year, for a total cost of $125 million for the FY 1998-2002.

I look forward to working with you to fulfill our promise to children by making health care more affordable and accessible through these efforts.

Attachment

Children's Health Care Coverage Initiatives

	Coverage by End of 2000	Cost in FY 02	5 Year Cost (FY 98-02)
1. Expanded Medicaid Outreach (off-budget) 66% Success Rate	2 million children	$1.5 billion	$4.7 billion
2. Enhanced State Partnerships	1.5 million children	$750 million	$3.75 billion
3. 12 Month Eligibility Option	1.25 million children	$1.1 billion	$3.5 billion
Totals	4.75 million children	$3.35 billion	$11.95 billion

December 9, 1996

MEMORANDUM TO HILLARY RODHAM CLINTON

FROM: Chris Jennings

RE: Children's Health Care

ISSUE

Children who lack access to health care are more vulnerable to health problems. Additionally the lack of health insurance for children may impact health care costs for the entire health care system. Today, an estimated 10 million children are uninsured and millions more are underinsured.

BACKGROUND

The General Accounting Office estimates that 10 million children (almost 15% of all children under age 18) were without health insurance -- the highest level of children uninsured since 1987. Millions more children are underinsured. These children have limited access to preventive and primary care and may lack the insurance or other resources needed to access care.

Additionally the number of children with private coverage has decreased. The decline in private health insurance among children may largely be attributed to an erosion in employer-sponsored health insurance due in part to the shift to more part-time work and more outsourcing to smaller firms.

As private insurance coverage shrinks, Congress has expanded kids' health coverage through Medicaid. State Medicaid expansions have extended coverage to millions of children, including children under the age of 6 whose family incomes are 133 percent above the federal poverty level. Each year a new age group of kids is "phased in" so that by 2002, all poor children under age 19 will be eligible for Medicaid. This will increase Medicaid eligibles by 1 million children.

Despite greater reliance on Medicaid, many eligible uninsured children do not enroll in Medicaid. According to a recent study by the Center on Budget and Policy Priorities, a variety of factors influence children's enrollment in Medicaid including: the scope of coverage under a state's welfare program, the uninsured rate in the state, and steps a state has taken to make the Medicaid program accessible to diverse populations.

The Democratic Leadership (Senator Daschle and Representative Gephardt) have a serious interest in developing a health care initiative for children. Even before they had real policy options, the Leadership included a proposal to expand coverage by requiring insurance companies to offer lower-cost "kids-only" policies. They included this proposal as part of the "Families First Agenda," akin to the GOP's 1994 "Contract with America." White House and HHS staff have provided technical assistance to Democratic staff to evaluate options.

OPTIONS

There are several options to improve access to health care for children. These options range from expanding federal funding of health care services or coverage to promoting states' development of child health initiatives to encouraging the private sector to provide more comprehensive coverage to children. Five of the major options are discussed below.

Option 1: Create a health subsidy for children. This option would require all insurance companies that do business with the federal government to offer "kids-only" policies and provide premium subsidies to help families afford health care coverage.

Option 2: Provide tax incentives to improve coverage for children. Similar to option 1, option 2 would expand access to health care coverage by making families eligible for tax credits for their children's "kids-only" health care policies.

Option 3: Expand children's health coverage under Medicaid. This option would employ an effective outreach initiative to expand coverage to the estimated 3 million children currently eligible for Medicaid who do not have coverage.

Option 4: Enhance partnerships with states to expand coverage for children. This option would provide grants to states to support innovative programs to insure children. Under this option, the federal government would provide matching funds to expand the number of states participating in such programs and to increase the number of uninsured children who have access to such programs. For example, the Children's Health Insurance Program (CHIP) of Pennsylvania is a state-supported program aimed at providing comprehensive health care services to children up to 14 years of age. The program is funded by a two cents per pack state tax on cigarettes.

Option 5: Expand access to community-based services. This option would make sure kids receive needed health care through clinics and community health centers. Through a public health approach, the federal government could enhance existing networks or create new partnerships of providers to provide health services to underserved populations of kids. One possibility is to require the 650 federally funded community health centers around the country to locate uninsured kids and notify their families that the centers are there to provide treatment at nominal cost.

RECENT REPORTS

In the past year, several reports on health care coverage for children have been released. Following is a summary of four of the most significant reports.

TAB 1. Health Insurance For Children: Private Insurance Coverage Continues to Deteriorate, GAO, June 1996

This report demonstrates that the number of children without health insurance coverage, 10 million children, was greater in 1994 than at any time in the last 8 years. Additionally private health insurance for children decreased primarily among children of poor families. Health care coverage remained relatively stable among non-poor children.

This report also finds that Medicaid continues to be an important source of insurance for children in working families. However, in 1994, approximately 3 million children who were eligible for coverage under Medicaid (30% of the total number of uninsured) did not enroll in the program.

TAB 2. Millions of Uninsured and Underinsured Children Are Eligible For Medicaid, Center on Budget and Policy Priorities, December 1996

This study finds that about 3 million children who may be eligible for Medicaid were not enrolled in the program. A variety of factors influence children's enrollment in Medicaid including: the scope of coverage under a state's welfare program, the uninsured rate in the state, and steps a state has taken to make the Medicaid program accessible to diverse populations. The authors continue to report that welfare law changes are likely to result in even lower Medicaid participation rates in the future, unless states revamp their Medicaid application procedures and outreach strategies.

This study concludes that the Medicaid program has the potential to provide health care coverage to a large number of children who are uninsured or underinsured.

TAB 3. Uninsured Children of the South, Southern Institute on Children and Families, November 1996

This report finds that the number of uninsured children in the South is disproportionately high. Of the 9.4 million uninsured children in the United States, a total of 4.1 million (43%) live in the South even though only 36% of all children live in this region. More than 100,000 (20%) of all children in Arkansas are uninsured.

States vary in their use of Medicaid to expand health care coverage for uninsured children. Arkansas is one of three states that has not expanded Medicaid eligibility beyond Federal minimums to cover children. To reduce the number of uninsured children in the South, the authors recommend that states: (1) raise Medicaid age and income eligibility levels, (2) eliminate the Medicaid assets test for children, and (3) use outreach to enroll eligible children in Medicaid.

TAB 4. Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children, GAO, January 1996

This report highlights six health insurance programs initiated by states and private organizations (in five states; AL, PA, NY, FL, and MN) to increase health care access for children. By 1995, 14 states and at least 24 private-sector organizations had such programs. The number of children enrolled in the six programs studied ranged from more than 5,000 to more than 100,000 and focused primarily on low-income, uninsured children not enrolled in Medicaid. These programs were funded by various nonfederal sources, such as dedicated state taxes and private donations.

Hillary Rodham Clinton: Options for Health Care Re-Engagement

Health Care Experts' Meeting and Op Ed Submission

- Hold private meeting(s) in early January with health care economists and other validators to discuss status of health care system.

- Use this information as basis for a mid-January Op Ed piece, designed to be subsequently validated by the participants at the meeting. Your piece would stress the positive, as well as the negative developments; it would be used to support the policy positions taken by the President in the budget submission in February. On the reform side, it could particularly highlight the President's workers in-between jobs initiative (helping at least 700,000 kids), additional children coverage/service expansions (outlined below), Medicare preventive care expansions, and other incremental, but important health reforms.

- Have staff work with the health economists to do follow-up responses that affirm your Op Ed's findings and suggestions by no later than the end of January.

Focus on Quality at Commission Event

- In response to an invitation of the Quality Commission, testify to further develop the quality in health care theme that would be no doubt part of your Op Ed message. And, although not directly related to charge of Commission, raise some of the coverage reform issues outlined above.

- Have staff work with Commission Members and outside experts to validate testimony.

Become More Visible on Children's Health Issues

- Help orchestrate and lead Federal/State attempts to expand coverage to the 3 million children currently eligible for, but not receiving Medicaid. Consider hosting an event with the President, the National Governors' Association (NGA), and other relevant "players" to develop strategies for much better outreach to children. (An effective outreach strategy cannot be implemented without the administrators of Medicaid -- the States.) This would be a logical amendment to the Medicaid eligibility work that will have to occur post enactment of welfare reform.

- Follow-up the kids outreach meetings as a visible advocate of any legislative and/or regulatory recommendation that emerges. Try to get visible Republicans to be associated with your efforts in this area.

- Conduct field studies of successful health care coverage and service expansion programs designed for children. A number of states, like Pennsylvania, have established insurance programs for kids, which have had some preliminary success. Highlight successful community health centers (and perhaps school based clinics), which are expanding access to health services. Both of these initiatives may receive additional support from our budget (if we can find the resouces) and would be great places to validate our budget proposal.

- Host meetings with representatives of small and medium businesses to create a cooperative environment that can begin to address why so many of these businesses are not providing coverage for dependents. While we can help the lowest income children get coverage and services, it is extremely difficult to develop any initiative (short of a mandate) that can expand coverage of the working uninsured without creating incentives for businesses now covering to drop coverage. This work would come under the heading of urging and rewarding responsible (and voluntary) business-sponsored initiatives.

United States General Accounting Office

GAO

Report to the Ranking Minority Member, Subcommittee on Children and Families, Committee on Labor and Human Resources, U.S. Senate

June 1996

HEALTH INSURANCE FOR CHILDREN

Private Insurance Coverage Continues to Deteriorate

GAO/HEHS-96-129

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-271717

June 17, 1996

The Honorable Christopher J. Dodd
Ranking Minority Member
Subcommittee on Children and Families
Committee on Labor and Human Resources
United States Senate

Dear Senator Dodd:

As the U.S. health care marketplace changes, having health insurance coverage has become increasingly important for children. The transition into greater reliance on managed care has left hospitals and physicians less willing to provide charity care for those who lack insurance. Children are particularly vulnerable to the lack of health insurance. Although a healthy group, they need preventive and acute care for their optimum development. If they do not get care when they need it, their health can be affected for the rest of their lives.

As we have reported earlier,[1] private health insurance coverage for children decreased between 1987 and 1993. Expanding children's coverage through the publicly funded Medicaid program helped to cushion the effect of this decrease. The Medicaid expansion increased health insurance coverage for poor children.[2] However, it did not lead to an overall increase in the percentage of children covered because children above the poverty level lost private coverage but were less likely to be eligible for Medicaid. Since our earlier report, the Congress has considered restructuring the Medicaid program, including children's eligibility for coverage. It has also considered proposals that would change the private insurance marketplace. In addition, the shift toward managed care in the health care marketplace has continued, which reduces providers' willingness to care for uninsured patients.

Concerned about these issues and their impact on children, you asked us to provide you with updated information for 1994 on whether health insurance coverage for children had increased and in particular how poor children were affected. You also asked us

[1]See Uninsured and Children on Medicaid (GAO/HEHS-95-83R, Feb. 14, 1995), Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-96-175, July 19, 1995), and Medicaid and Children's Insurance (GAO/HEHS-96-50R, Oct. 20, 1995).

[2]Poor children are children in families with income at or below the Federal Poverty Income Guidelines. These guidelines set income levels by family size to determine poverty. In 1996, a fa three with income at or below $12,980 is considered poor.

- whether more children in working families were depending on Medicaid than had previously been reported,
- how many uninsured children might be eligible for Medicaid but not enrolled in 1994, and
- why families of uninsured but Medicaid-eligible children might not be seeking Medicaid coverage for their children.

To answer these questions, we analyzed the Bureau of the Census' March 1995 Current Population Survey (CPS), which can be used to estimate health insurance coverage for children from birth through 17 years old in 1994. The methodology for the CPS questionnaire and data collection had been improved for the March 1995 CPS. In addition, the sample frame or sample selection process for families had been updated by using 1990 census information. While these changes provide better estimates of insurance coverage for 1994, in our opinion and that of Census Bureau officials, some estimates for 1994 are not comparable to prior years' estimates of insurance coverage primarily because of these methodological changes. In this report, we highlight comparisons of 1994 and earlier estimates that we think are most comparable. (See app. I.) Our work was conducted between January and May 1996 in accordance with generally accepted government auditing standards.

Results in Brief

The number of children without health insurance coverage was greater in 1994 than at any time in the last 8 years. In 1994, the percentage of children under 18 years old without any health insurance coverage reached its highest level since 1987—14.2 percent or 10 million children who were uninsured. (See fig. 1.) In addition, the percentage of children with private coverage has decreased every year since 1987, and in 1994 reached its lowest level in the past 8 years—65.6 percent or 46.3 million children. In comparison, the loss of health insurance coverage for adults 18 to 64 years old appears to have stabilized in the last 2 years. Between 1993 and 1994, the decline in health insurance coverage for children was concentrated among children in poor families. Health insurance coverage remained stable for nonpoor children.

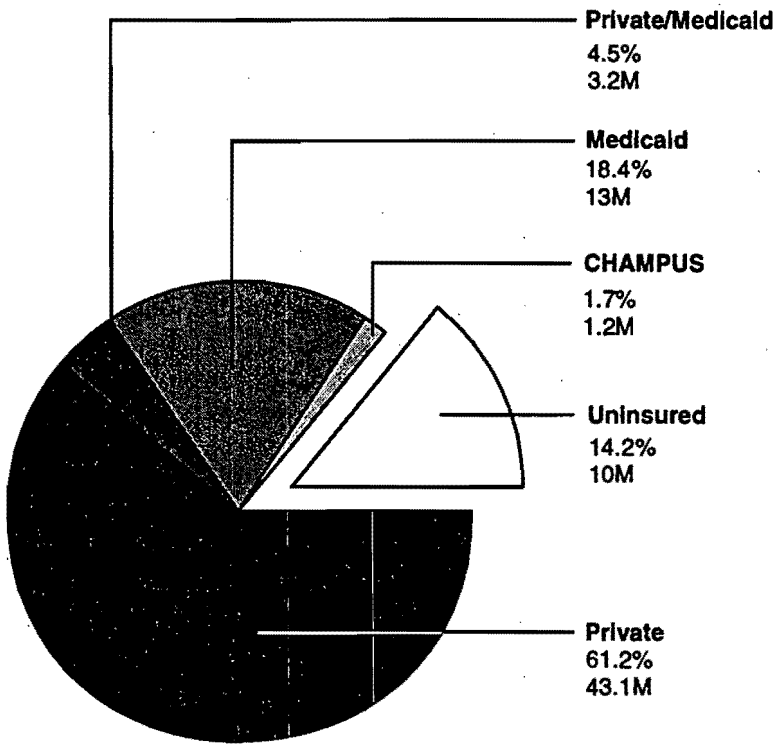
Among children whose parents are working, Medicaid continued to be an important source of insurance coverage. The Medicaid expansions in eligibility for low-income children not on welfare allowed more children of working parents to become insured through Medicaid—a trend that continued in 1994. But Medicaid coverage for children as estimated through the CPS was lower in 1994 than 1993—which may be due to

methodological changes in the CPS. (See app. I for more detail on these CPS changes and their effects.)

Despite greater reliance on Medicaid for covering children of the working poor, many eligible uninsured children do not enroll in Medicaid. For 1994, we estimate that 2.9 million uninsured children were eligible for Medicaid by federal mandate but did not enroll.[3] These Medicaid-eligible uninsured children represent 30 percent of all uninsured children. Unless the Congress changes Medicaid eligibility law, the group of children eligible for Medicaid will grow between now and 2002 because current federal law is phasing in Medicaid eligibility for poor teens 13 to 19 years old. In 1994, there were 4.1 million poor teens in this age group. This continuing expansion could cover more of the uninsured, because 1.3 million poor teens 13 to 19 years old were uninsured in 1994. However, Medicaid can only increase coverage if families of eligible uninsured children are informed that their children are eligible for Medicaid and enroll them.

[3]For 1993, these were children from birth to 5 years old with family income at or below 133 percent of the federal poverty level and poor children 6 to 10 years old. Because coverage is being phased in for children born after Sept. 30, 1983, for 1994, we considered children as Medicaid-eligible according federal mandate if they were from birth to 5 years old with family income at or below 133 percent the federal poverty level or if they were poor children 6 to 11 years old.

Figure 1: In 1994, 14.2 Percent of Children Were Uninsured



Note: M=million. Uninsured children are children who were reported to have no insurance coverage at all for the entire year. Children reported as having health insurance coverage may have been uninsured for some part of the year. Children with more than one source of coverage reported may have had duplicate coverage at the same time or may have had different types of coverage at different times of the year. CHAMPUS is the Civilian Health and Medical Program of the Uniformed Services. The Census Bureau includes other types of public coverage in the CHAMPUS coverage category, such as health coverage through the Indian Health Service or state-funded programs. For this figure, more than one source of coverage is shown only for children who have both private insurance and Medicaid coverage. Children with Medicare are included with the Medicaid group. Children with both private insurance and CHAMPUS coverage will be shown in the group with private insurance coverage. Children with Medicaid (or Medicare) and CHAMPUS insurance will be shown in the section for Medicaid.

Background

Studies have shown that uninsured children are less likely than insured children to get needed health and preventive care. The lack of such care can adversely affect children's health status throughout their lives. Without health insurance, many families face difficulties getting preventive and basic care for their children. Children without health insurance or with gaps in coverage are less likely to have routine doctor visits or have a

regular source of medical care. When they do seek care, they are more likely to get it through a clinic rather than a private physician or health maintenance organization (HMO).[4] They are also less likely to get care for injuries,[5] see a physician if chronically ill, or get dental care.[6] They are less likely to be appropriately immunized to prevent childhood illness—which is considered by health experts to be one of the most basic elements of preventive care.[7]

The Medicaid program is the major public funding source for children's health insurance. It is a jointly funded federal-state entitlement program that provides health coverage for both children and adults. It is administered through 56 separate programs, including the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. States are required to cover some groups of children and adults and may extend coverage to others. Children and their parents must be covered if they receive benefits under the Aid to Families With Dependent Children (AFDC) program. Children and adults may also be eligible for the program if they are disabled and have low incomes or, at state discretion, if their medical expenses are extremely high relative to family income.

Beginning in 1986, the Congress passed a series of laws that expanded Medicaid eligibility for pregnant women on the basis of family income, and for children on the basis of family income and age. Before these eligibility expansions, most children received Medicaid because they were on AFDC. Before 1989, coverage expansions were optional for states, although many states had expanded coverage.[8] Starting in July 1989, states had to cover

[4]See Barbara Bloom, "Health Insurance and Medical Care: Health of Our Nation's Children, United States, 1988," Advance Data From Vital and Health Statistics of the National Center for Health Statistics, No. 188, U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Health Statistics (Hyattsville, Md.: 1990), pp. 1-8; and Alexander M. Kogan, and others, "The Effect of Gaps in Health Insurance on Continuity of a Regular Source of Care Among Preschool-Aged Children in the United States," Journal of the American Medical Association, Vol. 274, No. 18 (1995), pp. 1429-35.

[5]Mary D. Overpeck, and Jonathan B. Kotch, "The Effect of U.S. Children's Access to Care on Medical Attention for Injuries," American Journal of Public Health, Vol. 85, No. 3 (1995), pp. 402-04.

[6]Alan C. Monheit, and Peter J. Cunningham, "Children Without Health Insurance," The Future of Children: U.S. Health Care for Children, Center for the Future of Children, The David and Lucile Packard Foundation, Vol. 2, No. 2 (Los Angeles, 1992), pp. 154-70.

[7]See David L. Wood, and others, "Access to Medical Care for Children and Adolescents in the U.S.," Pediatrics, Vol. 86, No. 5 (1990), pp. 666-73; Charles N. Oberg, "Medically Uninsured Children in the United States: A Challenge to Public Policy," Pediatrics, Vol. 85, No. 5 (1990), pp. 824-33; and David U. Himmelstein and Steffie Woolhandler, "Care Denied: U.S. Residents Who Are Unable to Obtain Needed Medical Services," American Journal of Public Health, Vol. 85, No. 3 (1995), pp. 341-44.

[8]Thirty-two states and the District of Columbia had expanded coverage for pregnant women and infants, and 26 states and the District of Columbia had expanded coverage for older children as of December 1988.

pregnant women and infants with family incomes at or below 75 percent of the federal poverty level. Two subsequent federal laws further expanded mandated eligibility for pregnant women and children. By July 1991, states were required to cover (1) pregnant women, infants, and children up to 6 years old with family income at or below 133 percent of the federal poverty level and (2) children 6 years old and older born after September 30, 1983, with family income at or below 100 percent of the federal poverty level. Current law expands the group of poor children over 6 years old eligible for Medicaid year by year until all poor children up to 19 years old are eligible in the year 2002. In addition, states may expand Medicaid eligibility for infants and children beyond these requirements by either phasing in coverage of children up to 19 years old more quickly than required, by increasing eligibility income levels, or both. (See table II.2 for current eligibility levels in states.)

These expansions partially fueled the increase in Medicaid costs in the 1990s, but children still represent less than one-fourth of Medicaid expenditures. In 1994, nondisabled children represented a large percentage of Medicaid recipients—49 percent—compared with the percentage of Medicaid expenditures for medical care that they accounted for—16 percent.[9] Nonetheless, Medicaid's overall cost and the rate of cost increases have raised concerns about the program's impact on the federal budget. Medicaid costs are projected to increase from about $156 billion in 1995 to $243 billion by the year 2000, according to the Congressional Budget Office. The Congress has recently considered different options to lower the cost of the program, including removing guaranteed eligibility for some types of current recipients and giving capped funding to the states as block grants.

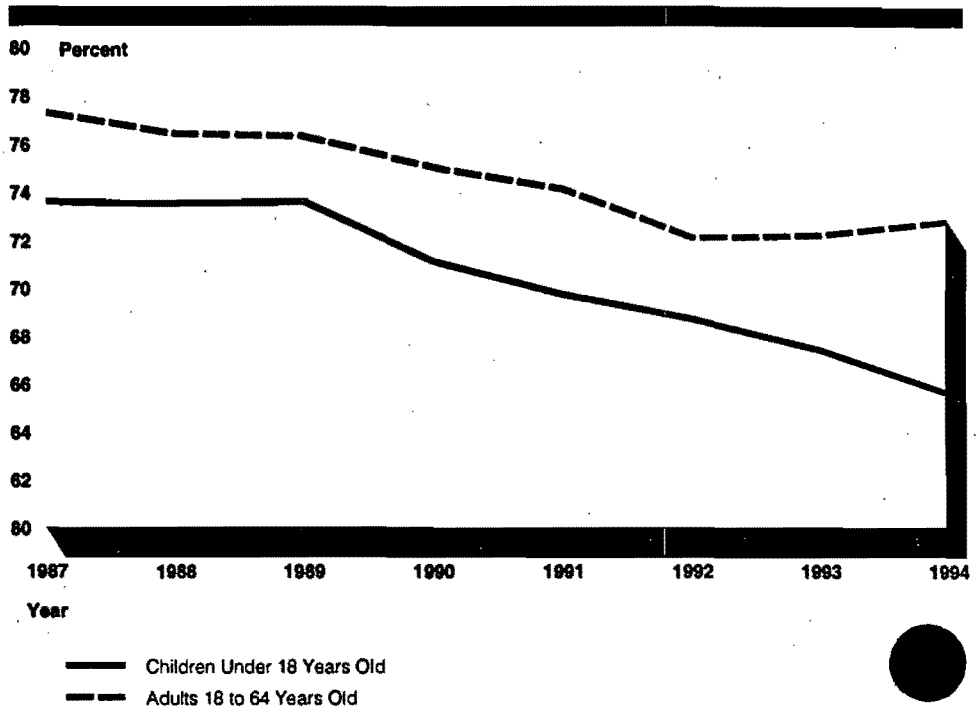
Health Insurance Coverage for Children at Lowest Reported Level Since 1987

In 1994, the percentage of children with private health insurance reached the lowest level reported in the last 8 years—65.6 percent or 46.3 million children.[10] (See fig. 1 and table II.1.) Mirroring this trend, the percentage of children who were uninsured rose to its highest reported level since 1987—14.2 percent or 10 million children. (See figs. 2 and 3 and table II.1.) Compared with adults 18 to 64 years old, for whom private insurance coverage has slightly increased in the last 2 years, coverage for children appears to be decreasing.

[9]This is for children under 21 years old and does not include disabled children. If disabled children under 21 are included, all children on Medicaid under 21 represent 52 percent of recipients and 23 percent of medical expenditures. (HCFA only collects data on children under 21 years old.)

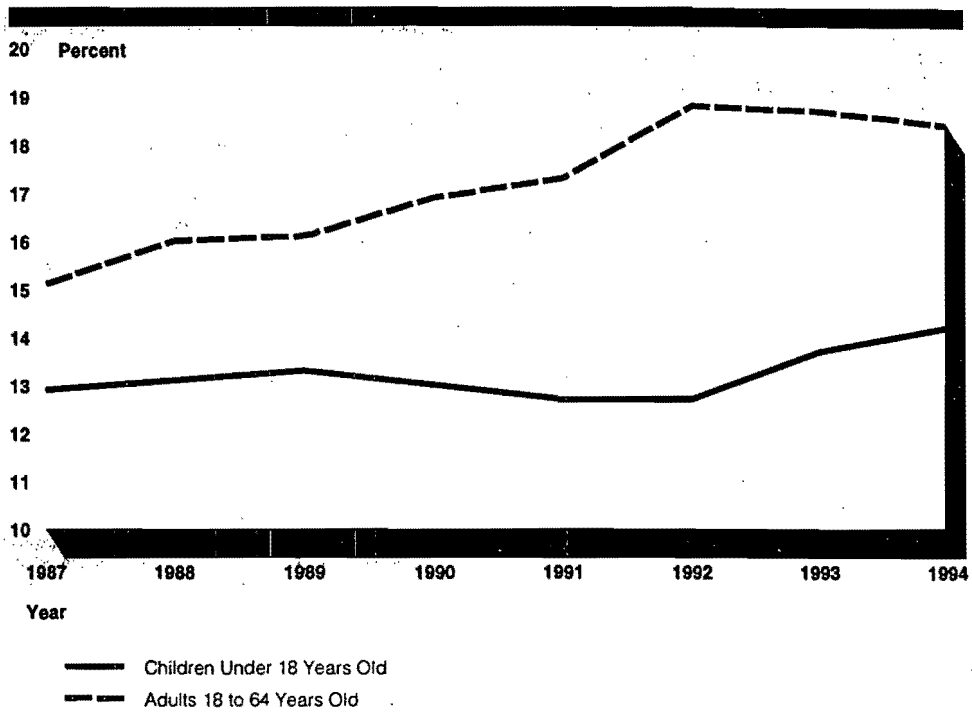
[10]These children might also have had other sources of coverage, such as Medicaid, in the same year.

Figure 2: The Percentage of Children and Adults With Private Insurance Declined Since 1987



Source: The Bureau of the Census.

Figure 3: The Percentage of Uninsured Has Begun to Rise in the Last 2 Years for Children but Not Adults



Source: The Bureau of the Census.

Decreased Coverage Reported Despite Increase in Parents Working Full-Time

The estimated decrease in children's coverage occurred although slightly more children were reported to be in families with a parent who worked full-time in 1994 than in 1993. Children of a parent who worked full-time for the entire previous year are more likely to have private health insurance than other children. However, in 1994, almost 25 percent of children with a parent working full-time did not have privately funded employment-based health insurance. Almost 12 percent of children with a parent working full-time were uninsured.

Children whose parents worked at less than a full-time job for the entire year were worse off for health insurance than children whose parents did not work at all in 1994. Only 37 percent had employment-based insurance (36.8 percent). More children of parents who worked less than full-time all year were uninsured (21.7 percent) than were children of parents who did not work at all in 1994 (14.6 percent). This is because children of parents who are not working tend to be enrolled in Medicaid.

More Poor Children Estimated as Uninsured in 1994 Compared With 1993

A higher percentage of poor children were reported as uninsured in 1994—22.3 percent—than in 1993—20.1 percent. In contrast, reported rates of being uninsured did not differ significantly between 1993 and 1994 for children above poverty. (See table 1.)

Table 1: Percent of Children Without Health Insurance Coverage, by Poverty Level

Figures are percents

	1989	1993	1994	Percentage point difference 1993-94
Poor[a]	25.0	20.1	22.3	2.2[b]
Near-poor[c]	26.5	24.5	24.9	0.4
Above near-poor[d]	7.5	9.1	8.9	(0.2)

Note: Figures in each year are percentages of children who were uninsured for one entire year within each income group. Only children who matched to a parent were included in this table.

[a]Poor families have incomes at or below 100 percent of the federal poverty level.

[b]Statistically significant at the 0.05 level.

[c]Near-poor families have incomes between 101-150 percent of the federal poverty level.

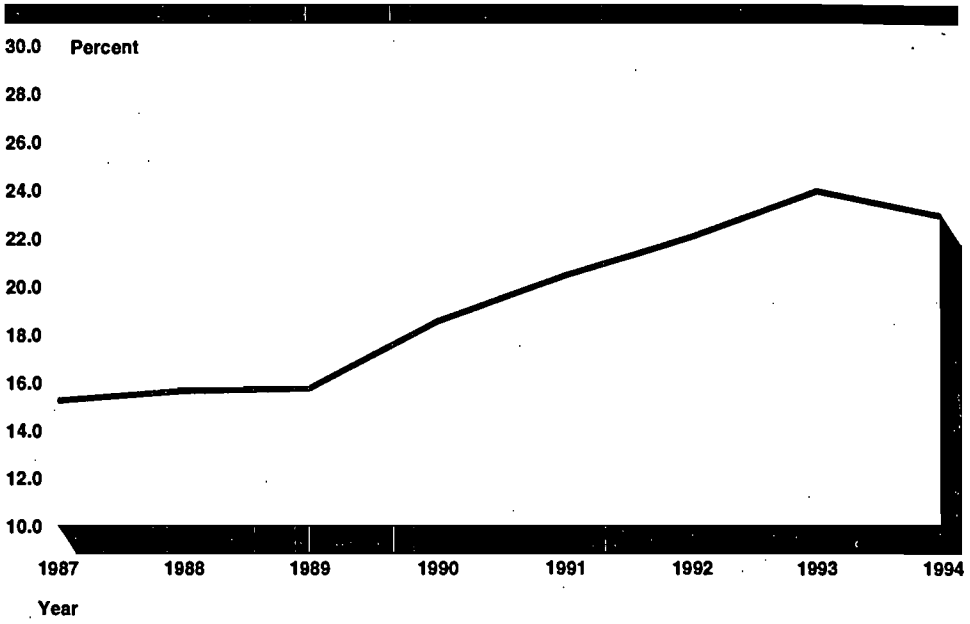
[d]Above near-poor families have incomes above 150 percent of the federal poverty level.

Medicaid Continues to Be a Significant Source of Coverage for Children, but Many Eligible Children Do Not Enroll

In 1994, Medicaid covered 22.9 percent of U.S. children—16.1 million children.[11] This number was lower than the Bureau of the Census estimated in 1993. The difference may be due partially to a reduction in the number of children on AFDC (who are automatically eligible for Medicaid) and partially to changes in CPS methodology that reduced the 1994 estimate, relative to the 1993 estimate. (See app. I.)

[11]These children are reported as having any Medicaid coverage, even if they also have employment-based coverage. Of these children, 3.2 million had private coverage as well as Medicaid coverage at some point in 1994. In our previous reports, children who had both Medicaid and employment-based private coverage were counted as having employment-based coverage and not counted as having Medicaid coverage.

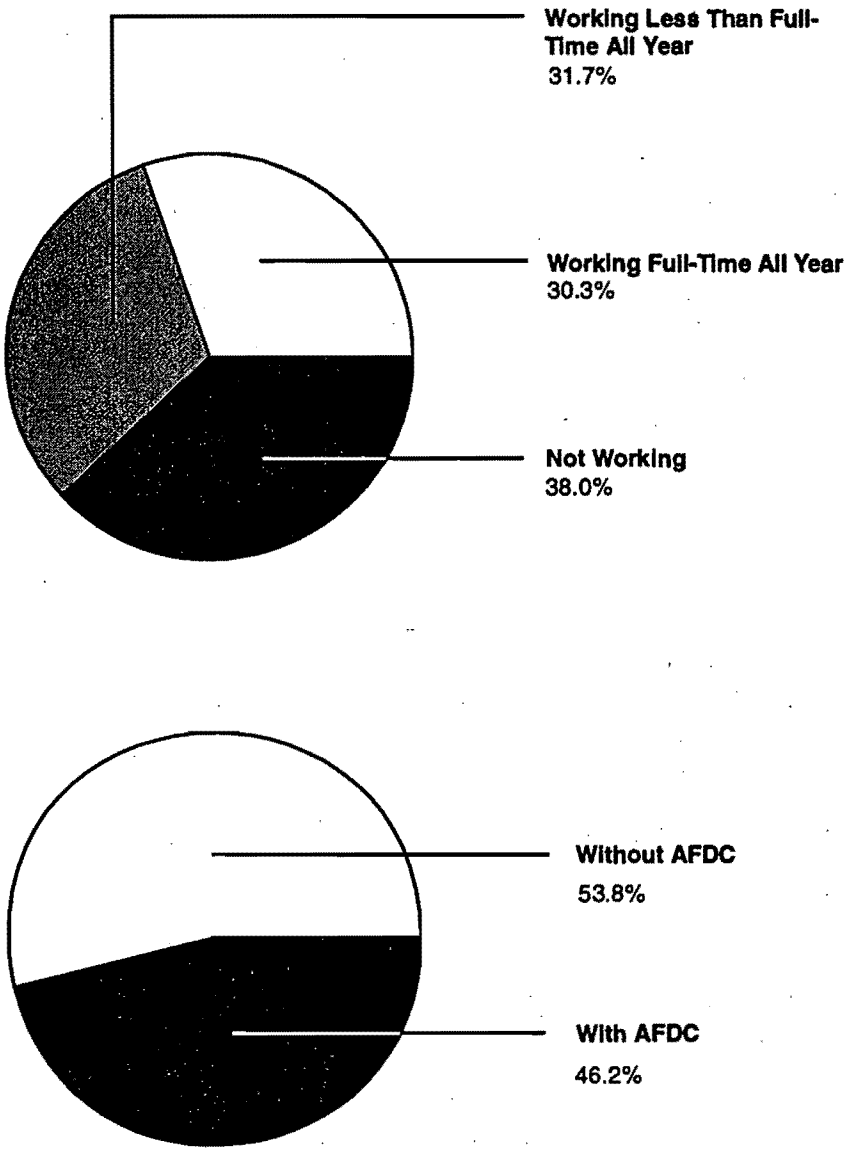
Figure 4: Estimated Medicaid Enrollment for Children Expanded Between 1989 and 1993, but Was Lower in 1994



Source: The Bureau of the Census.

Nevertheless, Medicaid's role as an insurer for children in working families not depending on welfare has grown. In 1994, 62 percent of children on Medicaid had a working parent. Thirty percent of children on Medicaid had a parent who worked full-time for the entire previous year and another 18.8 percent had a parent who worked full-time but for less than the entire year. Another 13 percent had a parent who worked part-time. Only 38 percent had no working parent. In 1994, more than 50 percent of the children on Medicaid did not receive AFDC or other public assistance.

Figure 5: More Than 60 Percent of Medicaid Children Had a Working Parent and More Than 50 Percent Did Not Receive AFDC in 1994



At Least 30 Percent of Uninsured Children Eligible for Medicaid by Federal Mandate

Many uninsured children who are eligible for Medicaid do not enroll. Present law mandates eligibility for children from birth to 5 years old with income at or below 133 percent of the federal poverty level and for poor children born after September 30, 1983. This means that poor children

under 13 years old are now eligible and, year by year, more poor children will become eligible until all poor children under 19 years old will be eligible in 2002. States have the option to expand age and income eligibility beyond this mandate for pregnant women, infants, or children, and 40 states have done so. (See table II.2 for states that have expanded eligibility beyond federal requirements.)

We estimate that 14.3 million children in 1994 were eligible for Medicaid by federal mandate because of their age and family income.[12] Of those children, 11.4 million had private or public insurance coverage and 2.9 million were uninsured (20.3 percent). The 2.9 million uninsured, Medicaid-eligible children accounted for 30 percent of all uninsured children.

Compared with children on Medicaid, higher percentages of uninsured, Medicaid-eligible children had a working parent in 1994 (80.4 percent). Almost three-fourths of these uninsured, Medicaid-eligible children lived in the South (41 percent) or the West (30.4 percent). Over one-half were African-American (21.7 percent) or Hispanic (34.7 percent).

More Uninsured Teens Will Become Eligible for Medicaid Coverage in the Next 6 Years

Poor teens under 19 years old will be phased into Medicaid eligibility in the next 6 years if current federal Medicaid eligibility mandates for children are maintained. In 1994, an estimated 4.1 million children 13 to 18 years old were poor. In 1994, 32 percent of poor teens 13 to 18 years old—1.3 million teens—were uninsured.

Parents May Not Enroll Eligible Uninsured Children in Medicaid for Various Reasons

As we have previously reported, there are several possible reasons why families may not enroll their children in Medicaid. First, low-income families may not know that their children could be eligible for Medicaid even if a parent works full-time or if the family has two parents. A study that interviewed current AFDC recipients and former recipients who had begun working found that 41 percent of AFDC recipients and 23 percent of former recipients did not understand that a parent could work full-time and receive AFDC for his or her children and an even larger percentage did

[12]For 1994 these were children from birth to 5 years old with family income at or below 133 percent of the federal poverty level and poor children 6 to 11 years old—federal law mandates coverage for children from birth to 5 years old, and for poor children older than 5 and born after September 30, 1983. For 1993, we counted children as eligible if they were up to 5 years old with family income at or below 133 percent of the federal poverty level or were poor children 6 to 10 years old.

not understand that children in two-parent families could be eligible for Medicaid.[13]

Families participating in other programs for low-income persons also have low rates of Medicaid enrollment. In 1992, only 48 percent of the women, infants, and children enrolled in the Special Supplemental Program for Women, Infants, and Children (WIC) were enrolled in Medicaid, even though over 72 percent were in families with incomes below 130 percent of the federal poverty level. In 1993, only 68 percent of children in Head Start, an early childhood education program for low-income children, were enrolled in Medicaid.

Second, getting enrolled in Medicaid is difficult for low-income families. In a previous report, we found that many Medicaid applicants never complete the eligibility determination process and about one-half are denied for procedural reasons; that is, applicants did not or could not provide the basic documentation needed to verify their eligibility or did not appear for eligibility interviews.[14] Finally, some families may not seek Medicaid until they face a medical crisis or may not want to enroll in Medicaid because they consider it a welfare program and therefore stigmatizing.

States can obtain federal matching funds to conduct outreach programs about the Medicaid program. States determine their own outreach programs—both the amount and the focus. According to one Health Care Financing Administration (HCFA) official, Medicaid outreach to children's families has focused more on encouraging the use of preventive care by enrolled children than on informing nonenrolled families that their children might be eligible. Some states do try to inform low-income families that they can get health insurance for their children through Medicaid—either by using informational billboards, 800 telephone referral numbers, or other means. In addition, HCFA and the Agency for Children and Families have developed a cooperative agreement to work together and with states and localities to improve outreach to families of potentially eligible low-income children, particularly those enrolled in federally funded child care and Head Start programs.

Fiscal pressures may have made some states less interested in expanding the number of children receiving Medicaid than they were several years

[13]Sarah C. Shuptrine, Vicki C. Grant, and Genny G. McKenzie, A Study of the Relationship of Health Insurance Coverage to Welfare Dependency (Columbia, S.C.: Southern Institute on Children and Families, 1994), pp. 21-25.

[14]Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People (GAO/HEHS-94-176, July 11, 1994).

ago. Even though children represent a relatively small percentage of Medicaid expenditures (about 16 percent of expenditures are for nondisabled children under 21 years old), growth in the number of children on Medicaid has contributed to program expenditure increases. Medicaid spending increases have become one of the largest budget problems for states—representing 19.4 percent of state expenditures in 1994.

Conclusions

Private health insurance is overwhelmingly employment-based in the United States, but many children do not get this benefit even if their parents work. Health insurance is less likely to be offered in the firms that employ low-income workers. If health insurance is available through work but is costly for workers, it is less likely to be affordable for low-income workers.

Part of the reason that families with children may have difficulty affording health insurance is that many children live in low-income families. Twenty-four percent of children lived in poor families in 1994, and another 21 percent lived in families with income between 101 and 200 percent of the federal poverty level. Moreover, families with employer-sponsored health insurance have faced sharply rising costs over the last decade to purchase family coverage through their employer. These rising costs may prove to be much more of a burden for lower-income families.

Private health insurance coverage has continued to decrease for children. As private coverage has decreased, Medicaid has become a more important source of health insurance coverage, especially for children in working families. Nevertheless, despite the expansion in public insurance funding, 10 million children were uninsured in the United States in 1994. Even more notable, the largest percentage of uninsured children were in families with a working parent or parents. In addition, at least 30 percent of uninsured children were eligible for Medicaid, which means that many uninsured children are not getting the advantage of publicly funded insurance.

As long as private coverage continues to decrease for children, the number of children uninsured or on Medicaid will continue to grow. This strains public resources—either to pay for Medicaid coverage or to provide direct care or subsidies to hospitals to care for the uninsured. In the past, providers have had various sources of funds to recoup some of the cost of caring for the uninsured patient. In the era of managed care and

cost-cutting, it is becoming more difficult for hospitals and physicians to care for patients without insurance. As these trends continue, it will likely become even more difficult to get care without insurance.

Medicaid cost increases are pressuring states and the federal government toward different types of program changes. Changes to the Medicaid program that remove guaranteed eligibility or alter the financing and responsibilities of the federal and state governments may strongly affect health insurance coverage for children in the future. Other types of changes that strengthen the private insurance market may also have significant effects on children's coverage in the future.

Agency Comments

We did not seek agency comments because this report does not focus on agency activities. We did, however, discuss relevant sections of this report with responsible officials in the Department of Health and Human Services, HCFA, and the Department of Commerce, Bureau of the Census. They offered technical suggestions that we included where appropriate in the report.

As agreed with your office, we plan no further distribution of this report for 30 days. At that time, we will make copies available on request. Please contact me at (202) 512-7114 or Michael Gutowski at (202) 512-7128 if you or your staff have any further questions. This report was prepared by Michael Gutowski, Sheila Avruch, and Paula Bonin.

Sincerely yours,

William J. Scanlon

William J. Scanlon
Director, Health Systems Issues

Contents

Changes in the CPS and Their Effect on Estimated Insurance Coverage and Other Methodological Considerations

The Bureau of the Census has made recent efforts to improve the accuracy and ease of administering the CPS. These changes should improve estimates of coverage, particularly for children. However, these changes can affect the estimates reported. As a result, estimates for 1994 and subsequent years may not be entirely equivalent to those for previous years. Several changes completely or partially implemented this year appear to have affected specific estimates of health insurance coverage.

CPS Improved, but Estimates Before 1994 May Not Be Comparable

Census reworded and reordered existing questions about health insurance and added new ones for the March 1995 CPS, which reports 1994 data. This was done as part of changing to a computer-assisted telephone interviewing methodology. Census also changed the sample frame—or types of families sampled to get a statistically representative estimate—from one based on the 1980 census to one based on the 1990 census. These changes appear to have affected the 1994 estimates of the percentage of people (particularly children) whose private insurance coverage is employer-based versus privately purchased and the percentage of children on Medicaid compared with previous years' estimates.

Most people in the United States who have private insurance get their insurance through their employer or union. The previous CPS questionnaire asked first whether a person had any private insurance, then if that person was the policyholder. Only after that did the questionnaire ask whether the insurance was obtained through an employer or union. The new questionnaire first asks directly whether a person has private insurance through an employer or union. The questionnaire then asks about private, individually purchased coverage.

Private Insurance Comparable, but Type of Private Insurance May Not Be

Officials at Census believe that the 1994 estimate of overall private insurance agrees well with previous years' estimates, and the estimates for individually purchased insurance and employment-based insurance are superior to previous years' estimates. However, the number of people who report that their private insurance came from an employer or union has increased, while the number who report that their private insurance was individually purchased has decreased. Therefore, because these apparent differences may be due to the questionnaire change rather than actual changes in the composition of private insurance coverage, comparisons of employment-based or private individual coverage in 1994 to previous years may not be appropriate to understand trends in coverage. This is why we

compared private coverage rather than employment-based coverage of children over time in this report.

In addition, we are using a different definition of children on Medicaid for this report than our previous report and correspondences. For this report, our group of children on Medicaid are children with any Medicaid coverage, even if they also have employment-based coverage. Previously, we had excluded children with Medicaid coverage who also had employment-based insurance in the same year from the Medicaid group. We considered employment-based insurance their primary source of coverage and included them in that group. But defining insurance coverage this way led to a lower overall number and percentage of children with Medicaid coverage. Therefore, for this report, we are including children with both private and Medicaid coverage reported in both categories. Figure 1 shows the overlap.[15]

Medicaid Estimates for Children May Be Affected by Decreases in AFDC Enrollment Rates and Change in Sampling Frame

In the past, researchers have been concerned that the CPS underreports Medicaid coverage, because CPS estimates of Medicaid enrollment have historically been lower than HCFA numbers on Medicaid program enrollment. Even if the CPS underreported Medicaid enrollment, consistent estimates can be useful to follow overall insurance trends over time. However, the calendar year 1994 CPS estimates of Medicaid coverage for children are lower than the calendar year 1993 estimates. This is puzzling to some researchers who have used the CPS in the past because HCFA data on Medicaid program enrollment showed an increase in coverage between fiscal year 1993 and fiscal year 1994. The apparent drop may be partially due to a reported drop in the number of children enrolled in AFDC and it may also be due to the change in the CPS sampling frame.

Between 1993 and 1994 the percentage of children who were reported to be receiving AFDC or other assistance dropped from 10.6 percent to 9.6 percent—about 600,000 fewer children. Because children on AFDC are entitled to Medicaid coverage, Census assigns Medicaid coverage to AFDC children even if their parents do not report them as receiving Medicaid. This partially explains why Medicaid coverage may have appeared to

[15]In our previous report and correspondences, we assigned a single source of coverage to children if they had multiple insurance sources reported for a single year. We based the assignment for insured children on a hierarchy—if they had any employment-based insurance, they were assigned to that category; if they had no employment-based insurance, but had Medicaid or Medicare, they were assigned to the Medicaid category; if they had neither employment-based insurance, Medicaid or Medicare, but had CHAMPUS, they were assigned to CHAMPUS; if they had private, individually purchased insurance, but none of the above categories, they were assigned to the individual privately purchased coverage category.

decrease. Department of Health and Human Services' data also show a small drop in the average monthly enrollment of children in AFDC between calendar years 1993 and 1994, although because of the differences between months included in calendar years and fiscal years, the drop does not show up in fiscal year data until fiscal year 1995. In fiscal year 1995, average monthly enrollment of children continued to drop.

Medicaid coverage also may have appeared to decrease because Census changed the sample frame—or types of families that Census interviews—from one based on the 1980 census to one based on the 1990 census. Because the March 1995 CPS was a transitional one for the sample frame, half the families were chosen based on the 1980 frame and half were chosen based on the 1990 frame. The percentage of children on Medicaid was lower in the half chosen from the 1990 frame (22.3 percent) than the half chosen from the 1980 frame (23.4 percent). While the sample chosen from the 1990 frame should be a more accurate report of Medicaid coverage, the differences between the two parts of the sample indicate that reported differences between 1993 and 1994 Medicaid coverage levels may be due in part to sampling frame changes rather than actual changes in coverage.

Other types of health insurance coverage did not appear to be affected much by sampling frame differences. Health insurance coverage estimates for workers with private insurance or with CHAMPUS were almost the same in the two halves of the sample frame.

Another issue with the 1993 estimate of children with Medicaid coverage—which Census informed us has been resolved—concerns miscoding. Last year, Census officials discovered some children appeared to be miscoded as receiving Medicaid. Census officials attempted to fix this through editing the CPS data tape, but the edited 1993 data tape may still contain inadvertently included data that show some children in the group with Medicaid who should not be in that group. According to Census, the coding issue was resolved for the 1994 estimates.

Effect on Comparing 1994 With Our Previous Estimates

These changes in reported coverage make some comparisons with our previous reports and others' reports based on the CPS problematic. While the estimate of the uninsured should not be affected to any great extent by changes in the questionnaire, estimates of employment-based insurance and private, individually purchased insurance are not comparable from 1994 to previous years. However, estimates of private insurance (the

combination of both) appear more comparable. Therefore, for this letter we are reporting on comparisons of private coverage. Similarly, whether private coverage came from employment or individual purchase can affect other estimates when using a hierarchy to assign one source of coverage. In addition, we are reporting children on Medicaid if they had any Medicaid coverage (including those who also had employment-based coverage) because this definition of Medicaid coverage should not be as affected by the questionnaire change and is more comparable to previous years' data and better captures the full extent of U.S. children enrolled in Medicaid.

Methodology for Matching Children and Determining Parental Work Status

To determine characteristics of children's parents, we followed a methodology discussed in our previous report (see app. II of Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175)). We matched children to a parent (18 to 64 years old) in their household (or a related adult who served as a parent, such as a grandparent or sister) and then linked that parent to a spouse, if any. We matched about 98 percent of children, but fewer Medicaid and uninsured children matched (about 96 percent) than did children with employment-based insurance. We determined parental work status by searching for a parent with the highest work status—full-time all year, less than full-time all year, or not working. Figures 1 through 4 and table II.1 are based on the total number of children—that is, unmatched children. Any discussions of employment status of parents are based on matched children, as are figure 5 and table 1.

Insurance Status of Children, 1987-94, and Medicaid Eligibility, by State, 1996

Table II.1: Health Insurance Status of Children Under 18 Years Old (1987-94—All Sources of Insurance Reported)

Year	Private insurance	Medicaid	Uninsured
1994[a]	65.6	22.9	14.2
1993[b]	67.4	23.9	13.7
1992[c]	68.7	22.0	12.7
1992	69.3	21.6	12.4
1991	69.7	20.4	12.7
1990	71.1	18.5	13.0
1989	73.6	15.7	13.3
1988	73.5	15.6	13.1
1987	73.6	15.2	12.9

Source: The Bureau of the Census.

Note: Rows may add to more than 100 percent because children with both private insurance and Medicaid will be counted in both categories. In any year, under 5 percent of children have other coverage, such as CHAMPUS. Children with coverage other than private insurance or Medicaid and who are not uninsured are not counted in this table.

[a]Data collection method changed to entirely computer-assisted telephone interviewing and sample frame partially changed.

[b]Data collection method partially changed to computer-assisted telephone interviewing.

[c]Implementation of 1990 census population weights, which affected the estimates—see other estimate for 1992.

Table II.2: Medicaid Eligibility Levels for Pregnant Women and Children, as of February 1996

	Percent of federal poverty level[a]			
State	Pregnant women and infants[b]	Children under 6 years old	Children 6 years old and older	Age under which children are eligible
Alabama	133	133	**133**	**13[c]**
Alaska	133	133	100	13[c]
Arizona	**140**	133	**100**	**14**
Arkansas	133	133	100	13[c]
California	**200**	133	**100**	**19**
Colorado	133	133	100	13[c]
Connecticut	**185**	**185**	**185**	**13[c]**
Delaware	**185**	133	**100**	**19**
Florida	**185**	133	**100**	**20**
Georgia	**185**	133	100	13[c]
Hawaii	**300**	**300**	**300**	**19**
Idaho	133	133	100	1

(continued)

State	Percent of federal poverty level[a]			
	Pregnant women and infants[b]	Children under 6 years old	Children 6 years old and older	Age under which children are eligible
Illinois	133	133	100	13[c]
Indiana	**150**	133	100	13[c]
Iowa	**185**	133	100	13[a]
Kansas	**150**	133	**100**	**16**
Kentucky	**185**	133	**100**	**19**
Louisiana	133	133	100	13[c]
Maine	**185**	133	**125**	**19**
Maryland	**185**	**185**	**185**	**13**[c]
Massachusetts	**185**	133	100	13[c]
Michigan	**185**	150	**150**	**15**[d]
Minnesota	**275**[e]	133	100	13[c]
Mississippi	**185**	133	100	13[c]
Missouri	**85**	133	**100**	**19**
Montana	133	133	100	13[c]
Nebraska	**150**	133	100	13[c]
Nevada	133	133	100	13[c]
New Hampshire	**185**	**185**	**185**	**19**
New Jersey	**185**	133	100	13[c]
New Mexico	**185**	**185**	**185**	**19**
New York	**185**	133	100	13[c]
North Carolina	**185**	133	100	13[c]
North Dakota	133	133	**100**	**18**
Ohio	133	133	100	13[c]
Oklahoma	**150**	133	100	13[c]
Oregon	133	133	**100**	**19**
Pennsylvania	**185**	133	100	13[c]
Rhode Island	**250**	**250**	100	13[c]
South Carolina	**185**	133	100	13[c]
South Dakota	133	133	**100**	**19**
Tennessee	**185**	133	100	13[c]
Texas	**185**	133	100	13[c]
Utah	133	133	**100**	**18**
Vermont	**225**	**225**	**225**	**18**
Virginia	133	133	**100**	**19**
Washington	**200**[f]	**200**	**200**	**19**

(continued)

State	Percent of federal poverty level[a]			
	Pregnant women and infants[b]	Children under 6 years old	Children 6 years old and older	Age under which children are eligible
West Virginia	**150**	133	**100**	**19**
Wisconsin	**185**	**185**	100	13[c]
Wyoming	133	133	100	13[c]

Source: National Governors' Association, State Medicaid Coverage of Pregnant Women and Children: Winter 1996, MCH Update (Washington, D.C.: National Governors' Association, 1996.)

Note: Percentages and ages in bold type show expansions beyond federal minimum requirements, either for age, family income, or both.

[a]The federal poverty level is the income level below which a family is poor, according to the federal poverty income guidelines published every year by the Department of Health and Human Services. The guidelines are for income by family size. For 1996, a family of three was poor if its family income was below $12,980.

[b]Infants are children less than 1 year old.

[c]Born after September 30, 1983.

[d]Born after June 30, 1979.

[e]Minnesota defines infants as up to 2 years old.

[f]Pregnant women are eligible if they have family income at or below 185 percent of the federal poverty level. Infants receive automatic coverage if their mother was on Medicaid when the child was born. In addition, infants are eligible if they are living in families with income up to 200 percent of the federal poverty level.

CENTER ON BUDGET AND POLICY PRIORITIES

December 6, 1996

MILLIONS OF UNINSURED AND UNDERINSURED CHILDREN ARE ELIGIBLE FOR MEDICAID

by
Laura Summer, Sharon Parrott and Cindy Mann

Summary of Findings

A new study completed by the Center on Budget and Policy Priorities finds that millions of children who are likely to be eligible for Medicaid are not enrolled in the program.

- Nationally, in 1994, one-fifth of all poor and near-poor children under age 11 who were income-eligible for Medicaid — nearly 2.7 million children — were neither enrolled in Medicaid nor covered by any other form of health insurance.

- These 2.7 million children accounted for nearly one-half of all the children under age 11 who were uninsured in 1994. If these children had been enrolled in the Medicaid program, the number of uninsured children under age 11 would have been reduced by as much as 45 percent.

- Nearly 80 percent of these uninsured children who were income-eligible for Medicaid lived in families with earnings.

- An additional 2.1 million children under age 11 who were income-eligible for Medicaid but not enrolled in the program had some form of private health insurance coverage at some time during the year. These children also could have benefitted from Medicaid either because their private health care coverage was not continuous throughout the year or because the services covered under their private plan were much more limited than coverage available under Medicaid. Additionally, Medicaid could have helped their families pay premiums, copayments and deductibles that can create barriers to care particularly for very low-income children.

Of particular significance, in light of the changes in welfare and Medicaid program rules that result from the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, is the very low Medicaid participation rate among children who are not receiving cash assistance (either AFDC or SSI).

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- In 1994, only 38 percent of the Medicaid-eligible children under age 11 who did not receive cash assistance were enrolled in the Medicaid program. In other words, almost two-thirds (62 percent) of all children who were not receiving welfare but who were income-eligible for Medicaid were not enrolled in the program. More than half of these children were *wholly uninsured.*

Welfare law changes are likely to give rise to even lower Medicaid participation rates in the future, unless states revamp their Medicaid application procedures and outreach strategies. Under the new law, the eligibility link between Medicaid and welfare is ended, and states are no longer required to enroll all children who are receiving TANF-funded aid onto the Medicaid program. Although Medicaid eligibility guarantees are maintained, Medicaid enrollment could plummet if steps are not taken to maximize coordination between welfare programs and Medicaid.

Even if states continue to enroll children who receive aid funded with TANF block grant dollars onto the Medicaid program, Medicaid enrollment is likely to be adversely affected by other welfare law changes. Over time fewer children are expected to receive cash aid because welfare rules will be more restrictive and because a large number of families are expected to leave the welfare rolls as parents find work. Children who no longer qualify for cash aid due to time limits and other restrictions, as well as many of the children whose parents find low-wage jobs, will continue to be eligible for Medicaid, but the data examined here strongly suggests that if current patterns persist only a small portion of these children will actually be enrolled in the Medicaid program.

It is particularly important for states to devise new systems for reaching children whose parents find work because these children are unlikely to be covered by employer-based health insurance. Department of Labor data show that in April 1993, only roughly 40 percent of workers earning less than $5 an hour had employers that offered any of their employees health care coverage, and many of these workers were not eligible to enroll in the employer-based plans because they worked part-time. Only 13 percent of all workers earning less than $5 an hour had employer-based coverage for both themselves and their families.

The Center's study also includes tables with estimates of Medicaid participation rates for young children in all fifty states, based on data covering the years 1992 through 1994. Participation rates across states vary considerably. A variety of factors influence these rates, including the scope of coverage under the state's welfare program, the uninsured rate within the state, as well as steps the state has taken to make the Medicaid program accessible to diverse populations. Due to limited sample sizes in a number of states, however, comparisons between individual states should generally be avoided.

The national and state data examined in this report demonstrate the potential for the Medicaid program to provide health care coverage to a large portion of the children who are uninsured or underinsured. The program is falling short of its potential, however, and the changes in the welfare law and trends in the private market are likely to widen the gap between eligibility and enrollment unless the states undertake aggressive new strategies to reach out to eligible children.

CENTER ON BUDGET AND POLICY PRIORITIES

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MILLIONS OF UNINSURED AND UNDERINSURED CHILDREN ARE ELIGIBLE FOR MEDICAID

by Laura Summer, Sharon Parrott and Cindy Mann

Overview

In 1995, some 3.1 million poor children under age 18 — approximately 21 percent of all poor children — had no health insurance coverage.[1] Yet, many of these children could have been insured because they were eligible for Medicaid, but were not enrolled in the program.

Medicaid now offers health insurance coverage to a broad group of poor children as a result of expansions in eligibility that began in the late 1980's and that are being phased in over time. Under federal law, children under age six are eligible for Medicaid if their family income is below 133 percent of the federal poverty line. Children between the ages of six and 13 are currently eligible if their family income is below 100 percent of the poverty line. Each year a new age group of children is "phased in" so that by the year 2002, all poor children under age 19 will be eligible for Medicaid.

Eligibility for coverage, however, does not necessarily translate into *actual coverage*. This analysis examines national and state-specific Medicaid participation rates for children under age 11 and finds that large numbers of income-eligible children were not enrolled in the program.[2] Many of these children lacked any health insurance

[1] U.S. Bureau of the Census, Current Population Survey, 1996.

[2] National participation rate estimates are for 1994 based on data from the Census Bureau's 1995 Current Population Survey which provides income and health insurance information for 1994. For this analysis, participation rates for children under age 11 were considered because in 1994, federal law mandated Medicaid coverage for poor children under age 11. State-specific estimates were calculated using data from Current Population Surveys for 1992, 1993, and 1994. Three years of data were used to assure larger sample sizes. While some states have expanded coverage to older children or to children with higher incomes, only the federal minimum standards were considered for both the national and state level estimates. A description of the methodology used for the analysis is presented in Appendix II.

coverage, while the rest had some health insurance but likely received less adequate coverage than is available under state Medicaid programs.

- Nationally, in 1994, one-fifth of all poor and near-poor children under age 11 who were income-eligible for Medicaid — nearly 2.7 million children — were neither enrolled in Medicaid nor covered by any other form of health insurance.[3] Nearly 80 percent of these children lived in families with earnings.

- These 2.7 million children accounted for nearly half of all the children under age 11 who were uninsured in 1994. If these Medicaid-eligible children had been enrolled in the program, the number of uninsured children under age 11 would have been reduced by as much as 45 percent.

- An additional 2.1 million children under age 11 who were eligible for Medicaid but not enrolled in the program had some form of private health insurance coverage at some time during the year. Despite being covered by private health insurance, many of these children could have benefitted from participating in the Medicaid program. First, private plans available to families with very low-paying jobs often provide only minimal coverage and frequently require families to pay a high portion of the costs of coverage and services. Medicaid can supplement private insurance and relieve families of unaffordable premiums, deductibles and copayments that can create barriers to accessing health care. In addition, some of these children had health insurance for only part of the year. Medicaid coverage would have allowed them to be insured throughout the year.

This analysis also provides state-level estimates of the number and proportion of children eligible for Medicaid but not enrolled in the program. These figures show that there are substantial numbers of children in every state who are not currently reached by the Medicaid program, despite their eligibility for coverage. Participation rates across all states do vary considerably. However, due to the limited sample sizes in a number of states, comparisons between individual states should generally be avoided.

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[3] In this analysis, children are defined as "income-eligible" for Medicaid if they meet the federal age and income eligibility requirements of the Medicaid program. States also may impose assets tests, and therefore, some poor and near-poor children who are income-eligible may not qualify for Medicaid coverage if the countable value of assets the family owns exceeds the allowable limits. The data did not allow for consideration of assets, but consideration of assets would likely have had only a small effect on the estimates here. (Currently, only ten states impose an asset test for children.) For simplicity, this analysis will hereafter refer to those children who are "income-eligible" simply as children "eligible" for Medicaid.

The new welfare law (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or "PRWORA") could lead to even lower Medicaid participation rates in the future. The new law makes profound changes in the welfare system and in the relationship between cash assistance and Medicaid. The AFDC program is replaced with a block grant that allows states broad flexibility to develop new rules for income support and work programs while imposing stringent new work requirements and time limits. Large numbers of families may no longer be eligible for assistance as a result of federally-mandated or state-imposed restrictions that will limit eligibility for cash aid and work programs. While the new law preserves Medicaid eligibility for families who would have qualified for Medicaid under the prior law, the data show that children in families who do not receive cash aid are much less likely to enroll in the Medicaid program.

- In 1994, only 38 percent of children under age 11 who did not receive cash assistance but were eligible for Medicaid were enrolled in the Medicaid program. In other words, almost two-thirds — 62 percent — of all children who were not receiving welfare but who were eligible for Medicaid were not enrolled in the program. More than half of these children were *wholly uninsured*.[4]

Moreover, Medicaid participation may drop even among those children who remain eligible for cash assistance under the new block grant programs. Under the new law, states are no longer required to automatically enroll children who receive assistance under the block grant in the Medicaid program. This could result in significant numbers of eligible children not receiving Medicaid if states do not take steps to assure that these very poor children are enrolled in the program.

The welfare changes also are expected to result in many families becoming ineligible for cash assistance because more parents will find jobs. Children in these families are likely to remain eligible for Medicaid if their parents have low earnings, but participation rates among children in working poor and near-poor families are particularly low. As noted above, nearly 80 percent of the uninsured children under age 11 who were eligible for Medicaid in 1994 but not enrolled in the program lived in families with earnings.

Children in families that become ineligible for cash assistance because their parents find jobs are unlikely to be covered by employer-sponsored health insurance.

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[4] Because children receiving Supplemental Security Income (SSI) benefits are also automatically enrolled in the Medicaid program, these figures represent the proportion of children living in families that receive neither AFDC nor SSI benefits.

- In April 1993, only roughly 40 percent of workers earning less than $5 an hour had employers that offered *any* of their employees health care coverage, and many workers whose employers did offer coverage were not eligible to enroll in the employer-based plans often because they worked part time.

- Only 13 percent of all workers earning less than $5 an hour had employer-based coverage for both themselves and their families.[5]

The expansions in Medicaid eligibility, still being phased in, could offset the reduction in coverage resulting from the decline in employer-sponsored coverage among poor children and could allow millions of uninsured and underinsured children greater access to health care. These data indicate, however, that the changes in welfare policy and declining employer-based coverage are likely to result in even more children being uninsured despite their eligibility for Medicaid unless states improve outreach and redesign their Medicaid enrollment procedures.

Eligibility For Medicaid Has Expanded In Recent Years

To consider Medicaid participation rates both nationally and in individual states, it is important to begin with a review of the Medicaid eligibility rules. Medicaid began as a program that provided health care coverage exclusively to individuals and families receiving cash assistance. Over the last decade, bipartisan support for covering a greater portion of uninsured children under the Medicaid program has allowed large numbers of poor and near-poor children who are not receiving cash assistance to qualify for Medicaid coverage. The shift in the Medicaid caseload has been dramatic. In 1990, fewer than one-third of the children covered by Medicaid did not receive cash assistance. Four years later, 45 percent of the children served by the Medicaid program were not receiving cash aid.[6]

Recent changes in federal Medicaid eligibility rules are largely responsible for the expansions in Medicaid coverage among low-income children who do not receive cash assistance. Currently, under federal law, children under age six with income below 133 percent of the poverty line and children ages six through 13 with income below 100 percent of the poverty line are eligible for Medicaid. Eligibility for older

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[5] U.S. Department of Labor, Social Security Administration, U.S. Small Business Administration, and Pension Benefit Guaranty Corporation, *Pension and Health Benefits of American Workers: New Findings from the April 1993 Current Population Survey*, 1994.

[6] Calculations based on data from the Urban Institute.

poor children is being phased in, so that by the year 2002, all poor children under age 19 will be eligible for coverage.[7]

These minimum federal eligibility requirements, moreover, have been augmented in many states; 40 states have expanded coverage beyond the federal requirements to make the Medicaid program available to even more children who need health insurance coverage. Currently, some 35 states and the District of Columbia provide Medicaid coverage for infants at income levels above those mandated by federal law, and eight states have raised the income limits for children through age six. In addition, 21 states have speeded up the phase-in of eligibility for older children, extending Medicaid coverage to children above the age limits required by federal law. A table listing state Medicaid income eligibility standards for children, based on a Center on Budget and Policy Priorities' survey of the 50 states and the District of Columbia, is presented in Appendix I.

In addition, since the passage of the Family Support Act in 1988, Medicaid coverage has been available to families who become ineligible for welfare because they have new or increased earnings or child support. This "transitional" Medicaid coverage is time-limited, but nonetheless is intended to assure that families do not lose their health care coverage immediately upon finding a job or receiving child support that makes them ineligible for welfare.[8]

Many Children Who Are Eligible for Medicaid Are Not Enrolled in the Program

Millions of children who are eligible for Medicaid under these expanded Medicaid eligibility rules are not participating in the program. Although Medicaid income eligibility standards vary among states, it is possible to examine Medicaid participation rates across all states by determining the portion of children whose family income is below the federal minimum standards who are participating in the Medicaid program. In 1994, the most recent year for which data are available, children under age six with family incomes below 133 percent of the federal poverty line and children ages

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[7] Under federal law, children age six and older and born after September 30, 1983 are eligible for Medicaid if their family income is below the poverty line. Thus, as of October, 1996, all states must cover children who are 13, and the age limit rises over time. In addition to these income eligibility standards, federal law allows states to impose an asset limit. Currently, only ten states impose an asset test for children, and two of these states do not consider assets for very young children.

[8] Transitional Medicaid coverage due to earnings is limited to 12 months while transitional Medicaid coverage due to child support is limited to four months. Twelve states, however, have used the waiver process to increase the number of months of transitional Medicaid coverage.

six through 11 with family incomes below 100 percent of the federal poverty line were eligible for Medicaid.[9]

- More than one-third of all children under age 11 who were eligible for Medicaid were not enrolled in the program in 1994. This represented 4.8 million children.

- More than half of the 4.8 million children eligible but not enrolled in Medicaid — nearly 2.7 million children — were wholly uninsured. *Stated another way, one-fifth of all children who were eligible for Medicaid lacked any form of health insurance.*

- These 2.7 million children account for 45 percent of the 5.9 million children under age 11 who were uninsured in 1994.

- Nearly 80 percent of the children who were eligible for Medicaid but who were wholly uninsured — more than 2 million children — lived in families with earnings.

- An additional 2.1 million children who were eligible for Medicaid but not enrolled had some form of private health insurance. Despite having private health insurance, many of these children could have benefitted from the Medicaid program. Medicaid pays for those benefits that are covered by Medicaid but not covered by the private plan and helps families afford the premiums, deductibles and copayments charged by their private health insurance.

It is not possible to determine from the data what type of insurance these 2.1 million children had. However, many poor children with private insurance coverage are likely to have limited benefit packages that may not cover preventive care or specialty services. Thus, while these 2.1 million children fall into the "insured" category, they may lack access to routine care, and those with special health care needs may not be able to access the medical care they require. In addition, some of these 2.1 million children were covered by private health insurance for only part of the year. (The Census data do not distinguish between children covered for part and all of the year.)

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[9] The following data are based on the Census Bureaus' 1995 Current Population Survey. The calculations reflect Medicaid income eligibility rules in effect in 1994.

Medicaid coverage would have ensured that these children were not left uninsured during those months when they were not covered by private insurance.[10]

Since cash assistance recipients in 1994 were automatically enrolled in Medicaid, the Medicaid participation rates among children who did *not* receive cash aid are particularly telling. These rates are quite low:

- Nationally, in 1994, only 38 percent of poor and near-poor children who did not receive AFDC or SSI but who were eligible for Medicaid were enrolled in the program. In other words, almost two-thirds — 62 percent — of all children under age 11 who were not receiving welfare but who were eligible for Medicaid were not enrolled. *More than half of these children were wholly uninsured.*

These very low participation rates among children who do not receive cash assistance are particularly worrisome given program changes prompted by the new welfare law that are likely to result in many fewer children receiving cash aid.

State Estimates

Table I shows estimates for each state of the number and proportion of Medicaid-eligible children who were not enrolled in the program. These estimates are based on data from 1992-1994. While small sample sizes make comparing participation rates across states ill-advised, taken as a whole, the data do show significant state variation in the participation rates among eligible children in the Medicaid program.

There are many reasons for such variation. One reason why participation rates will vary is that states in which a larger proportion of poor and near-poor children participate in the AFDC or SSI programs will tend to have a larger proportion of eligible children participating in the Medicaid program. Table II addresses this issue and show the number and proportion of income-eligible children not receiving AFDC and SSI who were not enrolled in Medicaid.

In addition, states in which a larger portion of Medicaid-eligible children have private health insurance coverage may have lower Medicaid participation rates. Table III shows the number and proportion of eligible children not receiving AFDC or SSI who were wholly uninsured.

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[10] A May 1996 Census report, "Who Loses Coverage and For How Long," shows that while 93 percent of all people had health insurance at some point during 1993, some 15 percent of these "insured" individuals lacked health insurance for at least one month during the year.

The variations in Medicaid participation rates across states may also be due in part to state administrative procedures and outreach efforts. Some states, for example, use one-page application forms and allow applicants to submit their forms by mail. Such simplified procedures are particularly important for working poor families unable to take time off from their jobs to apply in person and to families in rural areas or other communities where a lack of public transportation makes it difficult for families to come to the Medicaid office. In some communities, child care agencies, schools and health care providers, such as visiting nurses, community health centers, and hospitals help to enroll eligible families onto the program. In addition, some states have taken advantage of opportunities to improve participation rates by linking Medicaid eligibility determinations to other programs with similar eligibility rules, such as the WIC program, Head Start, and other child care programs.

More Eligible Children Could Be Uninsured In the Future

Provisions in the new welfare law coupled with low and declining rates of employer-provided health care coverage for children could mean even greater numbers of Medicaid-eligible children not participating in the program in the future. A large portion of these children will likely be wholly uninsured.

New Welfare Law Could Affect Medicaid Participation

Although it is commonly believed that the welfare law enacted in August 1996 did not include any significant changes in the Medicaid program, the new law does affect Medicaid eligibility and participation in fundamental ways. These changes could result in greater numbers of children who are eligible for Medicaid but not enrolled in the program.

Since the beginning of the Medicaid program, eligibility for AFDC and Medicaid have been linked. Families receiving AFDC have been automatically eligible for Medicaid and enrolled in the Medicaid program. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, however, replaced the AFDC program with the Temporary Assistance to Needy Families ("TANF") block grant. Under the block grant, states have broad flexibility to design income support and work programs for low-income families with children and are required to impose federally-mandated restrictions, such as time limits, on federally-funded assistance. The law does assure, however, that children and parents who would have qualified for Medicaid based on their eligibility for AFDC continue to be eligible for Medicaid regardless of whether they qualify for assistance under a program or programs that states establish with block

Continued Phase-In of Medicaid Coverage for Poor Children Will Increase the Number of Children Eligible for Medicaid and the Need for Outreach

In addition to the changes in the new welfare law, the continued phase-in of the recent Medicaid expansions means that large numbers of additional children will become eligible for Medicaid in the future. Under federal law, children under age six below 133 percent of the poverty line and poor children ages six and older born after September 30, 1983 are eligible for Medicaid. As a result, in 1994 poor children ages six through 11 were eligible for Medicaid while currently poor children ages six through 13 are eligible. By 2002, poor children under the age of 19 will be eligible for Medicaid.

In 1994, there were nearly 2.4 million poor children over the age of 11 who did not receive Medicaid, a rough estimate of the number of additional children who will become eligible and could be enrolled in Medicaid in the coming years.

grant funds. This is accomplished by carrying over to the Medicaid program certain eligibility rules from state AFDC programs.[11]

While children will not lose *eligibility* for Medicaid due to the new law, other changes in the law may cause Medicaid participation rates to drop substantially.

- Fewer children are likely to receive cash assistance under the new law due to restrictions placed on receipt of aid. States are required to impose a maximum five-year time limit on assistance funded with federal block grant dollars and are permitted to impose shorter time limits. States are also given vast new authority to limit access to assistance in other ways, such as by lowering income-eligibility limits and by limiting aid to teen parents.

  Children who no longer receive cash assistance due to such restrictions generally will be eligible for Medicaid, but they are likely to have low Medicaid participation rates. As noted above, close to two-thirds of the

[11] Under the welfare law, children and parents whose income and assets are below the state's AFDC income and resource standards in effect as of July 1996 and who meet the AFDC family composition rules in effect as of July 1996 will qualify for Medicaid. If a state has an AFDC waiver that affects these eligibility rules, the state may have the option to continue applying its waiver rules. States also have certain options to vary their income and asset standards and their rules for calculating financial eligibility. A state may lower the income standards for determining eligibility for older children and parents, but not below the levels that were in place in the state's AFDC program in May 1988. States may also raise their income and asset standards, but not by an amount that is greater than the raise in the Consumer Price Index. For more discussion of these new rules see, Cindy Mann, *An Analysis of the AFDC-Related Medicaid Provisions in the New Welfare Law*, Center on Budget and Policy Priorities, revised November 7, 1996.

children eligible for Medicaid who did not receive cash assistance — 62 percent — were not enrolled in the program in 1994.

- Medicaid participation may decline even among children who remain eligible for cash assistance and work programs funded under the block grant. Under the new law, there is no requirement that states automatically enroll children who receive aid funded under the TANF block grant in the Medicaid program. States have a number of options, however, under the law that allow them to keep Medicaid and welfare program rules aligned and to assure that children who receive cash aid and who are eligible for Medicaid are enrolled in the Medicaid program. (See box on page 11.)

- Fewer children may also qualify for cash assistance because their parents find jobs. The new law requires states to place increasing numbers of parents in work activities, and the law is expected to result in greater number of parents finding employment. While many of the children whose parents become employed are likely to remain eligible for Medicaid due to the low earnings of their parents, Medicaid participation rates among children in poor and near-poor working families are quite low.

In addition to these welfare-related changes, the new law makes significant changes in eligibility for children under the federal Supplemental Security Income (SSI) program. Under the law, a substantial number of children will lose SSI benefits — and, therefore, their automatic eligibility for Medicaid — due to new restrictions in the definition of disability. A majority of the children who are no longer eligible for SSI will be eligible for Medicaid under alternative avenues of coverage — many, for example, will meet the age and income eligibility criteria for Medicaid — but enrollment of these poor children who have significant medical problems will no longer be automatic.[12]

The extent to which states develop new approaches to assure that eligible children are enrolled in Medicaid thus will have a considerable effect on Medicaid

[12] Children who are currently receiving SSI but who become ineligible under the new disability standards should not be terminated from Medicaid coverage unless and until the state determines that they are not eligible under an alternate eligibility category. See HCFA fact sheet entitled "Link Between Medicaid and SSI Coverage of Children Under Welfare Reform." The Medicaid enrollment issue discussed here, therefore, concerns children who would have qualified for SSI in the future, not to current SSI recipients.

States Can Coordinate Medicaid and Welfare Program Enrollment

Although the new law does not require states to enroll all children who receive cash assistance under the TANF block grant into the Medicaid program, states could design their welfare and Medicaid systems so there is a single eligibility determination for both programs. The new law allows states flexibility in determining how they will administer their Medicaid program and the extent to which Medicaid rules and the rules for the program(s) funded with TANF block grant dollars will be the same.

The more closely the eligibility rules for the welfare and Medicaid programs are aligned, the easier it will be to coordinate program enrollment. For example, if a state keeps the basic financial eligibility rules for its new welfare program and for Medicaid consistent, a single application form can be used to determine eligibility under both programs and a single agency could make the eligibility determination. Coordination also can be achieved even in states that choose to change their welfare rules as long as the new rules are no more restrictive than the rules that were in effect in July 1996. The new welfare law maintains current rules as the *minimum* standard for Medicaid; states can modify and simplify their rules so long as the changes do not result in families losing coverage under the Medicaid program.[a]

Even if a state imposes restrictions or lowers eligibility standards for its TANF-funded program in ways that would not be allowed under Medicaid rules, a single application could still be used for the two programs since all TANF program recipients would likely still be eligible for Medicaid. The state could maximize participation in Medicaid (and limit state administrative costs) by coordinating eligibility between the two programs. The state would, however, have to ensure that children and parents who did not qualify for TANF-funded assistance are separately evaluated for Medicaid eligibility.

[a] States that keep welfare and Medicaid rules consistent may be able to minimize their state administrative costs and maximize their federal reimbursement. States can claim federal Medicaid administrative matching funds to cover the cost of determining eligibility under Medicaid, whereas under the TANF block grant, states do not receive additional federal funds for administration. If the eligibility process for the two programs remains closely linked, the work done on Medicaid could significantly simplify the administrative tasks required to determine eligibility for aid under TANF.

participation rates both among children who remain eligible for cash assistance and those who no longer qualify.[13]

[13] There are other changes in the new welfare law affecting Medicaid. Most significant is that most legal immigrants of any age who enter the country on or after August 22, 1996 (the day the new law was enacted) will not be eligible for Medicaid. Immigrants who are already in the country can be covered *at state option*. States that choose to withdraw Medicaid coverage for legal immigrants could see significant increases in the number of uninsured people.

Declines in Employer-Based Health Care Coverage

The number of low-income parents who work may increase as a result of changes in welfare programs and policies. However, few of the children in these families are likely to be covered in an employer-sponsored health plan.

- In April 1993, when the minimum wage stood at $4.25, only 21 percent of workers between the ages of 25 and 34 who earned less than $5 an hour were covered by an employer-provided health insurance plan.

- Similarly, among all workers earning less than $5 an hour, only 13 percent had employer-provided health care coverage for both themselves and their families. Among those earning between $5 and $7.50 an hour, only 26 percent had employer-provided coverage for both themselves and their families.

- Some low-wage workers who are not covered by an employer-based health care plan are covered by other private health insurance plans, including employer-based plans of other family members. Among those earning less than $5 an hour in private sector firms, however, nearly 60 percent worked in firms that did not offer *any* of their employees health insurance coverage. Among those that worked in firms that offered health insurance coverage to at least some of their workers, almost one-third reported being ineligible for coverage. The most common reason cited for ineligibility was that the employee worked part time.[14]

- Census figures show that in 1995, only about two-thirds of children under age 18 — 66.4 percent — had private health insurance coverage, down from about three quarters — 73.8 percent — in 1988.

Conclusion

Already, large numbers of eligible children are not enrolled in the Medicaid program, and many of those eligible but not enrolled lack any form of health insurance. Changes in the new welfare law coupled with low and declining rates of health insurance coverage through the workplace could mean that more Medicaid-eligible children will lack adequate health care coverage in the future. It is, therefore, more important than ever for states to improve their efforts to inform low-income families of their potential eligibility for Medicaid and to reexamine their systems for enrolling children and families in the Medicaid program.

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[14] U.S. Department of Labor, Social Security Administration, U.S. Small Business Administration, and Pension Benefit Guaranty Corporation, *Pension and Health Benefits of American Workers: New Findings from the April 1993 Current Population Survey*, 1994.

Table I

Percent and Number of Children Under 11 Who Were Income-Eligible For Medicaid But Not Enrolled

	Percent		Number	
	Low	High	Low	High
Alabama	36.9%	51.0%	72,000	130,000
Alaska	24.7%	38.7%	4,200	8,900
Arizona	35.4%	48.3%	74,700	130,800
Arkansas	36.2%	49.7%	42,000	75,200
California	33.5%	38.1%	673,700	838,100
Colorado	28.9%	46.2%	29,100	66,200
Connecticut	22.8%	40.1%	22,900	58,600
Delaware	30.2%	49.1%	5,400	13,000
Dist. of Col.	13.7%	24.1%	5,700	13,000
Florida	29.6%	35.7%	216,100	296,500
Georgia	29.1%	43.8%	70,200	142,500
Hawaii	34.5%	51.8%	12,800	26,800
Idaho	36.2%	48.5%	18,800	32,400
Illinois	24.0%	30.7%	135,200	200,400
Indiana	22.1%	34.8%	55,500	116,600
Iowa	39.7%	56.2%	34,800	68,100
Kansas	29.0%	43.6%	25,500	51,900
Kentucky	17.8%	28.9%	33,400	70,700
Louisiana	29.9%	41.4%	92,400	160,500
Maine	21.1%	36.7%	8,700	21,100
Maryland	36.2%	52.2%	62,500	124,400
Massachusetts	25.3%	34.4%	41,500	68,500
Michigan	20.2%	26.4%	93,200	141,100
Minnesota	25.0%	40.5%	35,500	80,100
Mississippi	22.3%	33.1%	33,800	63,300
Missouri	26.1%	39.8%	62,000	125,800
Montana	23.4%	37.7%	7,300	15,600
Nebraska	36.7%	52.6%	18,600	36,400
Nevada	51.6%	66.1%	27,200	46,500
New Hampshire	21.5%	39.0%	7,200	19,200
New Jersey	28.0%	36.5%	68,400	106,800
New Mexico	30.4%	42.7%	26,700	47,600
New York	25.4%	30.4%	230,600	307,300
North Carolina	30.3%	37.6%	87,000	125,300
North Dakota	25.7%	41.3%	4,600	10,300
Ohio	24.2%	31.0%	116,400	173,600
Oklahoma	43.5%	56.4%	75,400	125,700
Oregon	31.1%	47.4%	32,200	68,400
Pennsylvania	32.1%	40.0%	144,900	212,400
Rhode Island	21.4%	38.2%	6,200	16,300
South Carolina	23.8%	34.4%	46,300	84,100
South Dakota	40.3%	53.8%	11,800	20,500
Tennessee	17.1%	28.3%	37,000	80,500
Texas	37.1%	43.2%	427,100	560,900
Utah	40.5%	55.6%	26,600	48,800
Vermont	10.9%	25.1%	1,800	6,000
Virginia	40.2%	56.2%	66,400	127,600
Washington	24.7%	39.6%	40,600	89,300
West Virginia	20.6%	33.1%	18,200	38,200
Wisconsin	27.4%	42.7%	41,900	89,300
Wyoming	34.0%	53.4%	4,700	11,000
U.S.	35.2%	37.5%	4,650,700	4,946,900

How to Read This Table:

In the period 1992-1994, between 37 and 51 percent of children income-eligible for Medicaid were not enrolled in Alabama. This translates into between 72,000 and 130,000 children who were eligible but not enrolled in Medicaid in 1994.

Source: Center on Budget and Policy Priorities calculations based on pooled data from the Census Bureau's 1993, 1994, and 1995 March Current Population Surveys.

Table I NOTES:

1. To determine the Medicaid participation rates, children were considered income eligible for Medicaid if they met the age and income-eligibility requirements for Medicaid in the year they were interviewed for the Current Population Survey. In each year, children under age six with incomes below 133 percent of poverty were considered income-eligible for Medicaid. Those interviewed in 1993 were considered income-eligible for Medicaid if they were between the ages of 6 and 8 and had incomes below the poverty line. Those interviewed in 1994 were considered income-eligible for Medicaid if they were between the ages of 6 and 9 and had incomes below the poverty line. Those interviewd in 1995 were considered income-eligible for Medicaid if they were between the ages of 6 and 10 and had incomes below the poverty line. To calculate the number of children income eligible for Medicaid but not enrolled, the Medicaid participation rates were multiplied by the estimate of the number of children who would have met the 1994 Medicaid eligibility standards averaged over each of the three survey years.

2. For detailed description of the methodology used, see Appendix II.

Table II

Percent and Number of Children Under 11 Who Did Not Receive AFDC or SSI And Who Were Income-Eligible for Medicaid But Not Enrolled

	Percent		Number	
	Low	High	Low	High
Alabama	48.2%	64.2%	70,000	126,900
Alaska	50.1%	71.5%	4,100	8,900
Arizona	55.5%	71.4%	76,000	132,700
Arkansas	47.8%	64.2%	35,800	66,600
California	59.7%	65.8%	657,900	820,100
Colorado	51.8%	73.9%	28,800	65,300
Connecticut	64.7%	88.8%	21,100	53,900
Delaware	55.1%	77.1%	5,500	12,700
Dist. of Col.	42.5%	65.6%	5,100	12,500
Florida	50.4%	58.9%	209,900	290,300
Georgia	45.9%	64.4%	70,600	143,100
Hawaii	60.5%	81.4%	12,300	25,500
Idaho	57.0%	72.0%	18,900	32,400
Illinois	57.3%	68.6%	130,600	195,800
Indiana	37.3%	55.4%	54,400	116,900
Iowa	65.7%	84.2%	33,100	64,300
Kansas	50.9%	70.8%	24,100	50,000
Kentucky	38.2%	56.7%	32,700	70,900
Louisiana	58.2%	74.0%	85,400	150,200
Maine	39.7%	62.5%	8,500	20,800
Maryland	63.7%	82.8%	60,900	120,800
Massachusetts	59.8%	74.1%	39,300	65,700
Michigan	50.3%	61.9%	91,600	140,900
Minnesota	59.6%	83.1%	33,400	77,200
Mississippi	46.3%	63.6%	34,500	65,600
Missouri	45.1%	64.2%	55,500	116,200
Montana	41.5%	61.3%	7,000	15,200
Nebraska	60.0%	79.3%	17,700	34,900
Nevada	65.9%	80.5%	26,300	44,700
New Hampshire	52.2%	78.7%	7,900	20,500
New Jersey	62.9%	75.2%	68,400	106,600
New Mexico	51.3%	67.6%	26,000	46,700
New York	63.0%	71.4%	222,700	298,900
North Carolina	49.3%	59.2%	83,500	121,500
North Dakota	47.8%	70.2%	4,600	10,400
Ohio	60.4%	72.3%	108,900	165,300
Oklahoma	67.9%	81.5%	76,800	125,400
Oregon	57.3%	78.0%	31,500	66,900
Pennsylvania	64.0%	74.7%	141,000	206,500
Rhode Island	49.6%	77.3%	5,500	15,200
South Carolina	44.6%	60.5%	44,700	82,900
South Dakota	62.5%	77.9%	12,300	20,800
Tennessee	36.1%	55.4%	35,300	79,900
Texas	50.9%	58.2%	413,400	545,000
Utah	54.7%	71.4%	26,500	48,500
Vermont	26.4%	57.2%	1,500	5,800
Virginia	56.7%	74.3%	66,300	125,900
Washington	62.4%	81.0%	41,500	86,800
West Virginia	43.3%	63.2%	17,800	38,100
Wisconsin	66.8%	85.9%	42,700	87,600
Wyoming	60.9%	83.9%	4,600	10,600
U.S.	60.6%	63.6%	4,542,900	4,768,000

How To Read This Table:

In the period 1992-1994, between 48 and 62 percent of children who did not receive AFDC or SSI and were income-eligible for Medicaid were not enrolled in Alabama. This translates into between 70,000 and 126,900 children who did not receive AFDC or SSI and who were eligible but not enrolled in Medicaid in 1994.

Source: Center on Budget and Policy Priorities calculations based on pooled data from the Census Bureau's 1993, 1994, and 1995 March Current Population Surveys.

TABLE II NOTES:

1. To determine the Medicaid participation rates, children were considered income eligible for Medicaid if they met the age and income-eligibility requirements for Medicaid in the year they were interviewed for the Current Population Survey. In each year, children under age six with incomes below 133 percent of poverty were considered income-eligible for Medicaid. Those interviewed in 1993 were considered income-eligible for Medicaid if they were between the ages of 6 and 8 and had incomes below the poverty line. Those interviewd in 1994 were considered income-eligible for Medicaid if they were between the ages of 6 and 9 and had incomes below the poverty line. Those interviewed in 1995 were considered income-eligible for Medicaid if they were between the ages of 6 and 10 and had incomes below the poverty line. To calculate the number of children income eligible for Medicaid but not enrolled, the Medicaid participation rates were multiplied by the estimate of the number of children who would have met the 1994 Medicaid eligibility standards.

2. In this analysis, children whose families received any income from AFDC or SSI were excluded. Due to data limitations, we could not determine whether the child was an SSI recipient or whether someone else in the family received SSI benefits.

3. For detailed description of the methodology used, see Appendix II.

Table III

Percent and Number of Children Under 11 Who Did Not Receive AFDC or SSI Who Were Income-Eligible For Medicaid But Were Not Covered by Medicaid or Any Other Health Insurance Plan

	Percent		Number	
	Low	High	Low	High
Alabama	19.1%	33.1%	27,800	65,500
Alaska	5.8%	20.6%	500	2,600
Arizona	30.8%	46.6%	42,200	86,600
Arkansas	20.8%	35.8%	15,600	37,100
California	36.7%	42.9%	404,800	535,000
Colorado	15.6%	34.4%	8,700	30,400
Connecticut	10.2%	35.9%	3,300	21,800
Delaware	6.9%	24.1%	700	4,000
Dist. of Col.	18.3%	36.9%	2,200	7,000
Florida	26.6%	34.5%	110,900	170,100
Georgia	23.2%	40.4%	35,800	89,800
Hawaii	17.0%	38.5%	3,500	12,100
Idaho	19.4%	33.2%	6,400	14,900
Illinois	23.2%	33.7%	52,800	96,200
Indiana	9.6%	22.9%	14,100	48,300
Iowa	21.8%	39.9%	11,000	30,500
Kansas	13.2%	29.9%	6,300	21,100
Kentucky	15.0%	31.3%	12,800	39,100
Louisiana	35.4%	51.8%	51,900	105,200
Maine	4.7%	19.7%	1,000	6,600
Maryland	16.7%	35.7%	15,900	52,000
Massachusetts	23.1%	36.8%	15,200	32,700
Michigan	21.1%	31.4%	38,400	71,500
Minnesota	5.1%	20.5%	2,800	19,100
Mississippi	20.6%	36.4%	15,300	37,400
Missouri	12.2%	26.3%	15,000	47,600
Montana	9.2%	22.6%	1,500	5,600
Nebraska	12.0%	28.4%	3,500	12,500
Nevada	29.8%	45.7%	11,900	25,400
New Hampshire	19.1%	44.0%	2,900	11,400
New Jersey	23.6%	35.9%	25,700	50,800
New Mexico	30.8%	46.9%	15,600	32,400
New York	25.8%	33.9%	91,100	142,200
North Carolina	19.7%	28.1%	33,300	57,600
North Dakota	9.6%	27.2%	900	4,000
Ohio	23.5%	34.9%	42,300	79,800
Oklahoma	41.0%	56.9%	46,400	87,500
Oregon	17.9%	37.6%	9,800	32,200
Pennsylvania	24.6%	35.2%	54,100	97,300
Rhode Island	19.4%	45.5%	2,200	8,900
South Carolina	18.7%	32.5%	18,800	44,600
South Dakota	12.6%	26.0%	2,500	7,000
Tennessee	6.8%	20.2%	6,700	29,200
Texas	31.4%	38.3%	255,100	358,900
Utah	17.5%	32.4%	8,400	22,000
Vermont	0.9%	20.3%	0	2,100
Virginia	23.5%	40.8%	27,500	69,300
Washington	19.1%	40.8%	12,700	43,700
West Virginia	20.1%	38.3%	8,300	23,100
Wisconsin	25.9%	48.8%	16,500	49,800
Wyoming	22.2%	46.9%	1,700	6,000
U.S.	32.4%	35.3%	2,427,200	2,646,700

How To Read This Table:
In the period 1992-1994, between 19 and 33 percent of children who did not receive AFDC or SSI and were income-eligible for Medicaid were wholly uninsured in Alabama. This translates into between 27,800 and 65,500 children who did not receive AFDC or SSI and who were eligible for Medicaid but lacked any form of health insurance in 1994.

Source: Center on Budget and Policy Priorities calculations based on pooled data from the Census Bureau's 1993, 1994, and 1995 March Current Population Surveys.

TABLE III NOTES:

1. To determine the proportion of Medicaid-eligible children who lacked health insurance, children were considered income eligible for Medicaid if they met the age and income-eligibility requirements for Medicaid in the year they were interviewed for the Current Population Survey. In each year, children under age six with incomes below 133 percent of poverty were considered income-eligible for Medicaid. Those interviewed in 1993 were considered income-eligible for Medicaid if they were between the ages of 6 and 8 and had incomes below the poverty line. Those interviewd in 1994 were considered income-eligible for Medicaid if they were between the ages of 6 and 9 and had incomes below the poverty line. Those interviewed in 1995 were considered income-eligible for Medicaid if they were between the ages of 6 and 10 and had incomes below the poverty line. To calculate the number of children eligible for Medicaid but lacking any health insurance, the estimates of the proportion of Medicaid eligible children with no health insurance were multiplied by the estimate of the number of children who would have met the 1994 Medicaid eligibility standards.

2. In this analysis, children whose families received any income from AFDC or SSI were excluded. Due to data limitations, we could not determine whether the child was an SSI recipient or whether someone else in the family received SSI benefits.

3. For detailed description of the methodology used, see Appendix II.

Appendix I: Medicaid Income Eligibility Guidelines for Children Expressed As A Percent of the Federal Poverty Line

STATE	Infants (0-1)[1]	Children (1-6)[1]	Older Children[2]
Alabama	133%	133%	
Alaska	133%	133%	
Arizona	140%	133%	100% (under 14)
Arkansas	133%	133%	
California[3]	200%	133%	
Colorado	133%	133%	
Connecticut	185%	185%	185% (under 13)
Delaware	185%	133%	100% (under 19)
D.C.	185%	133%	
Florida	185%	133%	
Georgia	185%	133%	100% (under 19)
Hawaii[3]	185%	133%	133% (under 19)
Idaho	133%	133%	
Illinois	133%	133%	
Indiana	150%	133%	
Iowa	185%	133%	
Kansas	150%	133%	100% (under 17)
Kentucky	185%	133%	100% (under 19)
Louisiana	133%	133%	
Maine	185%	133%	125% (under 19)
Maryland[3]	185%	133%	
Massachusetts[3]	185%	133%	
Michigan	185%	150%	150% (under 15)
Minnesota[3/4]	275%	133%	
Mississippi	185%	133%	
Missouri	185%	133%	100% (under 19)
Montana	133%	133%	
Nebraska	150%	133%	
Nevada	133%	133%	
New Hampshire	185%	185%	185% (under 19)
New Jersey	185%	133%	
New Mexico	185%	185%	185% (under 19)
New York[3]	185%	133%	
North Carolina	185%	133%	
North Dakota	133%	133%	100% (under 18)

STATE	Infants (0 - 1)[1]	Children (1 - 6)[1]	Older Children[2]
Ohio	133%	133%	
Oklahoma	150%	133%	
Oregon	133%	133%	100% (under 19)
Pennsylvania[3]	185%	133%	
Rhode Island	250%	250%	100% (born after 6/30/83)
South Carolina	185%	133%	
South Dakota	133%	133%	100% (born after 6/30/83)
Tennessee	185%	133%	
Texas	185%	133%	
Utah	133%	133%	100% (under 18)
Vermont	225%	225%	225% (under 18)
Virginia	133%	133%	100% (under 19)
Washington	200%	200%	200% (under 19)
West Virginia	150%	133%	100% (under 19)
Wisconsin	185%	185%	
Wyoming	133%	133%	

1. To be eligible in the infant category, a child is under age 1 and has not yet reached his or her first birthday. To be eligible in the 1-6 category, the child is older than age 1 and has not yet reached his or her sixth birthday.

2. If the last column in the chart is left blank, the state provides Medicaid coverage to children age six or older who were born after September 30, 1983 and who have family incomes below 100 percent of the poverty line, as required by law. By October 1, 2002 all poor children under age 19 will be covered. If there is a notation in this column, it indicates that the state covers children in this age group who have family incomes higher than 100 percent of the poverty line, or that the state covers children born before September 30, 1983, thereby accelerating the phase-in period. States that have taken such steps have done so either through Medicaid waivers or the 1902(r)(2) provision of the Social Security Act.

3. The states noted operate state-funded health insurance programs available to children not eligible for Medicaid. Such programs may provide benefits similar to the Medicaid program or they may provide a limited benefits package. State-funded health insurance programs for children are as follows:

California (under age 2): 300 percent of the poverty line
Hawaii (under age 19): 300 percent of the poverty line; children older than 6 pay a premium
Maryland (under age 13): 185 percent of the poverty line
Massachusetts (under age 19): insurance buy-in program with sliding fee scale
Minnesota (under age 19): 275 percent of the poverty line
New York (under 15): insurance buy-in program with sliding fee scale
Pennsylvania (under 15): 185 percent of the poverty line

Colorado and Florida have state-funded health insurance programs for children, but these programs only are available to children in certain counties.

4. The Medicaid program in Minnesota covers infants and children under age 2 with family incomes below 275 percent of the poverty line.

Appendix II: Methodology for Calculating State Estimates

In this analysis, the March Current Population Surveys for 1993, 1994, and 1995 were used to develop state estimates of the number and percent of children eligible for Medicaid who were not enrolled in the program and who lacked any form of health insurance.[1] Three years of data were pooled to increase the sample size, and therefore the accuracy, of state estimates. The methodology for pooling the data and calculating the appropriate standard errors used in this analysis follows the Census Bureau's recommended procedures.[2]

Estimating the Proportion of Children Eligible for Medicaid Who Were Not Enrolled or Who Lacked Health Insurance

This paper looks at two different groups of children. Medicaid participation rates and overall insurance coverage are reported for each of these two groups of children.

The first group is comprised of all children who appear income-eligible for Medicaid. Children were considered income-eligible for Medicaid if they met the federal age and income eligibility requirements of the Medicaid program in place during the year about which they were interviewed. For example, children interviewed in 1993 about their income and health insurance coverage in 1992 were considered income-eligible for Medicaid if, in 1992, they were below age 6 and had incomes below 133 percent of the poverty line or if they were between the ages of 6 and 8 and had incomes below the poverty line. For those children interviewed in subsequent years, the Medicaid eligibility rules for the subsequent years were applied to determine if the child was income-eligible for Medicaid.[3] For each state in each survey year, estimates were made of the proportion of income-eligible children who received Medicaid or had some other form of health insurance. Following the methodology of the Census Bureau, these estimates were averaged and then the "standard error" of that estimate calculated in order to determine the appropriate range or "confidence interval" around the estimate.[4]

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[1] The Current Population Survey is conducted in March of each year and asks respondents about their income and health care coverage for the prior year.

[2] See the revised source and accuracy statement for the March 1995 CPS Microdata File.

[3] Children above the age thresholds were not considered Medicaid-eligible even if they received AFDC or SSI.

[4] Ninety percent confidence intervals were used.

The second group is a subset of the first group and is comprised of those children who both appeared income-eligible for Medicaid and lived in families that received neither AFDC nor SSI benefits. Due to data limitations, it was impossible to determine whether children were SSI recipients or whether other family members were receiving SSI.

Estimating the Number of Children Eligible for Medicaid Who Were Not Enrolled or Who Lacked Any Form of Health Insurance

The estimates of the proportion of Medicaid-eligible children who either were not enrolled in the Medicaid program or who lacked any form of health insurance were then applied to estimates of the number of children who met the *1994 Medicaid eligibility rules.*[5] This was done for both all children who were Medicaid eligible and those children who were Medicaid eligible and whose families did not receive AFDC or SSI.

For example, suppose that using the methodology described above, it is estimated that in a particular state between 20 and 30 percent of children who were income eligible for Medicaid did not receive Medicaid coverage. To translate that estimate into the *number* of children lacking Medicaid coverage, the number of children in that state who would have met the 1994 Medicaid eligibility guidelines was calculated. This was done by determining the number of children in each of the three survey years who would have met the 1994 Medicaid eligibility rules, averaging those estimates, and creating a confidence interval around that average. Suppose in this state, over the three year period, an average of between 130,000 and 160,000 children would have met the 1994 eligibility standards. The estimate that between 20 and 30 percent of these children would have failed to actually receive coverage was used to calculate that in 1994 roughly 26,000[6] to 48,000[7] children in this state lacked Medicaid coverage.

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[5] These are the eligibility rules used in the calculations to determine the proportion of children not receiving Medicaid or lacking health insurance for those children interviewed in 1995.

[6] Calculated by taking 20 percent of 130,000 children.

[7] Calculated by taking 30 percent of 160,000 children.

UNINSURED CHILDREN IN THE SOUTH

SECOND REPORT

Prepared By

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EXECUTIVE SUMMARY

In the area of public policy, there are few issues more compelling than the need to assure that children are not denied access to preventive and primary health care because of the inability to pay. Research has shown that Medicaid coverage improves children's access to primary health care.

In 1986, a breakthrough in public policy occurred when the federal law was amended to open the door for pregnant women and children to be eligible for Medicaid without having to be on welfare. Additional amendments were enacted by Congress in succeeding years to increase the age and income ranges at which children are eligible for Medicaid.

Medicaid continues to be viewed as a primary funding mechanism for providing health coverage for poor and low income children. In order to make informed decisions about health coverage for children, states need data on uninsured children and the potential role Medicaid can play in reducing the number of children who are without coverage.

The Southern Institute on Children and Families released the first report on ***Uninsured Children in the South*** in November 1992. The report provided estimates of uninsured children by state with age and income breakouts related to Medicaid. This is the second report on ***Uninsured Children in the South***. Support for both reports has been provided by The Henry J. Kaiser Family Foundation.

The fact sheets in Chapter 4 contain estimates of uninsured children for each of the following states and the District of Columbia:

Alabama	Louisiana	South Carolina
Arkansas	Maryland	Tennessee
Delaware	Mississippi	Texas
Florida	Missouri	Virginia
Georgia	North Carolina	West Virginia
Kentucky	Oklahoma	

This report also provides estimates of uninsured children, including the following:

- Number of uninsured children in 1993 with percent of uninsured children by age and income ranges.
- Decline or increase in the number of uninsured children between 1989 and 1993.

The source of the estimates of uninsured children is the Current Population Survey (CPS).

Estimates of Uninsured Children

Of the 9.4 million uninsured children in the United States in 1993, a total of 4.1 million (43%) resided in the South. The percentage of uninsured children in the South is disproportionately high since only 36% of all children lived in the 17 southern states and the District of Columbia. Analysis of the state and regional data show the following:

- Uninsured children as a percentage of a state's population of children age 18 and younger ranged from a high of 25% in **LOUISIANA** to a low of 10% in **MISSOURI** and **NORTH CAROLINA**.
- More than one million (25%) of all uninsured children in the South lived in **TEXAS**.
- In 12 southern states, less than one third of uninsured children lived in families with income at or below the poverty level.
- Older children in the South are much more likely to be uninsured than are children age five and younger. Between 1989 and 1993, the most dramatic increase in uninsured children occurred with children ages 13 through 18.
- Between 1989 and 1993, the most dramatic decrease in the number of uninsured children occurred with children age 12 and younger with income below the poverty level.
- The South had a much greater decline in the number of uninsured children age five and younger than the nation.
- In the South, age and income ranges which have the lowest percentages of uninsured children coincide with Medicaid age and income eligibility ranges.

Medicaid and Uninsured Children

All but three southern states (**ALABAMA, ARKANSAS** and **LOUISIANA**) have established eligibility levels broader than the federal minimum Medicaid eligibility levels for one or more age groups.

- 13 states and the District of Columbia have raised the minimum income eligibility level above the federally required income minimum of 133% of the poverty level for infants up to age one (**DELAWARE, FLORIDA, GEORGIA, KENTUCKY, MARYLAND, MISSISSIPPI, MISSOURI, NORTH CAROLINA, OKLAHOMA, SOUTH CAROLINA, TENNESSEE, TEXAS** and **WEST VIRGINIA**).

- Seven southern states have aggressively used Medicaid to cover uninsured children of all age groups (**DELAWARE, GEORGIA, KENTUCKY, MISSOURI, NORTH CAROLINA, VIRGINIA** and **WEST VIRGINIA**).

However, in 10 southern states and the District of Columbia, most children age 13 and older are only eligible for Medicaid if their income is within the more restrictive state welfare eligibility levels. These states have not raised Medicaid age limits for poverty related children above the minimum federal age requirement.

- **ALABAMA, ARKANSAS, LOUISIANA** and **TEXAS** use Medicaid eligibility levels below 20% of the poverty level for most children ages 13 through 18.

In examining the potential for utilizing Medicaid to reduce the number of uninsured children, it is necessary to recognize that not all children who are age and income eligible are covered by Medicaid. Lack of information about the availability of Medicaid coverage, eligibility barriers and other factors affect the ability of many needy families to gain Medicaid coverage for their children. The problem of children who are age and income eligible for Medicaid, but who are not covered by Medicaid, is a significant one for the southern states.

- In the South in 1993, there were 156,900 uninsured children age five and younger who were income eligible for Medicaid, but were not covered by Medicaid. In addition, it is likely that many of the 357,900 children in the age range of six through 12 were income eligible for Medicaid, but were not covered by Medicaid.

Actions States Can Take to Reduce the Number of Uninsured Children

Several actions states can take to provide health coverage for children are outlined in Chapter 5. These strategies rely heavily on Medicaid in recognition

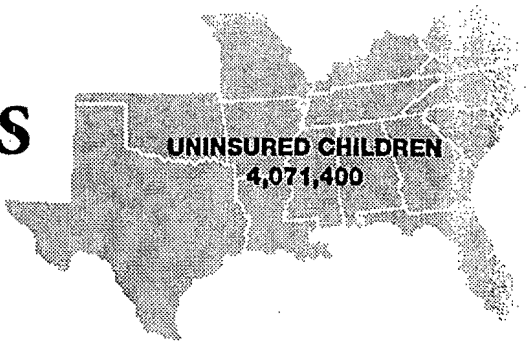
of the substantial financial assistance it provides to southern states in covering children in families who cannot afford to purchase health insurance. A federal Medicaid waiver is not required to take the following actions to reduce the number of uninsured children:

- Raise Medicaid age and income eligibility levels.
- Eliminate the Medicaid assets test for children.
- Use outreach to enroll eligible children in Medicaid.

In addition to the above, states and communities can utilize local resources to provide health coverage to children as either an alternative to Medicaid or when children are ineligible for Medicaid.

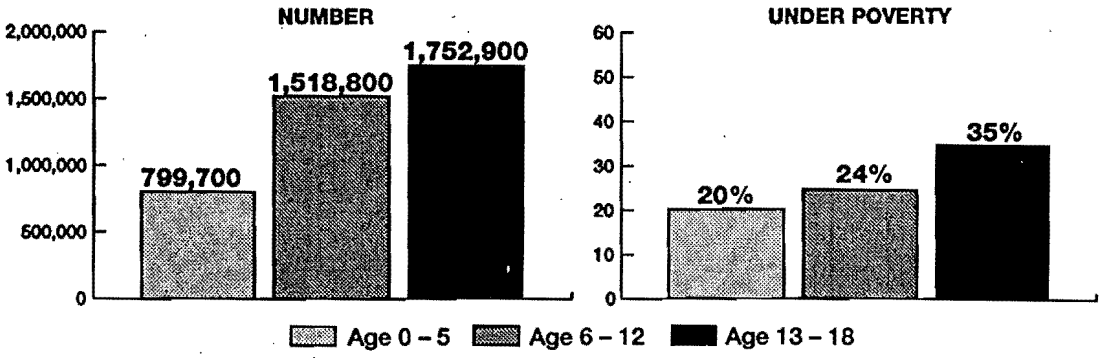
With over four million uninsured children living in the South, reducing the number of children who are without health coverage should be a major public policy priority for southern states. Providing health coverage for children addresses several public goals, including improving access to preventive and primary care and helping families to make a successful transition from welfare to work.

SOUTHERN STATES

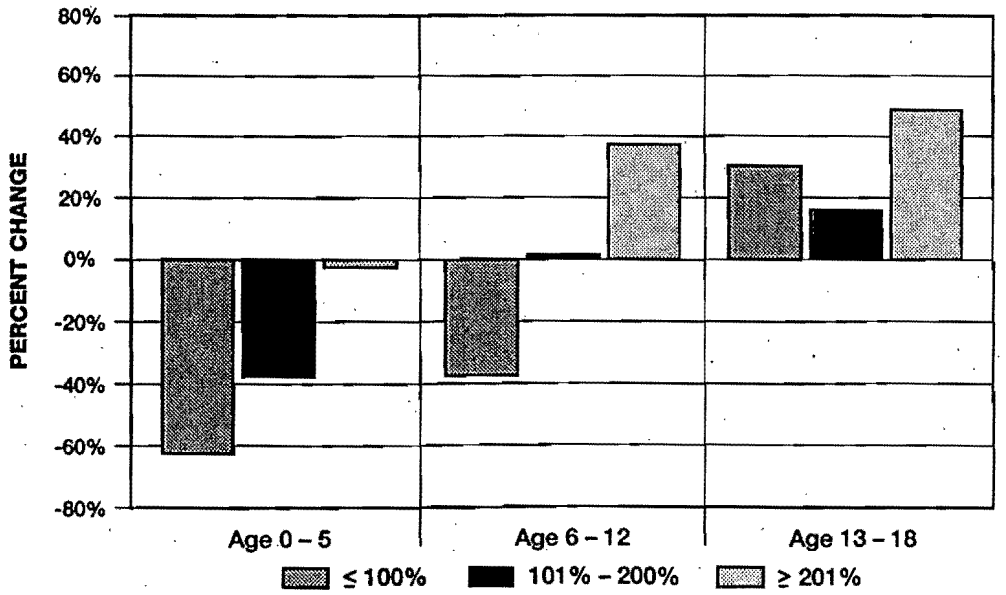


UNINSURED CHILDREN, 1993

4,071,400 TOTAL CHILDREN

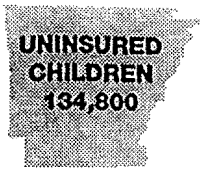


PERCENTAGE CHANGE IN UNINSURED CHILDREN BETWEEN 1989 AND 1993



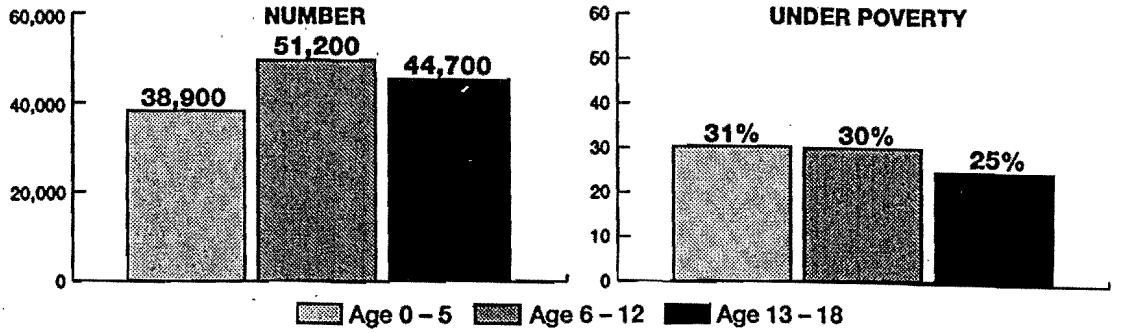
SOURCE: THE SOUTHERN INSTITUTE ON CHILDREN AND FAMILIES (1990 and 1994 CPS)

ARKANSAS



UNINSURED CHILDREN, 1993

134,800 TOTAL CHILDREN



PERCENTAGE CHANGE IN UNINSURED CHILDREN BETWEEN 1989 AND 1993

ARKANSAS MEDICAID ELIGIBILITY LEVELS

ANNUAL INCOME FAMILY OF THREE (1996)

Age	Income	Percent of Poverty
Birth to 1	$17,263	133%
Age 1-5	$17,263	133%
Age 6-12	$12,980	100%
Age 13-18	$ 2,448	18.9%

SOURCE: THE SOUTHERN INSTITUTE ON CHILDREN AND FAMILIES (1990 and 1994 CPS)

United States General Accounting Office

GAO

Report to the Ranking Minority Member, Subcommittee on Children and Families, Committee on Labor and Human Resources, U.S. Senate

January 1996

HEALTH INSURANCE FOR CHILDREN

State and Private Programs Create New Strategies to Insure Children

GAO/HEHS-96-35

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-259618

January 18, 1996

The Honorable Christopher J. Dodd
Ranking Minority Member
Subcommittee on Children and Families
Committee on Labor and Human Resources
United States Senate

Dear Senator Dodd:

Since 1987, the number of children covered by employment-based health insurance has decreased, and, by 1993, more than 9.3 million children lacked health insurance. Studies have shown that uninsured children are less likely than insured children to get needed health and preventive care. Lack of such care can adversely affect their health status throughout their lives.

In the mid-1980s, several states began using state and other nonfederal funds to develop health insurance programs for children who were caught in the uninsured gap between private insurance and Medicaid, the federal/state program that insures some low-income people. In addition to state efforts, Blue Cross/Blue Shield organizations throughout the United States developed privately funded programs to insure children. At the same time, the federal government and many states expanded eligibility for Medicaid, the primary source of insurance for poor children.[1]

The 104th Congress is considering legislation making the Medicaid program into a block grant, limiting the growth of program expenditures, and removing most guarantees of eligibility for coverage and requirements for states to cover services. Such restructuring could give states significantly more flexibility in how they provide insurance to children.

In light of these developments, you asked us to examine emerging state and private efforts to insure children who are not eligible for Medicaid and whose families are not able to purchase private coverage. Specifically, you asked us to provide information on (1) enrollment, costs, funding sources, and annual budgets of these state and private programs; (2) the strategies these programs have used to manage costs while providing children access to health care; and (3) program design elements that have facilitated program implementation.

[1]Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175, July 19, 1995).

To answer these questions, we visited six programs in five states: two privately funded programs—the Alabama Caring Program for Children and the Western Pennsylvania Caring Program for Children—and four state-funded programs—the Florida Healthy Kids Program, MinnesotaCare,[2] New York's Child Health Plus Program, and Pennsylvania's Children's Health Insurance Program.[3] We selected programs that had at least 2 years' operational experience at the time of our visit and that represented a variety of approaches in diverse geographic areas. (See app. II for more detail on specific programs.)

For each program, we reviewed relevant program documents and interviewed program officials, participating insurers or managed care organizations, and physicians. We also interviewed officials from the Department of Health and Human Services' Health Care Financing Administration (HFCA), which administers the Medicaid program, and representatives from children's advocate organizations in program states. We analyzed other information, including information collected by the National Governor's Association, on programs to insure children. We performed our work between November 1994 and October 1995 in accordance with generally accepted government auditing standards.

Results in Brief

In the mid-1980s, states and private organizations began developing health insurance programs to increase health care access for children. By 1995, 14 states and at least 24 private-sector organizations had such programs. The number of children enrolled in the six programs we visited ranged from more than 5,000 to more than 100,000. Unlike state Medicaid programs, which operate as open-ended entitlements funded in part by the federal government, these programs operated within fixed and often limited budgets and were funded by various nonfederal sources, such as dedicated state taxes and private donations. To better target their resources, the state- and privately funded programs restricted eligibility for subsidized services to low-income, uninsured, or underinsured children. Regardless, limited budgets compelled five of the six programs to cap enrollment at times and to place eligible children on waiting lists.

[2]MinnesotaCare began as a state-funded program and is classified as such in this report. However, the children participating in the program were transferred to Medicaid on July 1, 1995, as part of Minnesota's Medicaid 1115 waiver.

[3]We also visited Maine's Medicaid program, which now covers children of similar ages and family incomes as did the Maine Health Program, a state-funded program that is no longer in existence. However, this report focuses solely on programs that were state- or privately funded at the time of our visit.

To manage their costs, the programs used several strategies. Some limited services covered, but all covered basic preventive and outpatient services. Some of the programs that did not provide inpatient care relied on Medicaid to provide this service. Other cost-management strategies included patient cost-sharing through premiums and copayments, enrolling children in managed care, and using competitive bidding to select insurers.

The six programs were designed to attract both providers and families. Most operated, at least partially, through nonprofit or private insurers, which enabled the programs to use existing provider payment systems and physician networks and to offer near-market reimbursement rates—features that appealed to insurers and providers. For patients, the programs guaranteed access to a provider network, had simple enrollment procedures, and took specific steps to avoid the appearance of a welfare program. Moreover, initial surveys suggested that children in these programs increased their access to and appropriate use of health care.

Background

Health insurance helps children obtain health care. Children without health insurance are less likely to have routine doctor visits, seek care for injuries, and have a regular source of medical care. Their families are more likely to take them to a clinic or emergency room (ER) rather than a private physician or health maintenance organization (HMO).[4,5,6] Children without health insurance are also less likely to be appropriately immunized—an important step in preventing childhood illnesses.[7,8]

During the 1980s, employment-based health insurance—the most common source of health coverage for Americans—decreased. By 1993, more than 39 million Americans lacked any type of health insurance. Almost

[4]Barbara Bloom, Health Insurance and Medical Care: Health of Our Nation's Children, United States (Hyattsville, Md.: Advance Data from Vital and Health Statistics, National Center for Health Statistics, No. 188, 1990).

[5]David L. Wood and others, "Access to Medical Care for Children and Adolescents in the U.S.," Pediatrics, Vol. 86, No. 5 (1990), pp. 666-673.

[6]Mary D. Overpeck and Jonathan B. Kotch, "The Effect of U.S. Children's Access to Care on Medical Attention for Injuries," American Journal of Public Health, Vol. 85, No. 3 (1995), pp. 402-404.

[7]Charles N. Oberg, "Medically Uninsured Children in the United States: A Challenge to Public Policy," Pediatrics, Vol. 85, No. 5 (1990), pp. 824-833.

[8]David U. Himmelstein and Steffie Woolhandler, "Care Denied: U.S. Residents Who Are Unable to Obtain Needed Medical Services," American Journal of Public Health, Vol. 85, No. 3 (1995), pp. 341-344.

one-quarter of these people were children, despite the relative affordability of providing insurance for children.[9]

Uninsured children are generally children of lower-income workers. Lower-income workers are less likely than higher-income workers to have health insurance for their families because they are less likely to work for a firm that offers insurance for their families. Even if such insurance is offered, it may be too costly for lower-income workers to purchase.[10] In 1993, 61 percent of uninsured children were in families with at least one parent who worked full time for the entire year the child was uninsured. About 57 percent of uninsured children had family income at or below 150 percent of the federal poverty level.

Recognizing the need to provide insurance for children, the federal government and the states expanded children's eligibility for Medicaid, a jointly funded federal/state entitlement program. Beginning in 1986, the Congress passed a series of Medicaid-expansion laws that required states to provide coverage to certain children and pregnant women and gave states the option to expand eligibility further.[11] Many states opted to use this approach instead of funding their own programs, because expanding Medicaid allowed them to get matching federal funds. As of April 1995, 37 states and the District of Columbia had expanded coverage for infants or children beyond federal requirements. In addition to these expansions, between 1991 and August 1995, five states implemented Medicaid demonstration waivers, some of which included coverage expansions to some uninsured children. Between 1989 and 1993, Medicaid expanded from covering 14 percent of U.S. children (8.9 million) to 20 percent (13.7 million). Nevertheless, many uninsured children remain ineligible for Medicaid.

[9]Personal health care expenditures per capita for children were $737 in 1987 (the most recent national data available)—one-sixth those of the elderly. VHI-Lewin, a health care consulting firm, estimated that the United States could implement a Medicare-type system of coverage for children using existing public and private coverage plus an increase of $5.7 billion—an increase of 0.4 percent over current national health spending. See Robert G. Hughes, Tania L. Davis, and Richard C. Reynolds, "Assuring Children's Health As the Basis for Health Care Reform," Health Affairs, Vol. 14, No. 2 (1995), pp. 158-167.

[10]GAO/HEHS-95-175, July 19, 1995.

[11]The Omnibus Budget Reconciliation Acts of 1986 (P.L. 99-509), 1987 (P.L. 100-203), 1989 (P.L. 101-239), and 1990 (P.L. 101-508) and the Medicare Catastrophic Care Amendments of 1988 (P.L. 100-360).

State- and Privately Funded Programs Improved Children's Coverage

Beginning in 1985, states and private entities began to fund programs that provided insurance for children who were ineligible for or not enrolled in Medicaid and did not have private or comparable insurance coverage.[12] The programs we visited varied in several respects, but all were limited in how many children they could cover by the size of their budgets, which depended on their funding sources. Every state had substantially more uninsured children than children enrolled in one of these programs. Almost all of these programs have had to restrict enrollment and develop waiting lists of children who could not enroll because of insufficient funding. To target their funding, most programs restricted enrollment to low-income, uninsured children not enrolled in Medicaid.

Programs Varied in Several Respects, but All Provided Coverage Through Set Budgets

In 1995, 31 states had either a publicly or privately funded program that provided health insurance coverage for children.[13] (See app. I for a list of these states.) Fourteen states had publicly funded programs that provided insurance for children, which generally relied heavily on state funding. In 1994, these programs enrolled from 39 to 98,538 children and had budgets ranging from about $240,000 to about $71.5 million.

In addition to state-level efforts, the private sector developed voluntary insurance programs supported through philanthropic funding. The best known of these are the Caring Programs, sponsored by 24 Blue Cross/Blue Shield organizations in 22 states. The Caring Programs, which served more than 41,000 children in 1994, ranged in size from 400 to almost 6,000 enrolled children and had budgets from $100,000 to $4.3 million.

The four state- and two privately funded programs that we visited varied in enrollments and funding sources. They provided insurance coverage to between 5,532 and 104,248 children under set yearly budgets. Much of the state programs' funding came from state general revenues, cigarette or tobacco taxes, or health care provider taxes; counties; and foundations and other private-sector entities. The private programs each received funding from Blue Cross/Blue Shield and from private individuals and organizations.

[12]For other discussions of these programs, see Ian T. Hill, Lawrence Bartlett, and Molly B. Brostrom, "State Initiatives to Cover Uninsured Children," The Future of Children, The Center for the Future of Children, Vol. 3, No. 2 (Los Altos, Calif: 1993); Patricia Butler, Robert L. Mollica, and Trish Riley, Children's Health Plans, National Academy for State Health Policy (Portland, Maine: 1993); Christopher DeGraw, M. Jane Park, and Julie A. Hudman, "State Initiatives to Provide Medical Coverage for Uninsured Children," The Future of Children, The Center for the Future of Children, Vol. 5, No. 1 (Los Altos, Calif: 1995).

[13]Much of this information comes from Deborah F. Perry, "Innovative State Health Initiatives for Children," Stateline, National Governor's Association (Washington, D.C.: 1995).

The programs' costs, covered services, and premium subsidies also varied. Moreover, four of the programs operated statewide, but Florida Healthy Kids and the Western Pennsylvania Caring Program for Children operated only in certain counties. (See table 1.)

Table 1: Characteristics of the Six Programs

Program name, type, and implementation date	Enrollment, 7/95	Cost per child per month	Funding sources	Annual budget, 1994 (in millions)	Covered services	Premium, copayment, and deductible
Alabama Caring Program for Children (private, 1988)	5,922	$20.00	Private donations, Blue Cross/Blue Shield	$1.7	Outpatient only	No premium, some copayments, no deductibles
Western Pennsylvania Caring Program for Children (private, 1985)	5,532	70.60	Private donations, Blue Cross/Blue Shield	4.3	Outpatient; limited inpatient	No premium, some copayments, no deductibles
Pennsylvania's Children's Health Insurance Program (state, 1993)	49,634	62.60	State cigarette tax, premium payments, insurer donations	21	Outpatient; limited inpatient	Sliding scale premium, some copayments, no deductibles
New York's Child Health Plus Program (state, 1991)	104,248	54.71	State Bad Debt and Charity pool raised through hospital assessments and premium payments	55	Outpatient only	Sliding scale premium, some copayments, no deductibles
Florida Healthy Kids Program (state, 1992)	15,254	46.50[a]	State general revenue funds, several types of county funds, school board funds, premium payments	8.8	Outpatient and inpatient	Sliding scale premium, some copayments, no deductibles
MinnesotaCare (state, 1992)	44,689	53.00	State and federal Medicaid funds, premium payments	36.6[b]	Outpatient and inpatient	Sliding scale premium, no copayments, no deductibles

[a]For Volusia County.

[b]MinnesotaCare's budget included services for child and adult participants.

Unlike state Medicaid programs, which operate as open-ended federal/state entitlements, all the programs we reviewed operated within limited and fixed budgets. These budgets did not allow them to cover most of the uninsured children in their states. The private program budgets were limited by the amount that could be raised by corporate donors, such as Blue Cross/Blue Shield, and individual donors. The state-funded

programs had larger budgets, but they, too, were limited by the amount of funding states were willing to devote to insuring children.

All the states in which these programs operated had more uninsured children than children enrolled in the programs.[14]For example, New York's Child Health Plus Program represented a substantial investment for the state in children's health coverage—$55 million—and it had the largest enrollment: 104,248. But in 1993, New York State had almost half a million uninsured children. Other programs could only cover a small fraction of their uninsured. For example, Alabama had 156,000 uninsured children in 1993, and its Caring Program covered 5,922 in 1995—only about 3 percent. MinnesotaCare had the highest ratio of enrolled children in 1995 to uninsured children in 1993: 44,689 to 76,517, or 58 percent.

Lack of funding forced all the programs we visited (except Minnesota's) to restrict enrollment at times and to relegate children who applied for the program to waiting lists. According to child advocates and officials of these programs, restricting enrollment and developing waiting lists undermine program credibility. In addition, Florida has been unable to start its Healthy Kids Program in many interested counties because the program has lacked funding.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

DEC 9 1996

TO: Chris Jennings

FROM: Acting Assistant Secretary for Planning and Evaluation

SUBJECT: Follow-up Materials on Children

Attached is the information you requested following our November 27, meeting on children's reform: the GAO report, "Health Insurance for Children" and data on persons without access to a primary care provider and the role of community health centers in providing services to underserved persons.

I hope this information is helpful.

Jack C. Ebeler

Attachments

TAB I - IMPORTANCE OF SAFETY NET PROVIDERS AND THE ROLE OF HEALTH CENTERS

Health Centers are an essential part of the safety net, effectively serving (with the National Health Service Corps) an estimated 10 million persons per year, nearly half of whom are children.

Universe of Safety Net Providers

- In the broadest sense the safety net includes programs aimed at all levels of care for populations with special needs such as mothers and children, persons with AIDS, and those with mental health and substance abuse problems.

- Of particular concern are providers of preventive and primary care to uninsured and underserved populations.

- They include many rural health clinics, some public health departments and hospitals OPDs, privately supported free clinics and the programs supported by the Bureau of Primary Health Care.

The Role of Health Centers and the National Health Service Corps

What are the Programs?

- The programs described here include the Health Center programs of the Bureau of Primary Health Care. These programs, which comprise the Consolidated Health Services Cluster, include Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Care for Residents of Public Housing.

- In addition, integral to the safety net are the resources and providers offered through the National Health Service Corps (NHSC).

Who is Targeted?

- Safety net providers target the 43 million persons without access to a primary care provider -- 19 million of them children.

  - Among the 43 million, there are persistent disparities in health status that affect low-income and racial and ethnic minorities in particular.

  - These vulnerable populations have a myriad of health, mental health, and social service needs. They include persons with HIV infection, substance abusers, persons in need of mental health services, victims of domestic

violence, and the homeless.

- Of the 3,200 counties in the United States, 2091 are identified as having primary care access problems.

- In 1995, through the integrated Health Center Programs and National Health Service Corps, 10 million individuals received care through Health Centers and non-Health Center based NHSC physicians, in approximately 3000 sites. (See Attachment I-1.)

- Of the 2091 counties with access problems, 959 are now fully served or partially served due to Federal support of Health Centers, leaving 1132 underserved communities with no Federal support (see Attachment I-1).

- Health Centers and the National Health Service Corps are in many of the most difficult and most needy areas in the country, filling the gap between what the public and private sectors can do and what is needed.

- They provide first line care and entry into the health care system, making the goal of improving the public's health attainable. They offer the enabling services and case management that addresses all aspects of health and keep people from using more expensive curative care.

- Health Centers alone provide high quality cost effective accessible and affordable care to over 8 million underserved and uninsured persons in 2200 delivery sites across the country, using approximately 5500 providers (see Attachment I-2. There has been an increase in of approximately 2 million users in the last five years (see Attachment I-3).

Who is Served?

- Health Centers focus on the needs of children:

  - Approximately 3.5 million or 44 percent of the individuals receiving services at Health Centers are children from newborn infants to 19 years of age (see Attachment I-4).

  - Another 30 percent of Health Center users are women of child bearing age.

  - Health Centers were responsible for the delivery of 400,000 babies last year -- 1 of every 5 low income babies born in America.

  - Health centers provide a variety of preventive services, including immunizations, well-child care, and

nutrition, as well as primary care services focused on the needs of children.

- In addition, Health Centers link with other health and social service providers, including WIC, schools, and social service agencies, to assure that the full range of services are available and accessible to children and their families.

- Approximately 250 Health Centers have developed school-based or school-linked service programs to improve the health and school performance of at-risk children.

- Large proportions of poor people are served by health centers: 66 percent of health center patients are below the poverty level, 20 percent are between 100 and 200 percent of poverty, and 14 percent are above 200 percent (See Attachment I-5).

- Sixty-one percent of Health Center patients are minorities including 28 percent Black, 27 percent Hispanic, and 6 percent Asian/other (see Attachment I-6).

- Within the Health Center Program the migrant health program provides preventive and primary health care services to migrant and seasonal farmworkers and their families. In FY 1995 approximately 600,000 migrant and seasonal farmworkers were served through over 120 organizations and 390 sites.

- Also included in the Health Center program is the Health Care for the Homeless program which provides homeless individuals with access to preventive and primary care services, including immunizations and substance abuse services. In FY 1995 services were provided by 123 grantees to approximately 450,000 homeless individuals.

- Under Title IIIB of the Ryan White CARE Act, funds are provided to Health Centers to provide comprehensive primary care services to populations with or at risk for HIV disease. Under this authority Health Centers see approximately 100,000 patients per year.

Leveraging Other Sources of Support

- Collaborating with other public and private partners to obtain needed capital and infrastructure resources is increasingly essential for Health Centers. Grant dollars are successfully used by Health Centers to successfully leverage such funds. **Specifically, each grant dollar helps to leverage two additional dollars for Health Centers.**

- Health Centers depend on Medicaid revenue along with other Federal, State, and local support and private foundations to treat those with limited resources and no insurance - to serve as the safety net for these individuals. Approximately 30 percent of Health Center revenues are from the Federal grant, and 32 percent is from Medicaid. (See Attachment I-7 for CHC revenues by source.)

- We know that Health Centers function as economic engines for underserved communities. They are a catalyst for economic development - they empower their communities, generate jobs, assure the presence of health professionals and facilities, utilize local suppliers, and have an economic mutiplier effect on the community's economy. In FY 1995, the Health Center investment generated nearly $3 billion in revenues for impoverished, underserved communities across the country.

Proven Effectiveness

- There is substantial evidence that preventive and primary care delivered in Health Centers reduces hospitalization, improves health outcomes, saves total annual Medicaid costs for the beneficiaries who are Health Center patients, and helps prevent much more expensive chronic disease and disability. Specifically, a study of AFDC recipients in California and New York who use or do not use Health Centers indicated that:

  - Regular use of a Health Center results in a 30 percent savings to Medicaid (with the exclusion of Medicaid). When maternity related services are included, which tend to disproportionately increase costs for Health Centers, savings attributed to Health Centers range from 14 percent in California to 24 percent in New York.

  - Health outcomes are improved for both diabetics and asthmatics who use Health Centers compared to non-users of Health Centers. Specifically, diabetics who are regular users of Health Centers experience 62 percent fewer hospital days than non-users, and asthmatics experience 44 percent fewer hospital days.

- A recent study by the Arizona State Department of Health showed that in 1995 children enrolled in Health Centers in Arizona have utilization rates that are higher than those for any other provider in the State (public or private).

- There is also evidence that health centers are cost effective providers in managed care networks:

- In Maryland, Medicaid payments in a managed care setting were analyzed for four types of settings (hospital outpatient clinic, Community Health Center, physicians's office, and emergency room). After adjustment for severity of illness, patients of Health Centers and office-based physicians had lower total Medicaid costs, despite slightly higher primary care rates paid to health centers.

- Another study found that Health Centers had per member per month costs that were less than other primary care providers in their networks.

- Studies substantiate the fact that Health Centers provide high quality health care. In a recent study comparing Health Centers with other primary care providers in Maryland, a review of over 2,000 records found that Health Centers far outscored other systems of care on 21 different quality measures. In an examination of quality scores rating the treatment of well baby care, asthma, diabetes, and hypertension, Health Centers scored twice as high as the score of their nearest competitors.

- According to a 1993-1994 nation-wide study by the Commonwealth Fund, 96 percent of Health Center patients were very satisfied with their care and treatment.

Accountability

- Health Centers report annually on users, encounters, services provided, costs and revenues, allowing calculation of efficiency, productivity and utilization.

- A continuous quality improvement approach is used to ensure that the needs of the medically underserved are appropriately addressed by Health Centers. A critical component of that approach is the Primary Care Effectiveness Review (PCER) - an on-site review protocol for all Health Centers.

- The PCER reviews elements of the clinical and administrative systems of a health center which are either required by law, regulation, or program expectations, or recommended as good practice. The establishment of a technical assistance plan to aid in strengthening the Health Center is a primary objective of the PCER.

- A new quality initiative features an effort to secure formal accreditation using industry standards.

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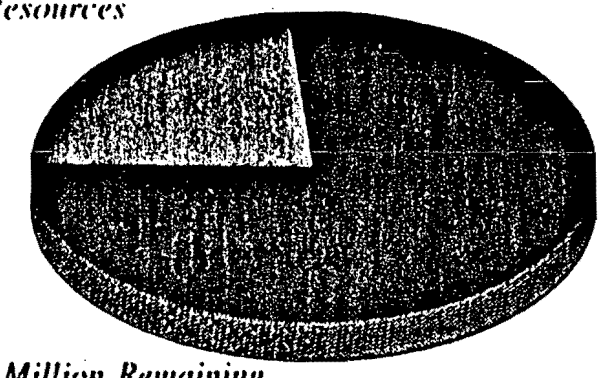
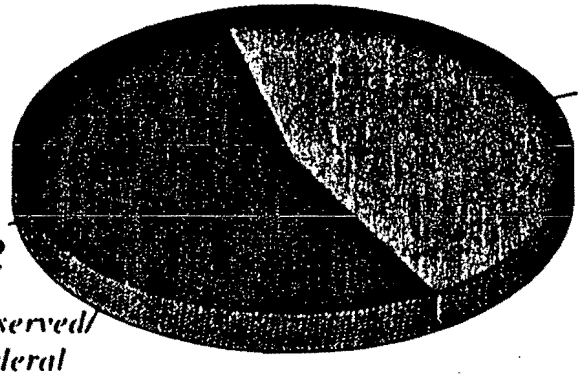
Proportion of Underserved Persons and Counties Served by BPHC Resources

10 Million People Served by BPHC Resources



33 Million Remaining Underserved People

Partially and Fully Served Through BPHC Support



Underserved/ No Federal Support

Of the 3,200 U.S. Counties, 2,091 Have Access Problems

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Health Center Program Statistics*

FY 1995

	Urban		Rural		Total
Grantee Organizations	333	(46%)	389	(54%)	722
Grant Awards	405	(44%)	508	(56%)	913
People Served	4,313,000	(53%)	3,806,000	(47%)	8,119,000
Service Delivery Sites	1,032	(47%)	1,172	(53%)	2,204
Health Center Grant Funds (millions)	$412.0	(54%)	$344.5	(46%)	$756.5
Other Funds (millions)	$912.4	(52%)	$841.1	(48%)	$1753.5
Total Funds (millions)	$1324.4	(53%)	$1185.6	(47%)	$2510.0

* Includes Community/Migrant Health Centers, Health Care for the Homeless, Health Services for Residents of Public Housing, and Healthy Schools, Healthy Communities Programs

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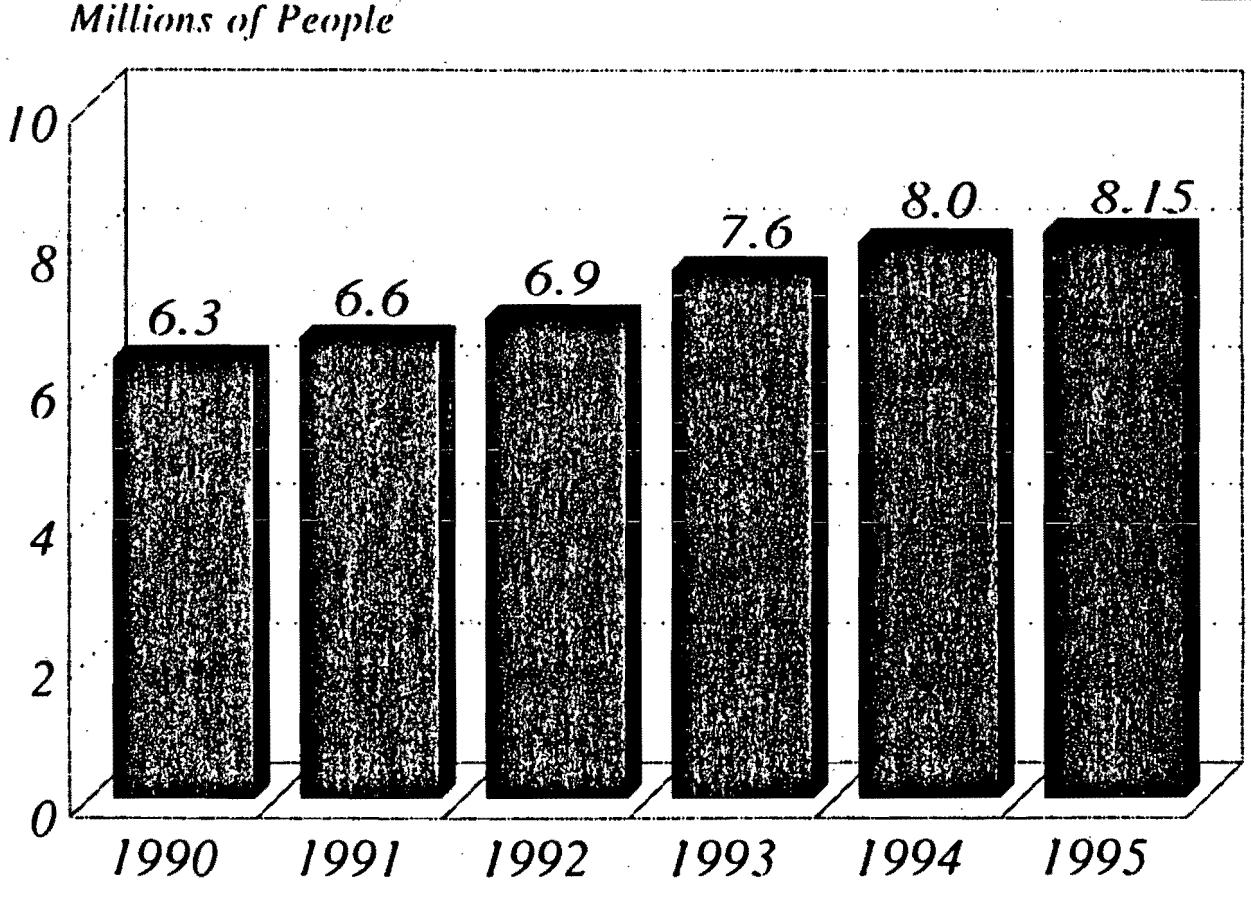
Health Centers: Numbers of People Served



BUREAU OF PRIMARY HEALTH CARE

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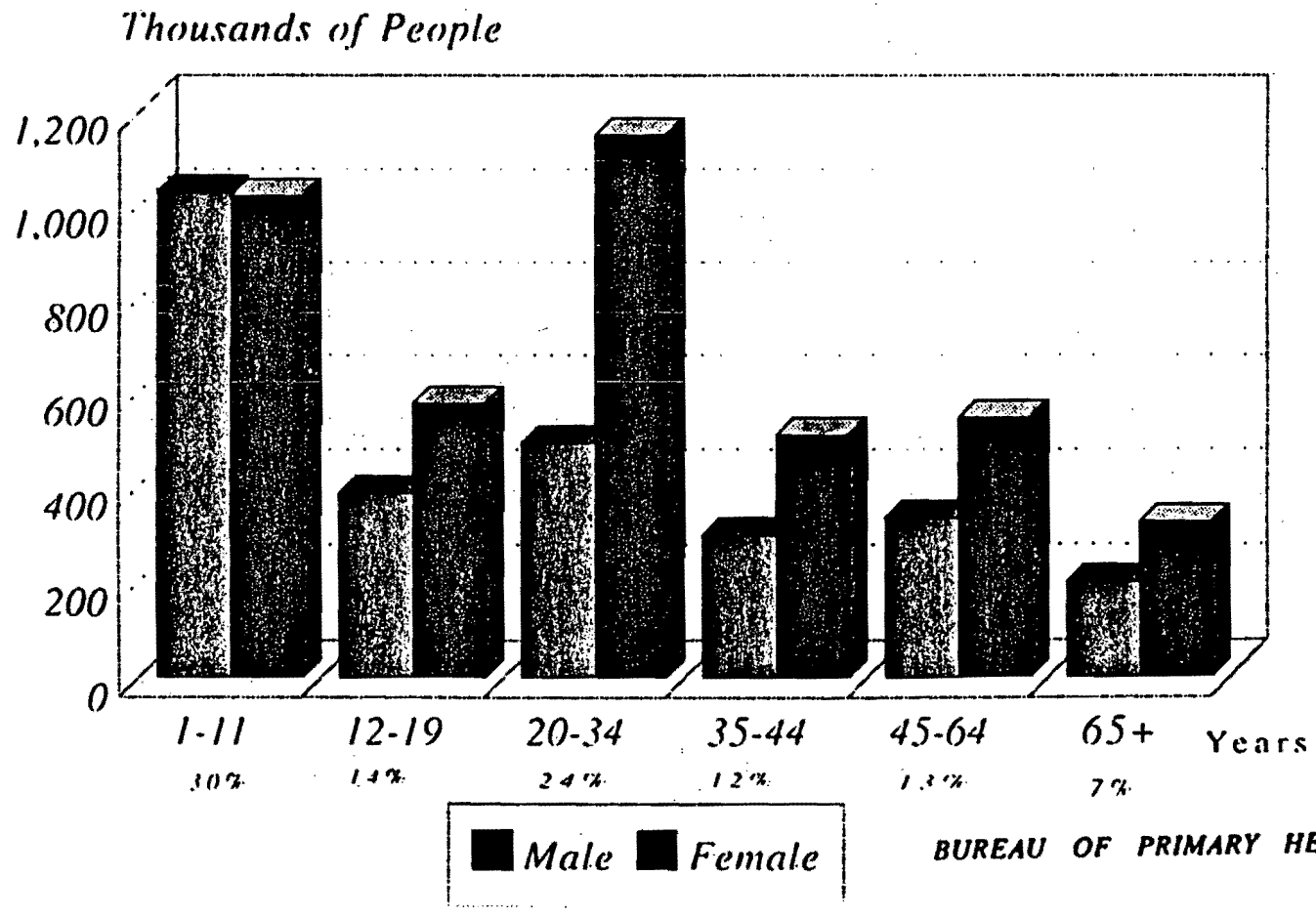
Health Centers: People Served
By Age/Sex



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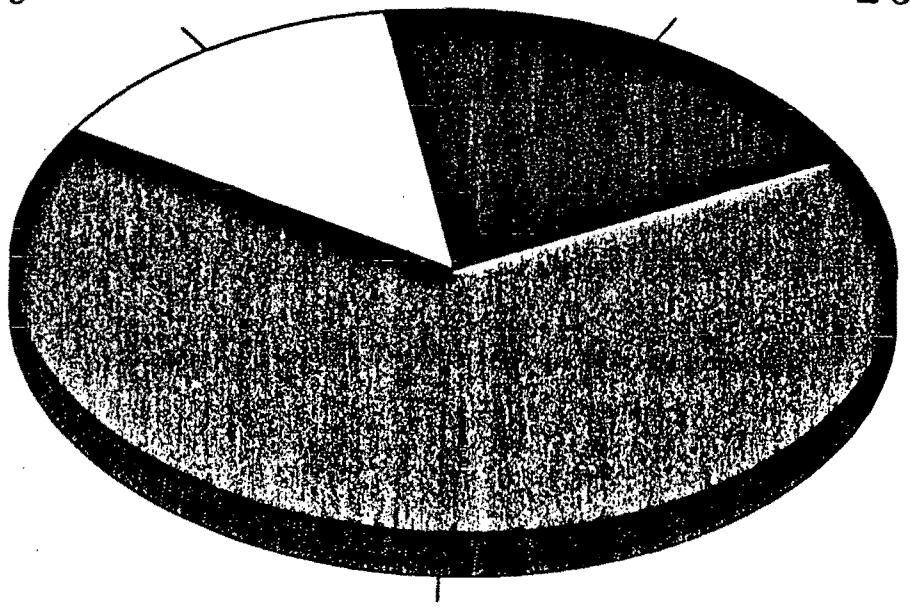
Health Centers: People Served By Economic Status



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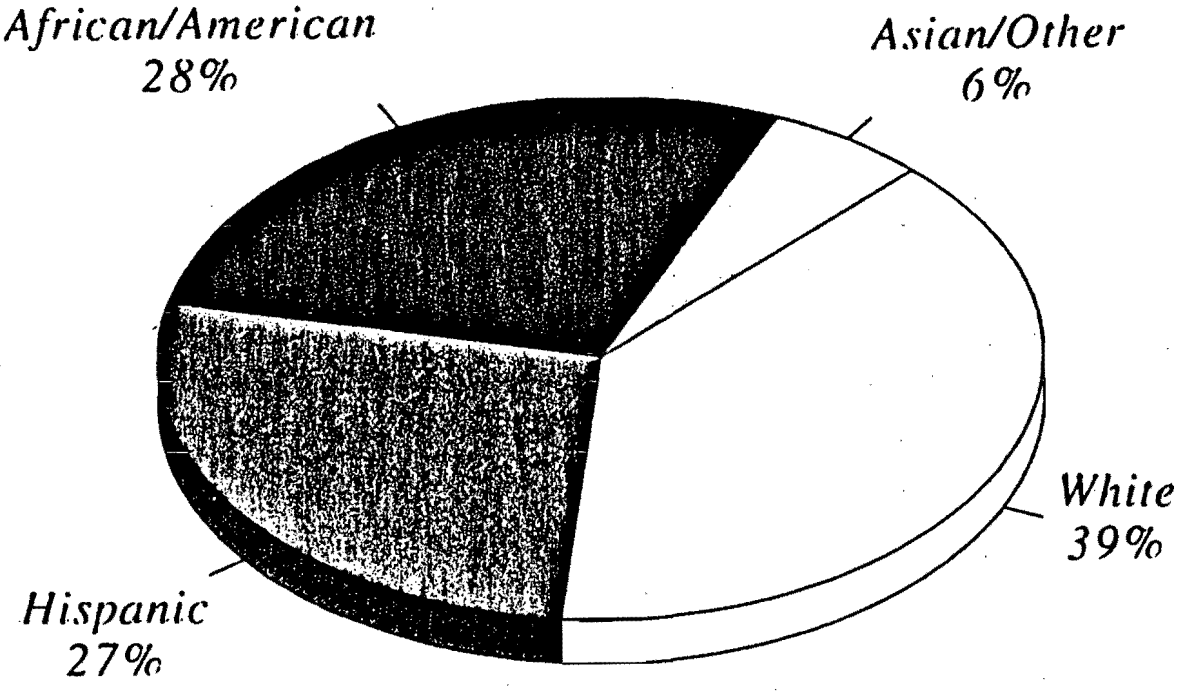
Health Center Patients By Ethnicity



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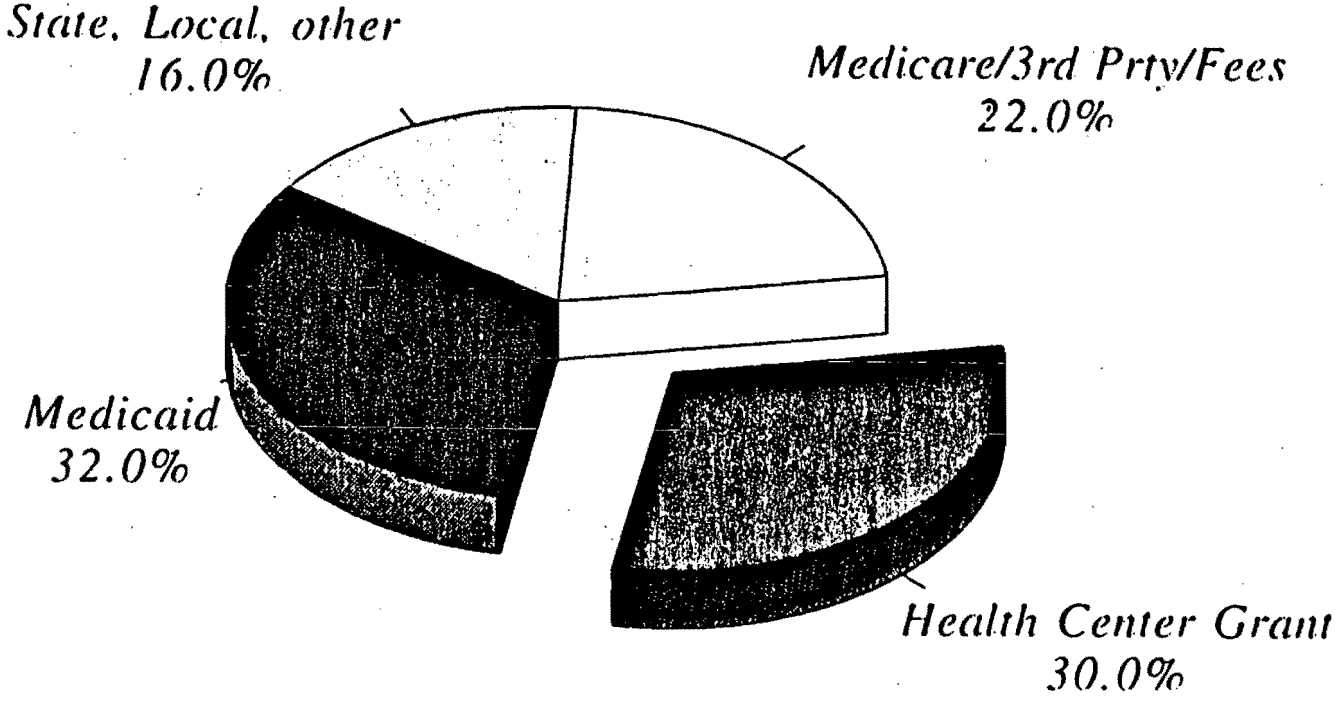
Health Centers: Revenue by Source FY 1995



TAB III - THE SAFETY NET AND THE UNINSURED

Cost reimbursement under Medicaid, as well as Federal and state grants and support from local tax dollars have allowed Health Centers to care provided to the uninsured. The growing number of uninsured has the potential to cause a serious financial crisis for many Health Centers, particularly if PHS grant funds do not grow and Medicaid funds were to decrease.

The Environment: Increases in the Number of Uninsured

Current

- While there is increased competition due to managed care for the AFDC Medicaid population, the same cannot be said for the uninsured population. In fact, the number of uninsured persons has been growing steadily, and is projected to expand at an ever greater rate. Nationally, the uninsured increased by 15 percent between 1990 and 1994, from 34.7 million to 39.7 million. Of the total uninsured, 7.1 million, or 18 percent are children under 19 years of age.

- Of those who were insured in FY 1994 but became uninsured in FY 1995 -- 31.5 percent were children under 18 years of age.

- Shifts in the labor market are causing a continuing decrease in the proportion of people insured through employers - a decline of about 1 percent per year.

  - States with the largest percentage of their populations with employer-based insurance include Wisconsin (71.7 percent), Delaware (68.2 percent), Maryland (66.6 percent), New Hampshire (66.0 percent) and Hawaii (66.0 percent).

  - States with the smallest percentage include Mississippi (42.9 percent), New Mexico (42.8 percent), Louisiana (44.6 percent) and California (47.9 percent).

- In order to contain and manage costs, many States have reduced the amount, duration and scope of benefits available under State-funded welfare and health programs. Although the Medicaid managed care programs have enabled some States to expand certain categories of Medicaid eligibility, other State activities (including State welfare reforms) have resulted in an increase in the number of uninsured.

Projected

There are several estimates of the number of uninsured Americans over the next five years:

- Analysis by Shactman, Thorpe and Altman indicates that if Medicaid enrollment is frozen and employer based insurance continues to erode at the same rate as it did from 1989-1993, the number of uninsured would increase from 40 to 67 million by 2002.

- Alternatively, with no change in Medicaid and a more conservative estimate of private insurance erosion, 45.9 million will be uninsured by 2002.

- A third scenario is suggested by the Congressional Medicaid reform proposal - the Medicaid Restructuring Act. Under this proposal the number of uninsured would increase to 52.7 by 2002.

- A fourth scenario relates to the Administration's Medicaid reform proposal. Even here, some decrease in coverage is likely to continue, with the number of uninsured estimated at 47 million by 2002.

Issues for Safety Net Providers

Effect on the Safety Net

- Lack of insurance coverage disproportionately affects the poor.

  - The rate of uninsurance is twice as high among low-income persons. In 1994, 15 percent of the total population was uninsured, while almost 30 percent of poor persons (under 200 percent of poverty) were uninsured.

  - In 1994 approximately 15 million, or 38 percent of the total uninsured were women and children under 200 percent of poverty.

- Among the poor, workers are even less likely to have coverage than nonworkers:

  - Specifically, among the poor, 44.9 percent who worked during the year lacked insurance coverage, compared to 26.4 percent of persons who did not work.

  - In addition, many low-paid individuals are only covered by major medical policies, which do not include preventive and primary care services.

- The Kennedy-Kassenbaum bill that has been proposed is limited and incremental - providing insurance protection only to those who lose their employer-based insurance coverage. However, this provides no help to the poor with

no long-term employment. The Kennedy-Kassenbaum bill is assumed in cost estimates to cover only those above 250 percent of poverty, and therefore will not help those who are traditionally covered by the safety net.

Effect on Health Centers

- There is a clear relationship between increases in the uninsured generally and in Health Centers. A State-level analysis shows that between 1990 and 1994, health centers in 28 States had an increase in their uninsurance rates of over 30 percent. Only 8 of these 28 States had an overall State increase in the uninsurance rate of over 30 percent. This demonstrates that for many States, the increase in the uninsured affects Health Centers more than other providers in the State.

  - Some States (i.e., Michigan and Ohio) have discontinued their general assistance programs resulting in 500,000 individuals formerly eligible for medical coverage becoming uninsured. Many of these individuals continue to receive services from Health Centers, but Health Centers no longer get reimbursed for the services.

  - Also, Health Centers in certain States (e.g., Illinois) that have experienced large increases in the number of uninsured have had to eliminate optional services such as dental.

  - In New Jersey hospital dumping continues to be a problem. That is, hospitals send uninsured to Health Centers instead of treating them at the hospital.

- The advent of managed care coupled with expansions in Medicaid eligibility has increased the number of Medicaid users in Health Centers. However at the same time there has been an increase in the number of uninsured seen by centers. (See Attachment III-1.) **Between 1990 and 1994, the number of uninsured nationally increased by 15 percent, while the number of uninsured persons in Health Centers increased 29 percent.** (See Attachment III-2.)

- Four million Health Center patients (or approximately 40 percent) are currently uninsured for health care. As the number of uninsured individuals continues to increase, the Consolidated Health Center and the NHSC will become even more critical to the nation as the provider of cost effective, high quality care to this underserved population.

- For those clients served in the Health Care for the Homeless program in the years 1990 - 1994, about 70 percent did not have any form of private or public insurance.

- Health Centers in communities with large groups of noncitizens, who are far less likely to have insurance coverage, face increased demands. The Immigration and Naturalization Service estimates that more than 3.2 million "unauthorized individuals" live in the United States, and they are concentrated most heavily in California, Texas, ad Florida.

- As the number of uninsured in Health Centers has gone up, patient collections from the uninsured have come down. Specifically, in 1990, Health Centers collected $61 per uninsured patient. In 1995 they collected only $55 per uninsured patient. When these actual dollars are adjusted for inflation, the collection of 1995 dollars have a value of approximately $41. This suggests that the ability of the uninsured to pay for their own care is declining, putting an increased burden on Health Centers. Attachment III-3 shows the trend in Health Center Revenues in the last five years - i.e., increases in Medicaid relative to patient fees (collections from the uninsured).

- As a result of the growing numbers of uninsured in Health Centers, cost shifting ability will be increasingly limited. The revenues Health Centers get are inter-related. That is, when Medicaid covers reasonable costs, then PHS grant money can go entirely for the uninsured and for enabling services (such as translation, transportation, outreach, parenting classes, infant feeding programs and day care). But when Medicaid or other providers cover less than cost, then grant dollars subsidize Medicaid and fewer uninsured persons are served.

- In a study of fifteen communities conducted by the Robert Wood Johnson Foundation, Health Centers that participated in capitated managed care reported that they were able to maintain the level of care they provided to the uninsured. Generally, however, this was possible only when these providers obtained additional funds from sources other than Medicaid, including more revenues from private-pay patients or increased funds from State or local governments.

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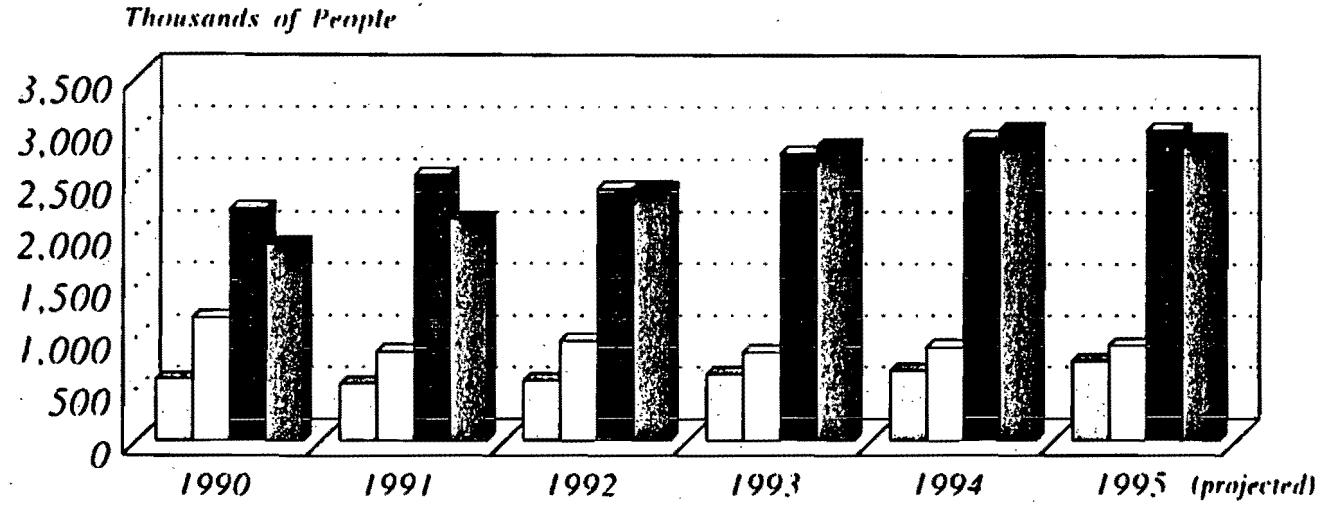
Community and Migrant Health Centers

Insurance Status of Patients



	1990	1991	1992	1993	1994	1995 (projected)
Medicare*	590	550	580	640	675	765
Other*	1,180	855	900	850	900	915
Uninsured*	2,240	2,560	2,430	2,770	2,925	3,000
Medicaid*	1,890	2,135	2,430	2,840	3,000	2,900
Total*	5,900	6,100	6,400	7,100	7,500	7,580

*Thousands of People

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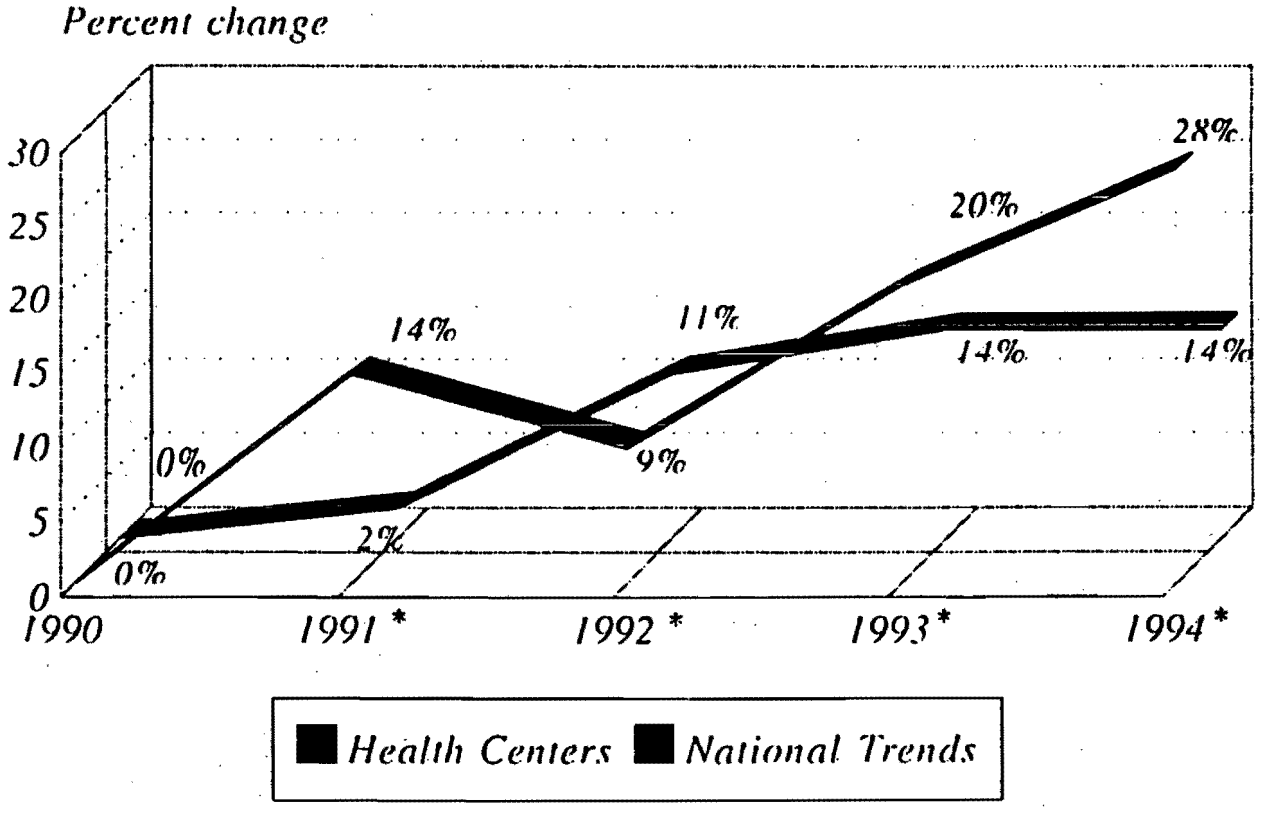
Uninsured

Percent Change: 1990 - 1994

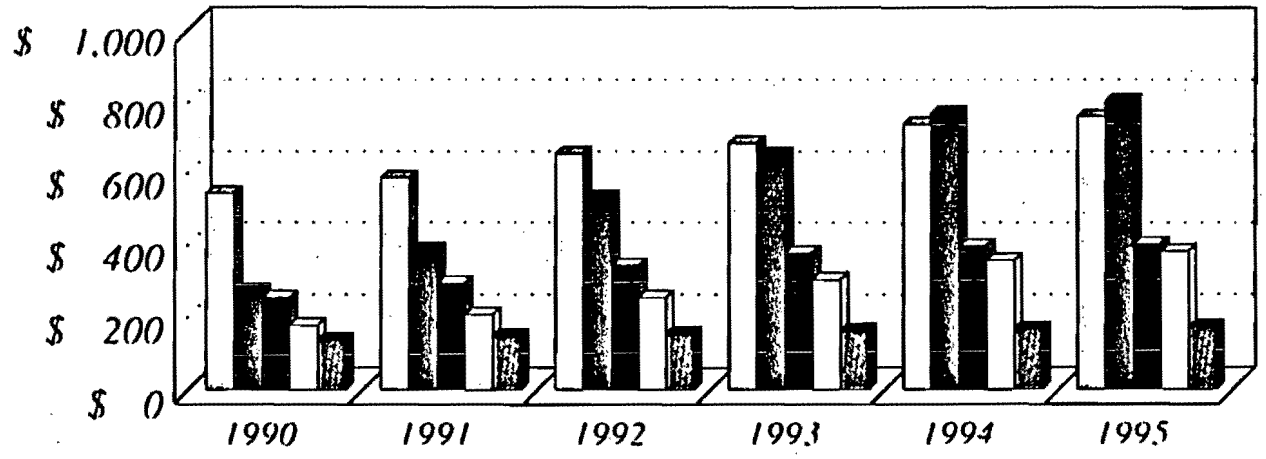


*In comparison to 1990

BUREAU OF PRIMARY HEALTH CARE

Health Center Revenues
1990 - 1995

Dollars in Thousands



	1990	1991	1992	1993	1994	1995
HC Grants	$ 542.2	$ 584.3	$ 651.7	$ 682.1	$ 734.5	$ 756.5
Medicaid	$ 270	$ 385	$ 530	$ 650	$ 765	$ 800
Other Grnts	$ 250	$ 290	$ 340	$ 375	$ 395	$ 400
Other Coll.	$ 175	$ 205	$ 250	$ 300	$ 355	$ 380
Patient Fees	$ 135	$ 145	$ 150	$ 160	$ 165	$ 170
Total	$ 1,372.2	$ 1,609.3	$ 1,921.7	$ 2,167.1	$ 2,414.5	$ 2,506.5

HC Grants Medicaid Other Grnts Other Coll. Patient Fees

Without Impact of Welfare Reform:

Outputs -- Number of People Served

	FY 1996 Enacted	FY 1997 Pres. Budget	FY 1998 w/o Request	FY 1998 w/ Request
Medicaid				
- Managed Care	1,100,000	1,500,000	1,950,000	2,000,000
- Non Managed Care	2,000,000	1,600,000	1,100,000	1,150,000
Medicare	800,000	800,000	800,000	825,000
Uninsured	3,300,000	3,350,000	3,350,000	3,600,000
Other 3rd Party	900,000	850,000	850,000	875,000
Total Patients	8,100,000	8,100,000	8,050,000	8,450,000

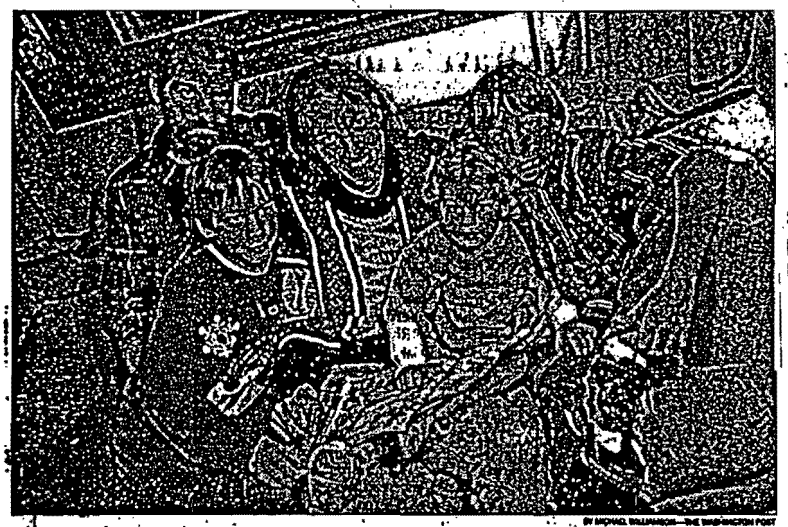
Sources of Funding for Consolidated Health Centers
(In millions of Dollars)

	FY 1996 Enacted	FY 1997 Pres. Budget	FY 1998 w/o Request	FY 1998 w/ Request
Health Centers	$755.1	$757.1	$757.1	$837.1
Other Sources:				
Medicare	175.0	175.0	175.0	180.0
Medicaid *	820.0	820.0	800.0	813.0
Other 3rd Party	210.0	210.0	210.0	216.0
Patient Fees	175.0	185.0	185.0	210.0
State/Local/other	380.0	370.0	370.0	370.0
Subtotal, other	1,760.0	1,760.0	1,740.0	1,789.0
TOTAL	$2,515.1	$2,517.1	$2,497.1	$2,626.1

* In FY 1998, health centers will experience a reduction of $20 million in Medicaid revenues due to the transition of their Medicaid health center patients into managed care arrangements. However, with the $60 million proposed increase in service capacity, health centers will be able to serve an additional 350,000 patients, including approximately 50,000 new Medicaid patients. These new Medicaid patients will increase Medicaid revenues by approximately $13 million. The FY 1998 Medicaid projection of $813 million reflects both of these activities.

The above estimates do not consider the impact of the recently enacted welfare reform legislation. With the implementation of this legislation, it is anticipated that there would be a further loss of Medicaid revenues as well as a corresponding loss of patients served.

Democrats to Seek Expansion of Health Coverage for Children



Rod and Elaine Gaither with their children, from left, Joshua, 8, Annmarie, 2, and Rod, 10, in their Clarksville, Md., home. The Gaithers, who don't get health insurance coverage from their employers, say they can't afford to buy it.

By Spencer Rich
Washington Post Staff Writer

Looking for a more measured way to expand health care to those without it, congressional Democrats have decided to make medical coverage for uninsured children one of their top legislative priorities in the new Congress.

The proposals, being drafted by Senate Minority Leader Thomas A. Daschle (S.D.), House Minority Leader Richard A. Gephardt (Mo.) and other key Democrats, essentially could create a new class of federal social support. Some of the initiatives would offer a tax credit to help a family buy their children a health care policy, while others would offer a direct federal subsidy of some type.

Although the details are still being worked out, most of the measures focus on children in families that fall between the cracks: They're not poor enough to qualify for Medicaid but not affluent enough to pay for private insurance entirely out of their own pocket.

By focusing on children's health, the Democrats believe they have seized on an issue that is politically more palatable than the ambitious health care reform plan that collapsed in Clinton's first term. And by taking a more tempered approach, they hope to build on the successes achieved last year in the bipartisan effort to pass the Kassebaum-Kennedy bill that strengthened coverage for the unemployed.

"We will be attempting to improve access to health care, especially for children, in the 105th Congress," said Daschle after his reelection to the leadership post last week. He called this one of his top priorities.

Within the administration, Secretary of Health and Human Services Donna E. Shalala has made it known she strongly favors some action to expand coverage of children, and on several occasions President Clinton himself has indicated an interest in expanding coverage of children as long as it were within the context of a balanced budget.

About 10 million American children are without health insurance, according to estimates by the General Accounting Office. Because nearly 3 million of those are eligible for Medicaid, part of the Democrats' effort will be aimed at spurring these parents to take advantage of this already existing federal program.

But many more ambitious plans are in the works. Among the most detailed thus far is a proposal being drafted by Sens. Edward M. Kennedy (D-Mass.) and John F. Kerry (D-Mass.) that would provide grants to the states to help families afford health insurance for their children.

The plan would target families in that no man's land—that is, those who are not poor enough to be eligible for Medicaid but who don't get insurance on the job and can't afford to pay for it themselves. Under the Kennedy-Kerry plan, families would be paid a federal subsidy that would gradually decrease as their income went up.

The plan would cost between $20 billion to $24 billion over five years and would allow subsidies for a majority of uncovered children, according to one estimate. As conceived, it would be paid for through an additional 75-cent-a-pack cigarette tax.

"Every American child deserves a healthy start in life, and every family should have the opportunity to help that child get that start," Kennedy said.

Few would disagree, but Republicans, whose support would be crucial for any of these efforts to succeed, say they want to see the actual proposals before signaling their support.

"Senator Roth is concerned that health care be available to children," said an aide to Senate Finance Committee Chairman William V. Roth Jr. (R-Del.). "He would like to see the details of the proposals before commenting."

Already, though, a coalition of children's groups is gathering behind the "Kiddycare" concept, the label being attached to many of these proposals. And, as their Democratic backers realize, the concept has strong political appeal for the millions of families without coverage, people such as Rod and Elaine Gaither of Clarksville, Md.

The Gaithers earn about $40,000 a year, but they don't get health insurance on the job and say they can't afford the $3,600 to $4,500 that buying insurance would cost them.

The size of the family paycheck sounds pretty respectable, admits Elaine Gaither. "But it shrinks very substantially after taxes, house costs, cars to go to work, food and clothing for three really fast-growing children and other day-to-day expenses," she said. "I get very creative with how far a pound of meat can go."

Once they had insurance based on a job she held, but when she left the job a few years ago, they lost it. Since then they have been searching for a modest-cost insurance policy, or at least something that would protect their children. But so far they haven't found a good policy that is also affordable.

"I worry every day," said the Howard County woman. "I've got three kids, one with asthma, which really frightens me. Once in a while he gets a bad attack. It's a scary proposition."

Groups lining up in support of these initiatives say that children who aren't covered often end up never getting treatment when they become ill.

"What happens to uninsured children? Usually their financially strapped families tend to delay or forgo needed pediatric medical care because of the out-of-pocket expense," said David Tayloe, a physician speaking for the American Academy of Pediatrics in a recent plea for action on the Kiddycare concept. They tend to get less preventive care, fewer immunizations and contract more diseases, he said.

Stan Dorn of the Children's Defense Fund, another backer of Kiddycare, said the 1987 National Medical Expenditure Survey, the most recent, found that one-third of uninsured children with two or more ear infections and a majority of uninsured children with asthma "never saw a physician."

Despite the emotional appeal of broadening coverage for children, the proposals could bog down in disputes over how much to spend, where to get the money, whether the plans would affect existing workplace insurance coverage of children and whether the initiatives would create a new federal entitlement.

The most frequently cited concern is the potential for something called "substitution"—the notion that employers may stop offering coverage for children of their workers if they know the government will provide it.

"My only concern is that whatever they do, it should not weaken the existing employer system," said Bill Gradison, president of the Health Insurance Association of America. "They might say, 'We don't have to do it. The government will do it.' "

Gradison and others are also concerned that if insurers are required to take any subsidized child who applies to them, part of the cost of covering these children may be pushed onto existing policyholders.

On the political front, obstacles also loom.

Congressional Republican aides note that conservatives have generally shown a resistance to initiatives that involve mass federal subsidies.

"Republicans generally prefer tax credits that would allow the market system to work," said one aide.

While some conservative policy groups such as the Heritage Foundation agreed that the problem of children's health is one worth addressing, they were quick to challenge the Kennedy plan or anything like it that establishes what they view as a new federal entitlement.

"We hope to draft a plan or policy concepts that conservatives could accept," said Heritage's Carrie Gavora. That plan, she assured, would bear little resemblance to the Kennedy proposal.