kaiser commission on medicaid and the uninsured
KEY FACTS
THE HENRY J. KAISER FAMILY FOUNDATION
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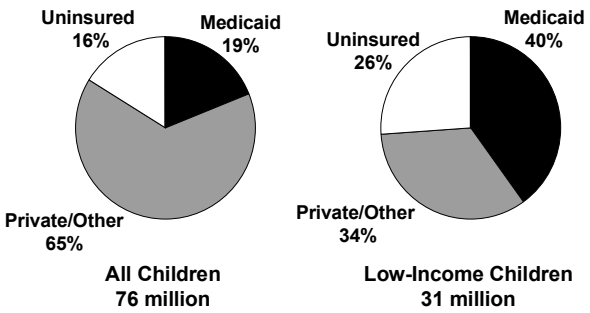
HEALTH COVERAGE FOR LOW-INCOME CHILDREN

Whether children are publicly or privately insured, having coverage has been shown to improve their access to care and ultimately, their health. Nationally, two-thirds of all children have private insurance (Figure 1). Medicaid covers one in five children in the U.S., while one in seven children remain uninsured. Low-income children are more likely to be covered by Medicaid or to be uninsured and less likely to have private coverage than those with higher incomes.

Figure 1

Health Insurance Coverage of Children, By Income, 1998



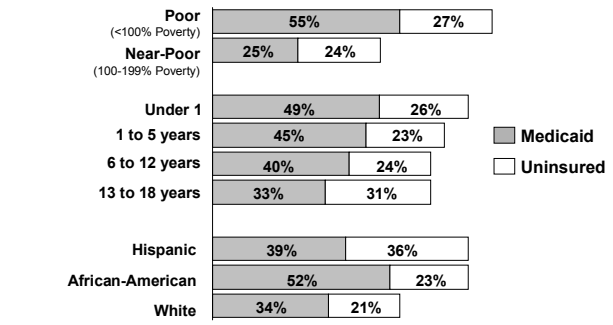
Note: Children under age 19, low-income with family income below 200% of poverty.
SOURCE: Urban Institute calculations from the 1999 Current Population Survey, 1999.

UNINSURED CHILDREN

Over 11 million children under 19 are uninsured today. Two-thirds of these children—8 million—live in families with household incomes below 200% of poverty; many may be eligible for, but are not enrolled in Medicaid. Eight out of ten (79%) low-income uninsured children have parents who work full- or part-time. The risk of being uninsured varies by income, age, and race and ethnicity (Figure 2).

Figure 2

Health Insurance Coverage of Low-Income Children, 1998



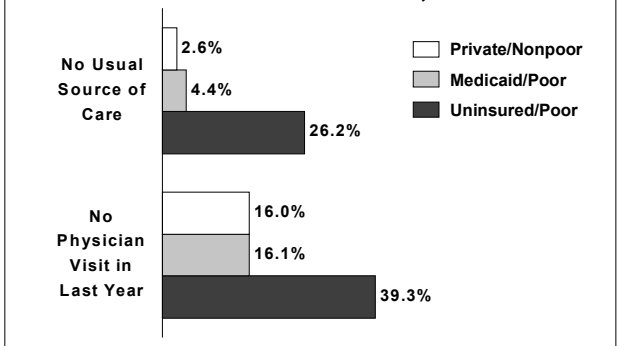
Note: Federal Poverty Level is $13,650 for a family of three in 1998.
SOURCE: Urban Institute calculations from the March 1999 Current Population Survey, 1999.

Despite the availability of Medicaid coverage for the poorest children, poor children are as likely (27%) as near-poor children (24%) to be uninsured. Adolescents are more likely than younger children to be uninsured, in part due to lower Medicaid income eligibility levels for older children. Hispanic children are the most likely to be uninsured.

The role of insurance in improving access to care is well documented. Poor uninsured children have markedly worse access to care than poor children with Medicaid or private coverage. Medicaid brings poor children closer to the level of access experienced by nonpoor children with private insurance coverage (Figure 3).

Figure 3

Children's Lack of Access to Care by Insurance and Income,1995



SOURCE: Newacheck et al.,1998, data from 1995 NHIS.

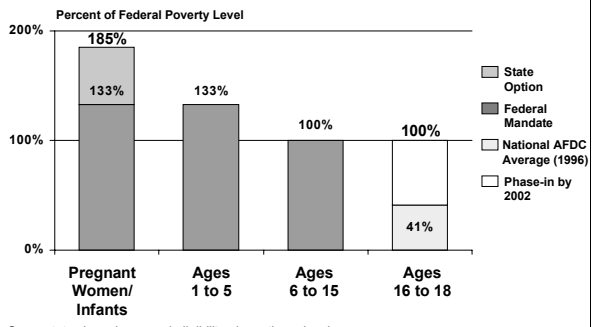
MEDICAID

The Medicaid program is a critical health care safety net for millions of low-income children. In 1997, 21 million children were enrolled in Medicaid, at a cost of $24.3 billion. Children represent half of all Medicaid enrollees, but account for only 16% of program spending. Per-capita costs for children are the lowest among the groups eligible for Medicaid, at $1,156, compared to $10,804 for elderly enrollees in 1997. Medicaid pays for a comprehensive set of services for low-income children, including physician and hospital visits, screening and treatment (EPSDT), well-child care, vision and dental care with no cost sharing.

Being poor does not automatically qualify a child for Medicaid. In the past, Medicaid primarily served children who received cash assistance through welfare, with state-determined eligibility levels well below poverty. In the late 1980s and early 1990s, eligibility was expanded to cover additional low-income children. Today, Medicaid covers children based on age and income (Figure 4).

Figure 4

Federal Medicaid Income Eligibility Standards for Low-Income Children, 1999



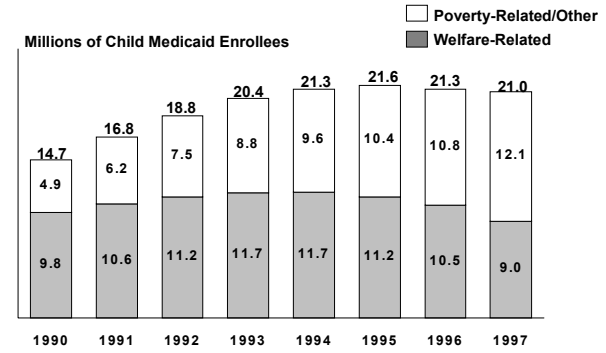
Note: Some states have increased eligibility above these levels.
Federal Poverty Level is $16,700 for a family of four in 1999.
SOURCE: National Governors' Association, 1999.

States can choose to expand Medicaid beyond federal minimum standards by raising age and income levels for children. As a result, Medicaid coverage varies across the states, ranging from 20% of low-income children in Nevada to 62% in Vermont between 1996 and 1998. Medicaid covered over one-third of births nationally in 1997, ranging from 20% in New Hampshire to 51% in New Mexico.

Despite efforts to broaden coverage, Medicaid coverage declined from a high of 21.6 million children in 1995 to 21.0 million children in 1997 (Figure 5). The reduction has been associated with the delinking of Medicaid and welfare and confusion about eligibility for immigrant children.

Figure 5

Medicaid Enrollment of Children,1990-1997



SOURCE: Urban Institute analysis of HCFA 2082 data, 1999.

State Children's Health Insurance Program

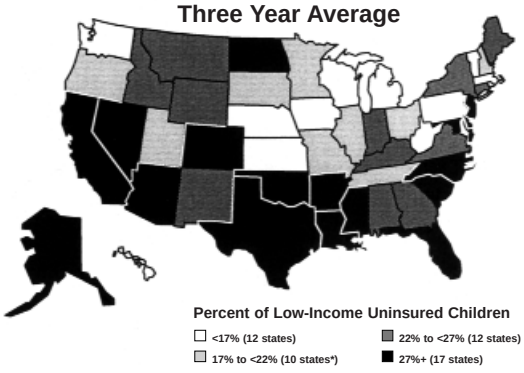
To broaden coverage to low-income uninsured children who do not qualify for Medicaid, Congress enacted the State Children's Health Insurance Program (CHIP) as part of the Balanced Budget Act of 1997. The program targets uninsured children under 19 with family incomes below 200% of poverty who are not currently eligible for Medicaid or covered by private insurance. This matched block grant program allocates $20.3 billion in federal funds for five years. As of October 1999, nearly 2 million children were covered through CHIP.

States can expand coverage to uninsured low-income children through either a separate state program or by broadening Medicaid—or both. If states use the Medicaid option, children become entitled to full Medicaid coverage. In implementing CHIP, 19 states expanded Medicaid, 15 created separate state programs, and 17 have combination plans (as of 3/00).

The share of low-income children who are uninsured varies by state, presenting different challenges as states implement CHIP. In 17 states, 27% or more are uninsured, compared to 12 states where under 17% are uninsured (Figure 6).

Figure 6

Low-Income Uninsured Children, 1996 to 1998 Three Year Average



* Includes the District of Columbia
SOURCE: U.S. Bureau of the Census, 1999.

Issues in Improving Coverage

Enrolling uninsured children eligible for Medicaid as well as CHIP is critical, but it has been challenging. Nearly two-thirds of low-income, uninsured children are potentially eligible for Medicaid (38%) or CHIP (24%). States can extend coverage to even more uninsured children than in their current plans and still receive federal matching funds.

Efforts to conduct outreach and simplify the enrollment process are greatly needed to improve program participation. Parents of low-income uninsured children want coverage for their children, but cannot afford to pay for private insurance. Many do not think they are eligible for public coverage, and have difficulties with the application process. Confusion about welfare and immigration policy changes have contributed to enrollment problems.

Effective outreach and streamlined enrollment processes will be key to the success of both Medicaid and CHIP in improving coverage for low-income children. In addition, states will have to focus on simplifying re-enrollment procedures to ensure that eligible children stay enrolled. If these efforts are broad and effective, Medicaid and CHIP together could cover up to two-thirds of the 11 million uninsured children in the United States.

The Kaiser Commission on Medicaid and the Uninsured was established by the Henry J. Kaiser Family Foundation to function as a policy institute and forum for analyzing health care coverage, financing and access for the low-income population and assessing options for reform. The Kaiser Family Foundation is an independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.