Child Health Facts:
National and State Profiles of Coverage

January 1998

Alina Salganicoff
Patricia Seliger Keenan
The Kaiser Commission on the Future of Medicaid

David Liska
The Urban Institute

A Report of the Kaiser Commission on the Future of Medicaid

Support for this report was provided by The Henry J. Kaiser Family Foundation and the Kaiser Commission on the Future of Medicaid. The Henry J. Kaiser Family Foundation is an indepenpendent, non-profit philanthropy and is not associated with the Kaiser Permanente Medical Care Program or Kaiser Industries.

Foreword

Nearly 10 million children in the United States lack health insurance coverage and over two thirds of them are low-income. The State Children's Health Insurance Program (CHIP), created as part of The Balanced Budget Act of 1997, provides an important new opportunity to extend health care coverage to low-income uninsured children. This new program allocates $20.3 billion to states in federal matching funds over five years and gives state considerable flexibility in program design to extend coverage. States can either build on their Medicaid program or create a separate program to reach uninsured children.

The Kaiser Commission on the Future of Medicaid was established to examine the role of the Medicaid program and access and health care financing for the nation's low-income population. As part of the Kaiser Commission's ongoing analytic efforts to provide timely information about the Medicaid program and coverage of the low-income population, we are pleased to release this overview of child health coverage and state-level databook on uninsured children and Medicaid's role. This report provides an overview of the new State Children's Health Insurance Program, charts on insurance coverage of children, and detailed state-level tables on health care coverage of children and Medicaid spending on and enrollment of children.

This databook provides baseline data on how many children are uninsured today and on the extent of Medicaid coverage. It provides a starting point to monitor and assess state efforts to reach and insure more children.

We wish to express our appreciation to all those who have contributed to this report. Special thanks go to Alina Salganicoff and Patricia Seliger Keenan of the Kaiser Commission staff and David Liska of the Urban Institute(link to http://www.urban.org) for their efforts in preparing and compiling the information presented in this report. We would also like to thank Barbara Lyons and Julie Hudman for their helpful comments, Brian Bruen for programming assistance, Frank Ullman and John Holahan for their description of child health insurance estimates, and Alan Schlobohm and Dawn Nelson for their editorial assistance. Finally we are indebted to the Commission members for their guidance and insight in directing our efforts.

James R. Tallon, Jr.
Chairman

Diane Rowland, Sc.D.
Executive Director

Table of Contents

List of Figures and Tables

FIGURES

Overview of Children's Insurance Coverage

TABLES

Children's Insurance Coverage by State, 1994-1995

Introduction

The enactment of the new state Child Health Insurance Program (CHIP) provides an important opportunity to expand coverage to millions of low-income uninsured children. This new federal program gives states broad flexibility in designing a program for children either by choosing to expand Medicaid or create a new state program - or a combination of both approaches. Because there is such considerable state to state variability in health insurance coverage for children, this report has been prepared to assist state policymakers and others interested in understanding the scope of current coverage for children both nationally and in each state. We hope this information will assist in the design and implementation of the new program.

A brief overview of key implementation issues in the CHIP program is provided in Part I. Part II presents figures on insurance coverage for children nationally. State-level estimates of the distribution of insurance coverage for children, from analysis of the March 1995 and March 1996 Current Population Survey (CPS), are included in Part III. Part IV provides state-level data on Medicaid enrollment and spending for children and trends in program growth compiled from state reports to the Health Care Financing Administration on the 2082 and 64 enrollment and expenditure forms. The tables in Parts III and IV are prepared from data analysis conducted by the Urban Institute for the Kaiser Commission on the Future of Medicaid.

The CHIP program provides an important opportunity to expand coverage to millions of uninsured low-income children. As states implement their programs, it will be important to evaluate the choices states make in program design and effectiveness of the new programs in expanding coverage to low-income uninsured children.

Part I

Summary of the State Children's Health Insurance Program

I. Summary of the State Children's Health Insurance Program

A. Program Overview

To expand insurance coverage to uninsured low-income children, Congress enacted the State Children's Health Insurance Program (CHIP) as part of the Balanced Budget Act of 1997. The CHIP program allocates over $20 billion in federal funds over five years to states for expansion of health coverage to low-income uninsured children. In order to participate, states must contribute funds to obtain the federal allotment based on an enhanced Medicaid match rate. States face a number of decisions when considering how to design and implement the new program, including whether to expand Medicaid or create a separate state program, what eligibility levels to set, what benefit package to use, whether to use a managed care delivery system, and how to achieve desired participation. All of these issues affect the ultimate cost and effectiveness of the program. Key program elements include:

- **Structure**
  States may use the CHIP funds to expand their current Medicaid program and/or establish a separate children's health insurance program.

- **Target Population**
  Uninsured children with incomes at or below 200 percent of the federal poverty level ($27,000 for a family of three in 1997). Eligibility levels can be set at a state's discretion within the law's guidelines. Children covered by private insurance, Medicaid, or who qualify for Medicaid are not eligible for programs funded by CHIP.

- **Financing**
  Over $20 billion over 5 years in the form of federal capped allotment to states for children's health insurance. States must spend their own funds to obtain the enhanced federal match. This rate essentially reduces the states' payments by 30 percent compared to Medicaid.

- **Benefits**
  States must offer one of the following three benefit packages:

  - ***Benchmark:*** can be one of the following: Blue Cross/Blue Shield Standard PPO (FEHBP), State Employee Plan, or state HMO with largest commercial enrollment.

  - ***Benchmark equivalent:*** includes a package with the total value greater than or equal to a benchmark plan. Hospital, physician, laboratory and x-ray, and well baby/child services must be included at a value at least actuarially equivalent to the benchmark benefit package.

  - ***Medicaid*** **:** includes all Medicaid benefits such as well-child care, immunizations, prescription drugs, doctor visits, hospitalization and EPSDT.

- **Cost-Sharing**
  States choosing to establish separate programs may charge nominal premiums and cost-sharing to children with incomes below 150 percent of poverty, and for families with income above 150 percent of poverty, cost sharing and premiums up to a maximum of 5 percent of family income (about $1,000 for a family of three at 150 percent of poverty). Under Medicaid, states may not charge premiums and cost sharing to children. States are not permitted to charge cost-sharing for preventive care under Medicaid or a separate program.

B. Implementation Issues

A key choice facing states electing to participate in the new children's initiative is whether to expand Medicaid, establish a separate state program, or use a combination of the two.

Issues to Consider for a Medicaid Program Expansion

- ***Established program and administrative structure:***
  Medicaid has an existing infrastructure in each state. States are already serving millions of children under their Medicaid programs. Broadening Medicaid to include children eligible for assistance under the new initiative would be the simplest and fastest way to expand coverage. Medicaid administrative costs increases should be marginal, because many of the fixed costs of operating the Medicaid program remain the same.

- ***Enrollment:***
  Given long-standing problems with complex and long application processes under Medicaid, careful attention should be given to enrollment and outreach policies. States can develop shortened application forms, use outstationed eligibility sites, and adopt presumptive eligibility policies. States also have the new option of offering children 12 month continuous eligibility (regardless of changes in family income during that period) which may facilitate enrollment.

- ***Scope of Benefits:***
  Medicaid offers low-income children a comprehensive benefit package that is generally broader than a benchmark package. Cost sharing and premiums are generally prohibited under Medicaid, which reduces financial barriers to care.

- ***Enhanced federal match for new children; regular match for spending over allotment:***
  Under CHIP, states obtain an "enhanced" federal matching rate based on their Federal Medical Assistance Percentage (FMAP) rate. If the allotment is exhausted, under a Medicaid expansion new children made eligible under CHIP will still qualify for Medicaid assistance and states would still receive federal matching funds at the states' Medicaid matching rate.

- ***Established operating rules and consumer protections:***
  Medicaid has established administrative and operating rules, as well as consumer protections and grievance procedures.

- ***Use of Managed Care:***
  States will have to decide what type of delivery system to use for the CHIP program. Many states have already implemented Medicaid managed care programs for children which achieves greater financial predictability and uses existing provider networks.

Issues to Consider if Designing a Separate State Program

- ***Not an Entitlement:***
  Under a separate program states would not have to create another entitlement. This would allow states to control the amount they spend on coverage of low-income children.

- ***Enrollment May Be Capped:***
  A separate program would allow states to place limits on the number of children served, while states that expand Medicaid must provide coverage to any child who is determined to be eligible. A capped program allows states greater predictability in expenses over time. All eligible children, however, may not be assisted if cap is reached.

- ***Can Specify Eligibility Criteria and Set Limits on Coverage:***
  States may establish eligibility standards based on geographic area, age, income and resources, residency, disability status, and also limit the duration of coverage. However, states cannot exclude children based upon a preexisting condition or diagnosis, and cannot cover higher income children before lower income children.

- ***Flexibility in Designing Benefit Package:***
  States may offer the benchmark plans which may be less expensive and less comprehensive than the Medicaid benefit package. The ability to charge cost-sharing and premiums may be viewed as making the program more similar to private coverage and limit unnecessary use of care. This can possibly lower the costs to the state, but could create barriers to enrollment and access to care.

- ***Establishment of Administrative Structure:***
  States need to consider what administrative structure will be used to operate the separate program. State have the flexibility to use the existing Medicaid structure, create a new system, or build on another program already underway.

- ***Coordination with Medicaid*:**
  Children who are eligible for Medicaid do not qualify for coverage under CHIP. States operating separate programs will need to coordinate with Medicaid to ensure that systems are in place for Medicaid eligible children to be enrolled in Medicaid. An estimated 3 million children are eligible for but not enrolled in Medicaid.

- ***Participation and Substitution of Employer-Based Coverage:***
  The way that states structure their program eligibility, benefits, and costs will affect the degree of partipation and substitution of private employer coverage with a publicly funded program. If a separate state program includes includes premiums and cost-sharing, it may result in reduced participation among those at the lowest income levels.

C. Assessing the Impact of CHIP

As states implement CHIP, there are several factors that will affect the success of the programs:

- ***Coverage:*** The level of participation among eligible children, the effectiveness of outreach efforts, and the ease of the enrollment process will be important to assess.

- ***Comprehensiveness:*** The scope of covered benefits and the nature of the provider networks will affect the care that children receive.

- ***Cost:*** The cost for each child in the program will depend on many factors, including the structure, the benefit package, payment rates for providers and health plans, administrative costs, and adverse selection by enrollees. Also, what constitutes state matching funds will need to be considered.

- ***Coherence:*** This new program builds on a complex array of health programs for children. Coordination with Medicaid eligibility screenings as well as the integration of insurance coverage for families is important to consider.

- ***Clout:*** Assessing the market share and purchasing power of the children's program, as well as the type of providers and plans that participate, will reflect on the program's effectiveness at providing coverage to uninsured children.

D. Conclusion

As states design and implement their new programs under CHIP, it will be critical to evaluate the effectiveness of the new programs. Some key questions to examine include: How many previously uninsured children have been assisted? What models have been found to be most effective in enrolling and serving low-income children? Which programs are the most cost-effective? Are the federal allocations adequate to cover the targeted children? This new program has the potential to provide coverage to millions of unisured children. It will be important to assure that the limited public dollars are used in the most effective manner.

Part II

Overview of Children's Insurance Coverage

PART II: NATIONAL PROFILES OF CHILDREN'S INSURANCE COVERAGE

Nationally, estimates of uninsured children under age 19 range from 7.3 million to 10.5 million from the CPS.[1] Low-income children are less likely to have employer coverage, and more likely to have Medicaid (low-income is defined as income below 200 percent of the federal poverty level, or about $24,000 per year for a family of three in 1995). Overall, six out of ten children are covered by employer-based coverage, as compared to one third (34 percent) of low-income children. In recent years, the share of children with employer coverage has declined, falling from 67 percent to 59 percent of children.

Medicaid plays a particularly important role for children, covering nearly one quarter of all children (23 percent) and almost half (48 percent) of low-income children. Medicaid coverage of children has grown considerably as a result of federal and state expansions of eligibility for children. The number of children receiving Medicaid coverage for health care services rose from 11.5 to 17.5 million beneficiaries between 1990 and 1995.

Uninsured children are predominantly members of low-income working families. Seven out of ten uninsured children are in families with incomes below twice the poverty level, and eight out of ten have parents who work full or part time. Studies show that children who lack insurance have poorer access to care than children with private insurance or Medicaid coverage.

[1] Estimates of insurance coverage vary depending on the database and the model used for analysis. An explanation of the differences in estimates of insurance coverage is found in Appendix B.

Insert Figures 1 - 13 here.

Part III

Children's Insurance Coverage by State, 1994 - 1995

PART III: CHILDREN'S INSURANCE COVERAGE BY STATE, 1994-1995

Children's insurance coverage varies by state and is influenced by a number of factors, including Medicaid eligibility policy, the extent of employer coverage, and state poverty levels.

- While nationally ten percent of children are uninsured, this proportion ranges from under five percent in Minnesota and West Virginia to 21 percent in New Mexico.[2]

- Medicaid coverage ranges from 11 percent of children in Utah to over 30 percent of children in California, the District of Columbia, New Mexico, and West Virginia.

- The proportion of children covered by employers varies from less than half of children in the District of Columbia, Louisiana, and New Mexico to over three quarters of children in New Hampshire and Wisconsin.

Income, work status, and family structure also influence the level of children's insurance coverage, with low-income children (income below 200 percent of poverty) more likely to be uninsured than higher income children.

- **Low-Income.** Across states, the share of low-income uninsured children ranges from 5 percent in Hawaii to 27 percent New Mexico. Medicaid coverage ranges from 26 percent of low-income children in Utah to 63 percent in West Virginia. Employer coverage varies from 20 percent of low-income children in New Mexico to over half in Hawaii, Nevada, and Utah.

- **Low-income Children in Working Families.** Among low-income children in full-time working families, the proportion uninsured ranges from 7 percent in Tennessee to 29 percent in Texas. Medicaid coverage varies from 17 percent in Hawaii and Oregon to 52 percent in West Virginia, and employer coverage from 28 percent in New Mexico to 76 percent in Hawaii.

- **Family Structure.** Low-income children in two parent families are more likely to be uninsured than low-income children in single parent families. Due to its historical link to the welfare program, Medicaid plays a strong role in covering low-income children in single parent families, ranging from 37 percent in Nevada to 75 percent in New York.

[2] The numbers presented in Part III of this report are prepared with the Urban Institute TRIM model, which adjusts for underreporting of insurance coverage on the CPS and results in a lower estimate of uninsured children (7.3 million nationally versus 10.5 million from the unedited CPS). See Appendix B for additional information.

Insert Tables 1- 14 here

Part IV

Medicaid's Role for Children, State Profiles 1990-1995

PART IV: MEDICAID'S ROLE FOR CHILDREN, 1990-1995.

Medicaid covered 17.5 million children and spent $25.4 billion on services for children in 1995.

- Nationally, half of all Medicaid beneficiaries are children, ranging from 40 percent of beneficiaries in Tennessee to 60 percent in three states. Medicaid spending on services for children ranged from slightly less than 11 percent of total spending on services in Connecticut to 32 percent in Arizona.

- Almost all spending for children was for acute care services (93 percent) with the remaining share for long-term care. States vary widely in the distribution of expenditures. For example, nationally inpatient care constitutes 28 percent of Medicaid spending on children's services, but ranges from 8 percent of spending in Washington to 47 percent of spending in Illinois.

- Costs per beneficiary are the lowest for children, at $1,451 per child beneficiary as compared to spending per adult ($2,080), blind and disabled ($8,784), and elderly Medicaid beneficiaries ($10,308) nationally.[3] Massachusetts spent the most per child ($2,701), and Idaho the least ($740).

Relative to annual rates growth between 1990 and 1993, Medicaid enrollment and spending growth slowed from 1993 to 1995. Variations in the magnitude of change across states reflect welfare policy changes, expanded Medicaid eligibility, and fluctuations in state economies.

- Nationally, the number of child Medicaid beneficiaries grew at an annual average rate of 9 percent between 1990 and 1995, but only by 4 percent between 1993 and 1995. Over the latter time period, eleven states actually experienced declines in enrollment of children, while in six states enrollment grew by over 10 percent.

- In response to the growth in enrollment, particularly between 1990 to 1993, Medicaid spending on children increased at an average annual rate of 17 percent from 1990 to 1995. In some states that implemented broad expansions growth was significant, while other states experienced only modest spending increases for children.

- Spending per child beneficiary grew at substantially slower rates than overall spending for children. Over the period 1990 to 1995, spending per child beneficiary grew at an average annual rate of 8 percent, ranging from declines in spending in three states to increases of over 20 percent in Delaware and West Virginia.

[3] Beneficiaries are defined as Medicaid enrollees who use services in a given year. Since not all Medicaid enrollees use services, spending per Medicaid *enrollee* may be lower than spending per *beneficiary*.

nsert Tables 15 - 20 here

Appendix A

Insert Tables A1 - A4 here

Appendix B

An Explanation of Estimates of Uninsured Children

Frank Ullman and John Holahan
The Urban Institute

During recent debates on children's health insurance, numerous estimates on the number of uninsured children have been generated. Perhaps the mostly widely cited number estimated that approximately 10.5 million children were uninsured in 1995. Yet another estimate, using the same survey data, placed the number of uninsured children at 6.9 million. This paper explains some of the reasons behind various estimates and draws upon and summarizes information recently produced by researchers at Mathematica Policy Research and the Urban Institute (see sources).

ESTIMATES OF UNINSURED CHILDREN

Most estimates of uninsured children are based on two sources of data, the Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP). However, a number other surveys—the Community Tracking Study, the Kaiser/Commonwealth Survey of Americans, the Medical Expenditure Panel Survey, and the National Health Interview Survey—have also generated estimates of uninsured children. This paper focuses on the CPS and the SIPP because these surveys are conducted on a regular basis and are used for most estimates. By contrast, the other surveys are either one-time surveys, surveys conducted irregularly or infrequently, or surveys with minimal information on children.

CPS Estimates of Uninsured Children

The most commonly cited estimates of the number of uninsured children are based on the CPS. The CPS is a monthly survey of approximately 57,000 households in the United States. The survey is primarily used to generate data on labor force participation. However, each March, the CPS contains supplemental questions related to health insurance status. Specifically, individuals are asked whether they had any of various types of private or public health insurance in the previous year. Individuals who do not report insurance coverage are categorized as having been uninsured.

If people responded to the question as asked, estimates from the CPS should only include those who were without health insurance for the entire prior year. However, there is disagreement among researchers when interpreting uninsured numbers generated from the CPS. Some researchers believe that people are reporting their insurance status for the prior year while other researchers believe that individuals are misinterpreting the time-frame question and reporting their insurance coverage at the time of the interview. In the first case, estimates of uninsured children would represent the number of uninsured children who were uninsured for the entire prior year. In the latter, the estimates would represent the number of uninsured at a given point in time. Alternatively, respondents may be reporting their health insurance status during the previous year, but with so much recall error that the estimate approximates a point-in-time estimate more closely than an estimate of those uninsured throughout the previous year.

Regardless of which interpretation is correct, CPS estimates are problematic given that respondents are believed to under report insurance coverage. This is particularly true with respect to the Medicaid program where individuals on Medicaid do not report this coverage to individuals conducting the CPS survey. Therefore, estimates of the uninsured are over-estimated to the extent that some of those categorized as uninsured had, in fact, received Medicaid (or other) coverage.

A variety of research institutions—the Employee Benefits Research Institute (EBRI) (link here to http://www.ebri.org), the Census Bureau (link here to http://www.census.gov), the Congressional Budget Office (CBO) (link here to http://www.cbo.gov), the U.S. General Accounting Office

(GAO) (link here to http://www.gao.gov), and the Urban Institute (UI)—consistently generate estimates of the number of uninsured children using the CPS.

With the exception of the UI, all of the institutions cited above began to generate identical estimates of uninsured children beginning with the March 1995 CPS (see Figure 1)

Figure 1: CPS Estimates of the Uninsured by Source

Source	Data	Time Period	Population	Numbers (millions)	Percent
Census Bureau, EBRI, CBO, and GAO, and others	1996 CPS	1995	Children ≤ 18 Children ≤ 17	10.5 9.8	14.0% 13.8%
Urban Institute	1996 CPS	1995	Children ≤ 17	6.9	9.8%

The UI's estimates differ from the other estimates because they adjust for the under reporting of Medicaid in the CPS. The undercounting of Medicaid enrollment in the CPS results in a likely over count of the number of uninsured. To address this problem, the UI uses a micro simulation model, TRIM, to impute Medicaid coverage to some children to match the administrative data reported by states. The UI uses Health Care Financing Administration enrollee data (HCFA 2082) edited on a state-by-state basis for consistency in enrollment estimates among eligibility groups as well as over time. TRIM uses state eligibility rules to identify all individuals on the CPS that are eligible for Medicaid. TRIM then assigns enrollees randomly to those deemed to be Medicaid eligible until CPS totals match the adjusted HCFA enrollment number.

The UI approach assumes that CPS questions respondents are reporting any coverage during the prior year. For example, individuals are asked whether they have Medicaid coverage in the past year. This is interpreted as ever having had Medicaid any time during the past year. Similarly, the HCFA enrollee data are also unduplicated counts of those who are on the program at any time during the year. The UI adjustment increases the number with Medicaid, thus reducing the uninsured. For 1995, the TRIM adjustments increase the number of children enrolled in Medicaid as reported in the raw CPS data (16.5 million) to the number enrolled at any point during the year as reported in Medicaid administrative data (21.4 million). Correspondingly, the number of uninsured children decrease from 9.8 million in the raw data to 6.9 million in UI adjusted data (Figure 2) .

Figure 2: Estimates of Medicaid Enrollment and Number of Uninsured, 1995 (in millions)

Child Enrollees (Age 0-17)	Medicaid	Uninsured
CPS Raw Data (EBRI estimates)	16.5	9.8
HCFA Administrative Data	21.4	n/a
CPS Edited Data (UI estimates)	21.4	6.9

Note: Most, though not all individuals with imputed Medicaid coverage under UI estimates would be categorized as uninsured in EBRI estimates.

If the CPS is really providing point-in-time numbers, as many researchers believe, it can be argued that Medicaid enrollment numbers to which TRIM adjusts should be point-in-time as well. This type of adjustment will result in less of a CPS undercount of Medicaid and less of an over count of the uninsured than now reported in Urban Institute data. Some observers have argued that if the UI were to adjust to full-time equivalent Medicaid enrollment, which is virtually the same as point-in-time estimates, the result may be more accurate than either the UI estimates or the raw CPS. Or stated differently, the truth may lie in between the CPS and UI numbers.

One reason why researchers rely on the CPS, despite its shortcomings, is that it is the only data source with the capacity to generate state-by-state estimates of uninsured children over time. Unfortunately, state-by-state estimates of uninsured children in a given year rely on very small sample sizes and may not be reliable, especially estimates generated for the least populous states. In an effort to address this problem, many research organizations, beginning with the UI, have pooled CPS data over a period of years to generate average rates of uninsured children by state over a multi-year period. Because of concern over variability in single year estimates, the distribution formula under the State Children's Health Insurance Program relies on three year averages of CPS data on low-income uninsured children.

SIPP Estimates of Uninsured Children

The SIPP is a survey of adults in a sample of approximately 20,000 households. The SIPP, unlike the CPS, is designed to track a set of individuals over time. The SIPP interviews a set of respondents every four months for approximately 2 ½ years. The SIPP asks respondents whether they were covered by public or private coverage. Like the CPS, estimates of the uninsured using SIPP are calculated based on those who do not report insurance coverage. Unlike the CPS, though, SIPP respondents are asked about health insurance coverage in each month of the 4-month reference period.

One benefit of the SIPP in comparison with the CPS is that it enables researchers to examine how estimates of the uninsured vary as the reference period varies. For example, the SIPP can estimate how many individuals were uninsured for at least a month in a given year and estimate the average length of duration. For example, a recent analysis of SIPP data conducted by the Census Bureau suggests that approximately 30 percent of children were uninsured at least one month during a 28 month period from early 1992 through 1994 with four months being the median number of months uninsured.

One drawback of SIPP is that the survey only enables researchers to generate national estimates. To generate state-by-state estimates of uninsured children over time, researchers must rely on the CPS. Another problem with SIPP, like the CPS, is that respondents also under report Medicaid coverage. Self reports of participation in social policy programs are consistently under reported regardless of the survey instrument.

Many researchers have compared estimates of uninsured populations generated by the SIPP in comparison with estimates of uninsured populations generated by the CPS. In sum, these researchers have found that annual SIPP estimates of the uninsured are consistently smaller than estimates of uninsured generated by the CPS. For example, when examining the entire population, the CPS annual estimate for the uninsured in 1993 was 15.3 percent, whereas the SIPP annual estimate for uninsured for 1993 was 7.7 percent. By contrast the SIPP quarterly estimate for uninsured was 14.5 percent. As evidenced, CPS estimates more closely resemble SIPP quarterly estimates or point-in-time estimates rather than representing individuals who were uninsured for an entire year. Thus caution is warranted when relying upon survey estimates of uninsured children, especially estimates generated by the CPS. For more thorough discussions of differences in estimates of the uninsured, please consult the sources cited below.

Sources:

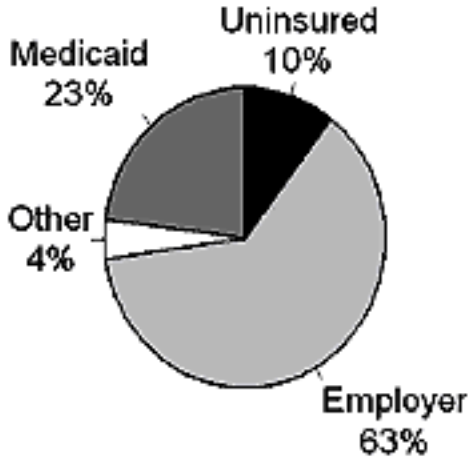
Lewis, Kimball, and Marilyn Ellwood. “Children’s Health Insurance Patterns: A Review of the Literature: Draft Report” Mathematica Policy Research, Inc. September 1997. Report submitted to the U.S. Department of Health and Human Services.

Uccello, Cori, Badawi, Adam, and Stephen Norton. “Uninsured Rate Estimates from Four Surveys: Why Do They Differ? Draft Report.” The Urban Institute. August, 1997.

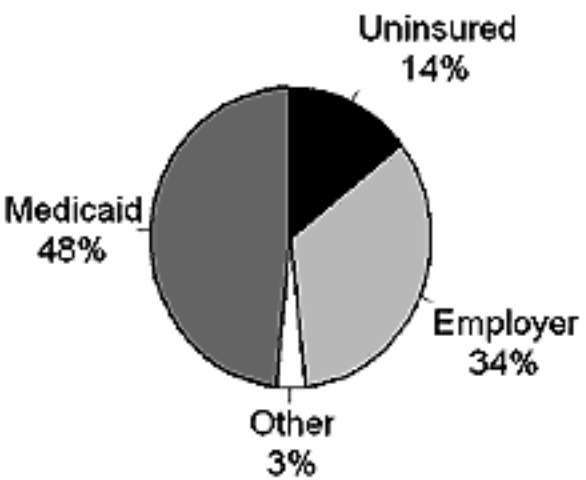
Appendix C

Figure 1

Health Insurance Coverage of Children, 1994-95



All Children
73.2 Million



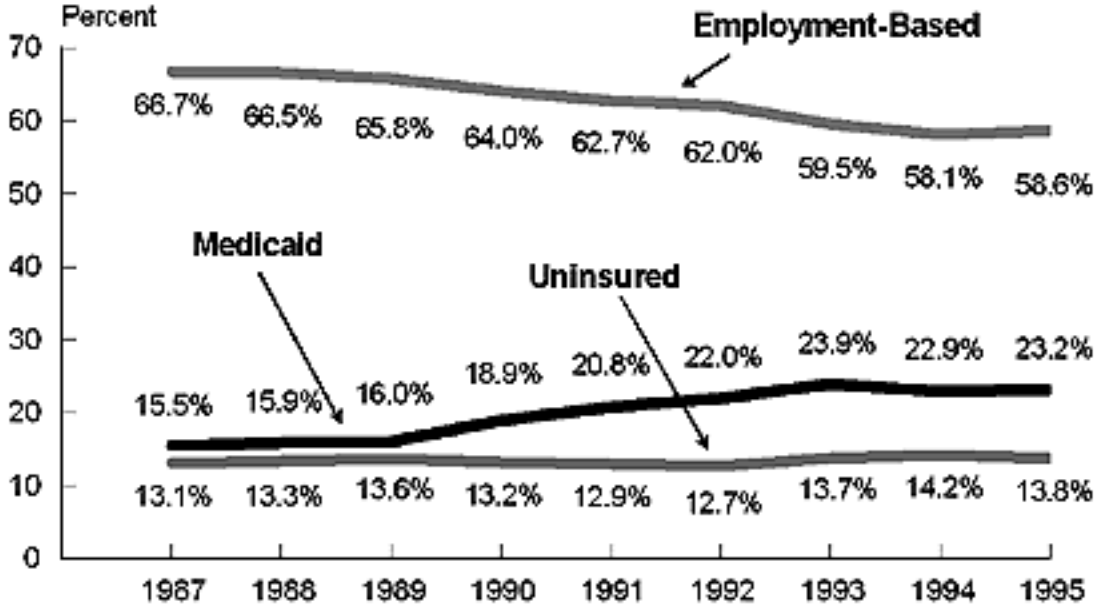
Low-Income Children
33.8 Million

Note: Children under age 19. Low-income is below 200% of poverty.
SOURCE: Urban Institute estimates based on TRIM adjusted March 1995 and March 1996 Current Population Survey.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 2

Trends in Coverage for Children, 1987-1995



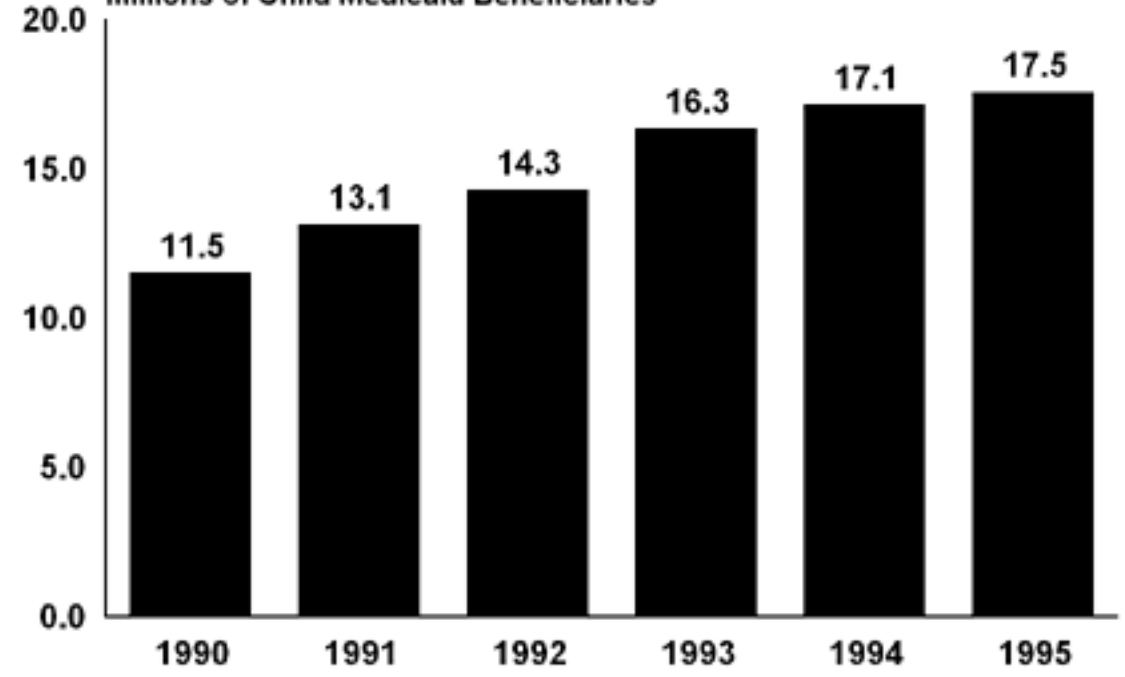
Note: Children under age 18.

SOURCE: Employee Benefit Research Institute, 1997.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 3

Growth in Medicaid Coverage of Children, 1995



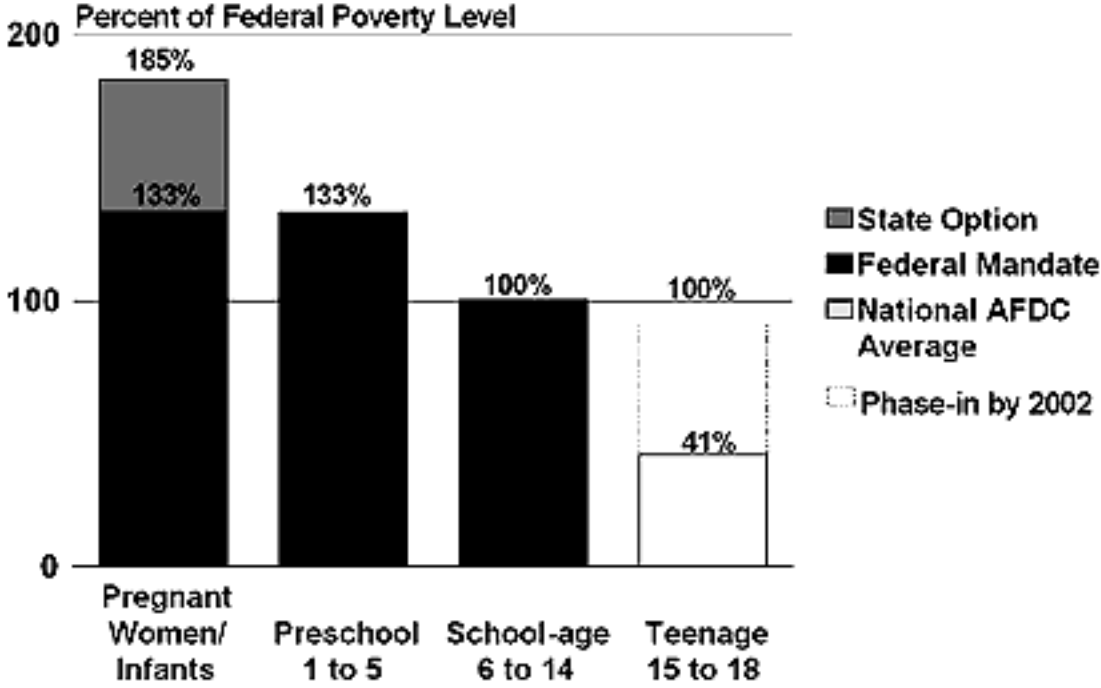
*Excludes SSI children.

Source: Kaiser Commission on the Future of Medicaid, 1997.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 4

Medicaid Eligibility Standards for Children and Pregnant Women, 1997

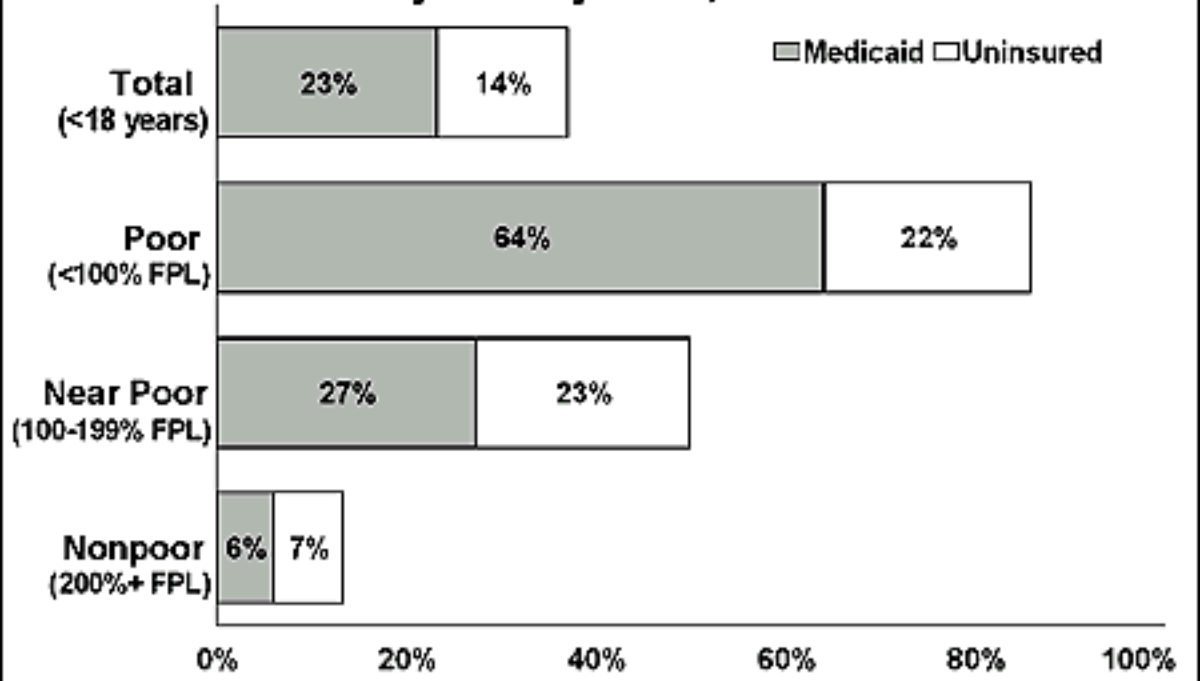


Note: Some States have increased eligibility through Sec. 1115 or Sec. 1902 (r)(2.)
Federal Poverty Level is $16,050 for a family of four for 1997.
Source: National Governors Association, 1997.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 5

Health Insurance Coverage of Children, by Poverty Level, 1995



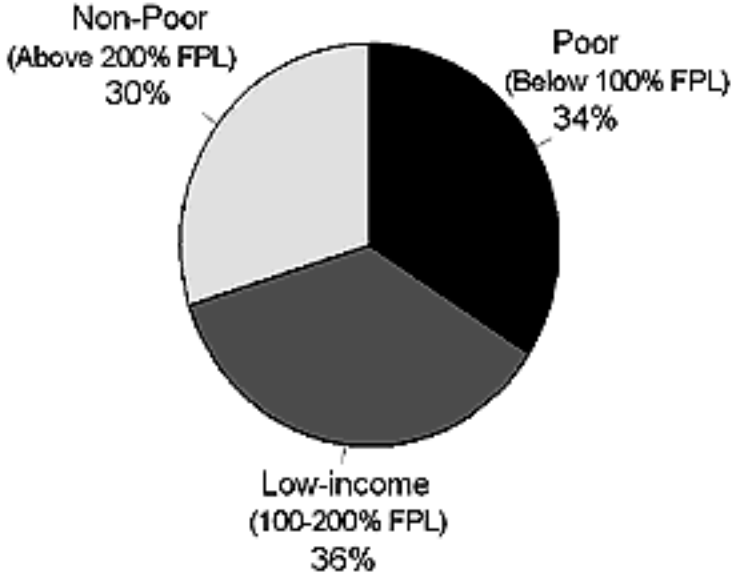
Note: Federal Poverty Level (FPL) is $12,158 for a family of three.

Source: Employee Benefits Research Institute, 1996.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 6

Distribution of Uninsured Children Under Age 18 by Poverty Level, 1995



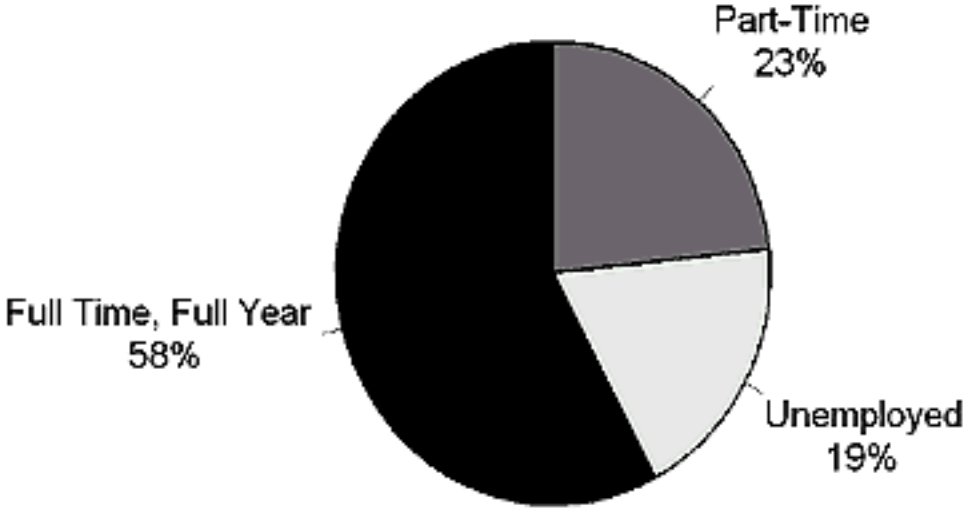
Total = 9.8 Million

Federal Poverty Level (FPL) is $12,158 for a family of three in 1995.
Source: CRS analysis of the 1996 CPS, 1997.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 7

Distribution of Uninsured Children Under Age 18 by Parent's Work Status, 1995



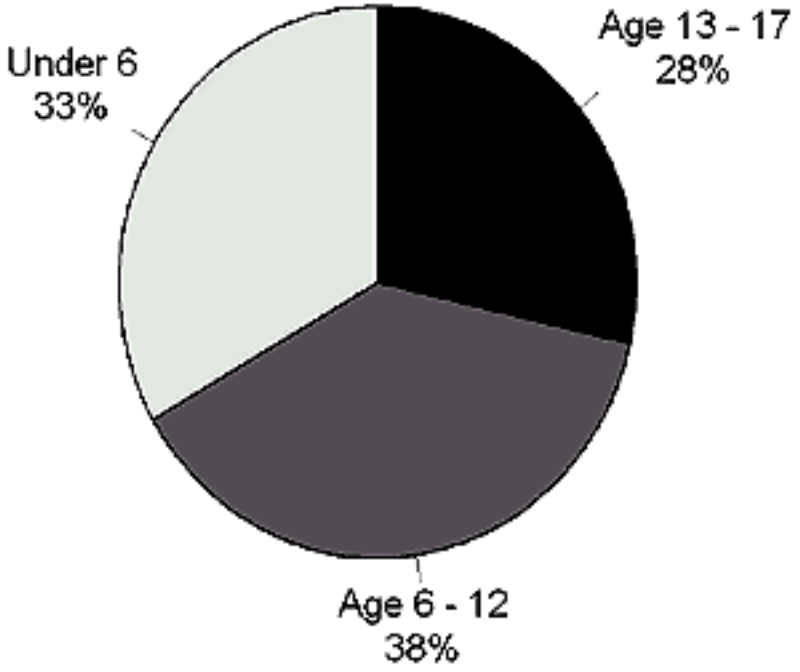
Total = 9.8 Million

Source: CRS analysis of the 1996 CPS, 1997.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 8

Distribution of Uninsured Children Under 18 by Age, 1995



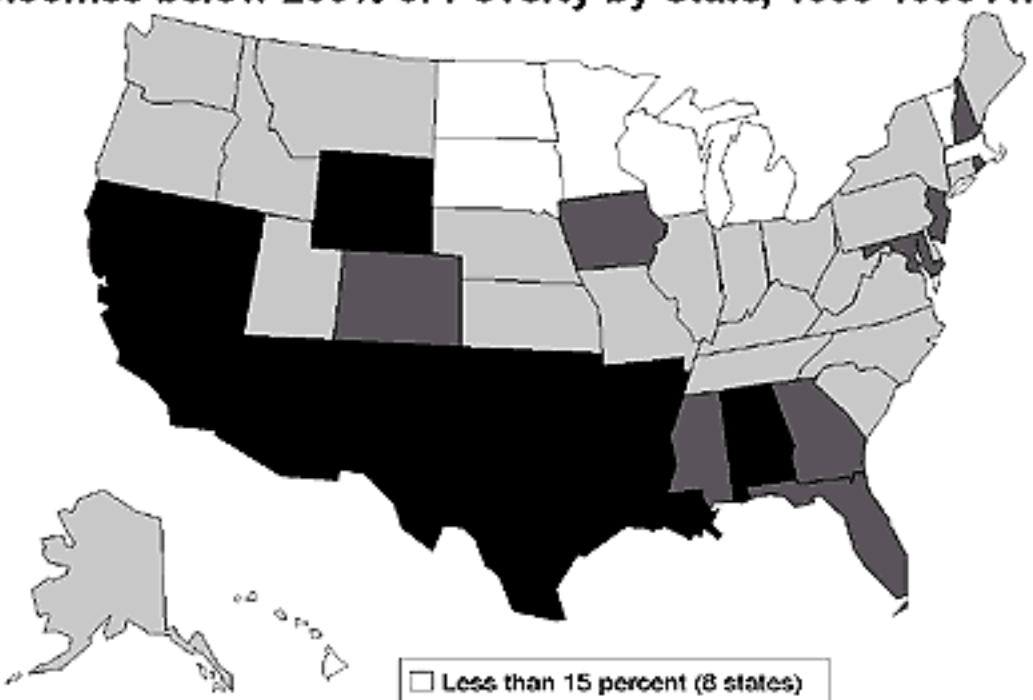
Total = 9.8 Million

Source: CRS analysis of the 1996 CPS, 1997.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 9

Percent of Uninsured Children Under Age 19 with Family Incomes below 200% of Poverty by State, 1993-1995 Average



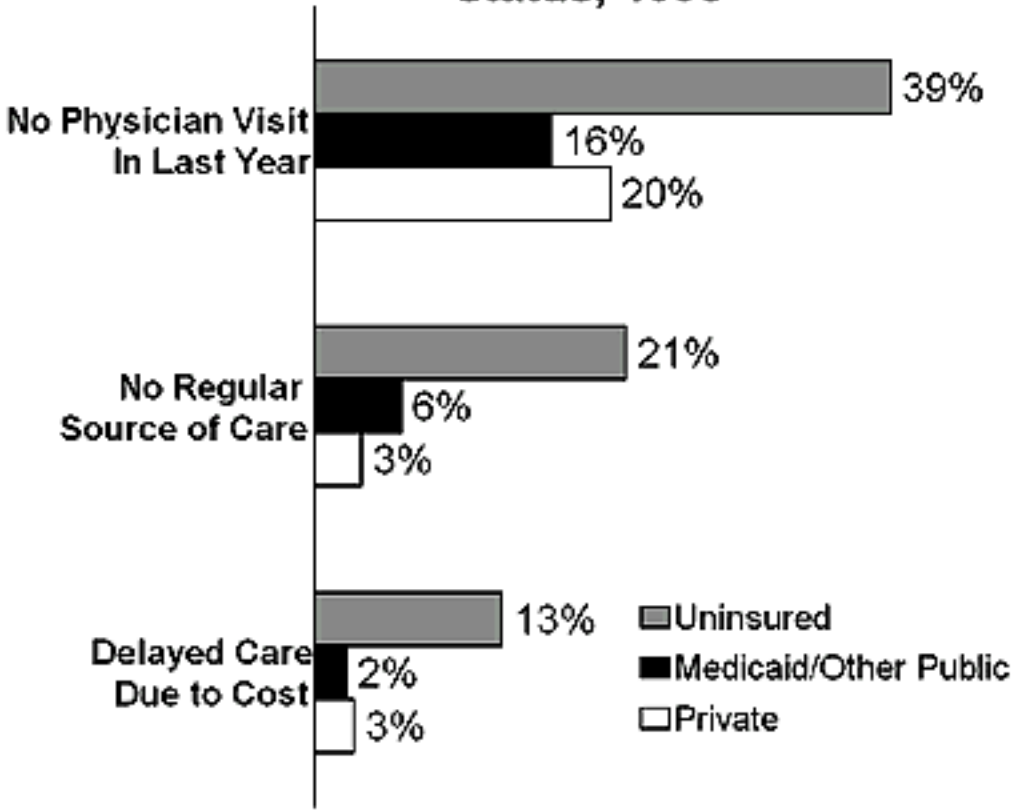
* Includes the District of Columbia.

Source: The Urban Institute. 1997.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 10

Access to Care for Children by Insurance Status, 1993



Source: National Center for Health Statistics,1997. Kaiser/Commonwealth Survey, 1997.

The Kaiser Commission on THE FUTURE OF MEDICAID

Figure 11

State Children's Health Insurance Program (SCHIP)

- Federal block grant assistance to states for coverage of children
- States can cover children through Medicaid or set up a separate children's health program
- Targets children under age 19 with incomes below 200% of poverty
- States required to spend own funds to match federal block grant allocation
- Federal spending of up to $20.3 billion over 5 years

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 12

State Implementation Issues

- Medicaid or state program
- Eligibility levels
- Benefits Offered/Benchmark Packages
  - Blue Cross/Blue Shield Standard PPO (FEHBP)
  - State employee plan
  - HMO with largest commercial enrollment in the state
- Use of managed care
- Participation rates/crowdout
- Cost

Figure 13

Evaluating the Choices

- Coverage:
  - How many children participate
  - How many were previously uninsured?
  - How accessible is enrollment?
- Comprehensiveness:
  - What scope of benefits are covered?
  - What financial contributions are required?
  - What providers are included?
- Cost:
  - What is the cost per child?
  - What is the cost of administration?
  - What are family obligations?
  - What constitutes the state's matching funds?
- Coherence:
  - How does new coverage mesh with existing?
  - How is screening for Medicaid eligibility done?
  - How well integrated is coverage for families?
- Clout:
  - What market share does the program have?
  - What type of providers and plans will participate?