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Health, Education and Human Services Division

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October 20, 1995

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:

Medicaid is the primary source of health insurance for poor children in the United States, covering 13.7 millon children in 1993. Current proposals to transform Medicaid from an open-ended entitlement program to a block grant to states would "cap" federal funding to states and remove most federal requirements that guarantee children eligibility and coverage for specific services.

To respond to your concerns about the impact of proposed Medicaid changes on children, we prepared this correspondence, which summarizes facts from a report we issued previously on the health insurance status of children and one we will be issuing soon.[1] Specifically, you asked us to describe (1) recent trends in children's health insurance coverage, particularly for children in working families, and Medicaid's impact on such coverage; (2) the degree to which states expanded coverage for children beyond federal requirements and the percentage of the states' children who are uninsured or are on Medicaid; (3) the requirements for which changes are proposed in the current bills before the Congress, particularly provisions

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[1]The first study analyzed the March 1990 and 1994 U.S. Bureau of the Census' March Supplement of the Current Population Surveys (CPS) for information on children and their health insurance status before and after the federally mandated expansion of children's Medicaid eligibility. The results of this first study were reported in Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175, July 19, 1995) and Uninsured and Children on Medicaid (GAO/HEHS-95-83R, Feb. 14, 1995). The second study is a case study on state and privately funded programs to provide health insurance for children who lack coverage. We plan to issue a report on this second study soon.

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that affect children and their health insurance coverage; and (4) the experiences of state-funded non-Medicaid programs providing health insurance for children.

MEDICAID'S ROLE IN PROVIDING CHILDREN'S HEALTH INSURANCE

As employment-based insurance in the United States declined, Medicaid has become an increasingly important source of health insurance for poor and near-poor children under age 18.[2] Medicaid is the primary insurer for poor children. In 1993, 13.7 million children were on Medicaid.

Between 1989 and 1993, the number of children covered by Medicaid increased 54 percent, as the federal government expanded children's eligibility for Medicaid. Beginning in 1989, the federal government required states to begin providing coverage to pregnant women and children on the basis of their income and children's age. The federal government also gave states the option to receive federal matching funds to expand such eligibility further.[3]

One result of the expansion was that poor and near-poor children in working families were able to get insurance through Medicaid. In 1993, at least half the children on Medicaid were in families in which at least one parent worked. The percentage of children on Medicaid with a full-time working parent increased from 13.2 to 20.1 percent--or 1 in 5. Medicaid coverage also increased for children in two-parent families, and the proportion of Medicaid children who were not on Aid to Families With Dependent Children (AFDC) increased to 46.9 percent.

The expansion also resulted in Medicaid coverage offsetting the decrease in private employment-based

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[2]Poor children are children living in families with income at or below the federal poverty level. For July 1, 1992, through June 30, 1993, the federal poverty level for a family of three was an annual income of $11,570 or less. We define "near-poor" children as children living in families with income between 101 and 150 percent of the federal poverty level. For a family of three, this means an annual income between $11,571 and $17,357.

[3]The federal government began to give states options to expand coverage in the Omnibus Budget Reconciliation Act of 1986.

coverage for children. Between 1989 and 1993, both children and adults were affected by this decrease, but, in contrast to adults, the proportion of children who were uninsured only increased from 13.3 to 13.5 percent because more children were covered by Medicaid.

Medicaid expansions helped the poor most. The percentage of poor uninsured children decreased from 25 to 20.1 percent. In contrast, the percentage of uninsured children with family incomes above the near-poor level increased. (See enclosure 1.)

Employment-based insurance declined for children in all income brackets. This decline led to more children of a full-time working parent being uninsured, even though Medicaid's coverage of such children expanded. In 1993, almost 90 percent of uninsured children had a working parent--61.4 percent had a parent who worked full time.

STATES' ROLE IN MEDICAID EXPANSIONS

Most of the Medicaid expansion in coverage for children was due to federal mandates, not to state actions. As of April 1995, 37 states and the District of Columbia had expanded eligibility for Medicaid beyond federally mandated levels; however, only 21 states had expanded eligibility for children age 1 or older beyond federal mandates. At least 70 percent of the national increase in coverage for children was in states responding only to federal mandates for children age 1-17.

The Medicaid expansion led to the greatest increase in the number of children on Medicaid in the South--a 69-percent increase. Generally, states in the South and the West have higher proportions of uninsured children, while states in the North and the South have higher proportions of children on Medicaid. Some of the states in the South with the highest proportions of uninsured children are also states where higher proportions of children rely on Medicaid for their coverage--states such as Louisiana, Texas, Mississippi, Arkansas, and West Virginia. (See enclosures 2 and 3.)

CURRENT PROPOSALS FOR CHANGE

The current proposals to change Medicaid that have been

reported out of committee in the House and Senate[4] limit federal funding growth, substantially eliminate federal requirements for eligibility and required services, and reduce the amount of funding that must be spent on low-income families. Medicaid would change from an entitlement program with an open-ended match on state expenditures to a block grant program with fixed federal funding to states. Under the proposed reform, in 2002, states will receive almost a 40-percent increase in federal funding over 1995 levels. However, the proposal would represent a 19-percent reduction in federal funding over the 1996-2002 period relative to Congressional Budget Office (CBO) estimates of future Medicaid expenditure increases.

The House bill and Senate resolution differ in proposed federal requirements for eligibility, set-aside funding, covered services, cost-sharing for children, and performance objectives and reporting. The House bill would remove children's entitlement to services, while the Senate resolution retains entitlement for pregnant women and children up through age 12 in families with income at or below poverty level and for disabled persons, as defined by states. Both the House and Senate would require set-aside spending for low-income families, but the Senate resolution uses a larger basis.[5] Both bills remove most of Medicaid's requirements to cover specific services. Both the House bill and the Senate resolution require coverage for immunizations, and the Senate resolution requires states to cover immunizations and prepregnancy family planning services and supplies. Current law forbids states to require any cost sharing for children's services. The House bill allows cost sharing but forbids premium charges for pregnant women, children, and families below the poverty level, while the Senate resolution allows no cost sharing for services to

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[4]Sources for this information include Amendment to Committee Print of September 18, 1995 Offered by Mr. Bliley on Title XVI--Transformation of the Medicaid Program and Chairman's Mark Senate Finance Committee Recommendations to Meet the Budget Reconciliation Instructions, September 22, 1995 with List of Amendments Offered During Markup.

[5]Medicaid spending has been steadily increasing, so the Senate resolution, which uses actual fiscal year 1995 spending, represents a larger basis than the House bill, which uses average fiscal years 1992 to 1994 spending.

children. Both would require states to set and monitor performance objectives for infant mortality and children's immunization rates. The Senate resolution also requires CBO to monitor children's health insurance status. (See enclosure 4.)

STATE-FUNDED HEALTH INSURANCE PROGRAMS FOR CHILDREN

States that developed programs to insure children with their own funding have used their flexibility to design programs that differ from Medicaid and also differ from each other in some ways. On the basis of our classification of programs surveyed by the National Governors' Association,[6] 15 states have publicly funded programs to insure children that generally relied heavily on state funding.

We studied four state-funded programs,[7] one of which has since become incorporated into a Medicaid demonstration waiver. The programs we visited were designed with fixed and limited budgets. These programs do not entitle children to services; and when enrollment becomes too great for their funding, they stop enrolling children. Except for Minnesota, all of the programs we visited have been forced to close enrollment at some times.

The state-funded programs sometimes have more limited benefit coverage than Medicaid, but at a minimum they cover preventive and primary care and prescription drugs. New York does not cover--and Pennsylvania limits--inpatient care. Both programs depend on Medicaid to cover such care for enrolled children if needed. Pennsylvania's Children's Health Insurance Program is designed to work with the state Medicaid's Medically Needy program and only covers children for 90 days of inpatient care if their families cannot qualify for Medicaid. Minnesota and Florida have a more comprehensive benefits package that

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[6]Deborah F. Perry, Providing Health Insurance Coverage to Uninsured Children, Issue Brief, National Governors' Association (Washington, D.C.: 1995) and Deborah F. Perry, Innovative State Health Initiatives for Children, StateLine, National Governors' Association (Washington, D.C.: 1995).

[7]Florida's Healthy Kids program, Minnesota's MinnesotaCare (now part of a Medicaid 1115 waiver), New York's Child Health Plus program, and Pennsylvania's Children's Health Insurance Program.

includes inpatient and outpatient care, prescription drugs, and other services.

State-funded programs require cost sharing, but most either limit premium costs for the lowest income families or charge none. New York and Pennsylvania charge no premium to families in their lowest income brackets; Minnesota and Florida charge all families some part of the premium.[8] The state-funded programs also do not charge copayments for outpatient visits. Three of the four charge copayments for prescription drugs, and some have other copayments. (See enclosure 5.)

In addition to limiting services covered and requiring cost sharing, the programs we visited use managed care. Most or all of the children in the programs we visited are enrolled in managed care through health maintenance organizations. With the exception of Minnesota, the other three programs have most or all of their children enrolled in managed care and paid insurers fixed, lump-sum payments to cover needed health services. Minnesota is planning to transition to managed care in 1996.

SUMMARY

As previously reported, changes to the Medicaid program that remove guaranteed eligibility and change the financing and responsibilities of the federal and state governments may strongly affect health insurance coverage for children in the future. Since 1987, the percentage of children with employment-based insurance has steadily declined and the trend may continue. Changes to Medicaid that result in reducing the number of children covered--without any accompanying changes in the health insurance market either to encourage employers to provide dependent insurance or to encourage families to purchase insurance or to provide other coverage options for children--could lead to a significantly increased number of uninsured children in the future.

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Because the information in this correspondence was summarized from previous GAO work, for which we obtained comments, we did not obtain comments on this correspondence from HCFA or the state-funded programs.

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[8]Most families are in the lowest income brackets for the New York, Pennsylvania, and Florida programs; Minnesota could not provide us with a breakdown by income.

The information in this correspondence was prepared by Sheila Avruch, Paula Bonin, Marie Cushing, and Jay Goldberg. Should you have further questions about this information, please contact Sheila Avruch at (202) 512-7277.

Sincerely yours,

Mark V. Nadel
Associate Director
Public Health Issues

Enclosures - 5

CHANGE IN PERCENTAGE OF POOR, NEAR-POOR, AND ABOVE NEAR-POOR CHILDREN WHO HAD DIFFERENT TYPES OF INSURANCE OF WERE UNINSURED, 1989 AND 1993

Health insurance of child	Family income by poverty level			
Poor[a]				
	Percent 1989	Percent 1993	Percentage point difference	Percent change
Employment-based	17.8	14.0	-3.9[b]	-22
Medicaid	50.7	61.3	+10.6[b]	+21
CHAMPUS[c]	1.0	0.9	-0.1	-8
Private/ individually purchased	5.4	3.8	-1.6[b]	-30
Uninsured	25.0	20.1	-5.0[b]	-20
Total	100	100		
Near-poor[d]				
Employment-based	46.9	40.6	-6.2[b]	-13
Medicaid	13.7	24.9	+11.2[b]	+82
CHAMPUS[c]	3.2	2.4	-0.8	-25
Private/ individually purchased	9.7	7.6	-2.1[b]	-22
Uninsured	26.5	24.5	-2.0	-8
Total	100	100		
Above near-poor[e]				
Employment-based	80.2	77.4	-2.8[b]	-4

Medicaid	1.7	3.1	+1.5[b]	+88
CHAMPUS[c]	2.5	2.0	-0.5[b]	-21
Private/ individually purchased	8.1	8.4	+0.3	+4
Uninsured	7.5	9.1	+1.6[b]	+21
Total	100	100		
All U.S. children				
Employment-based	63.2	57.6	-5.6[b]	-9
Medicaid	13.6	19.9	+6.3[b]	+46
CHAMPUS[c]	2.2	1.8	-0.5[b]	-21
Private/ individually Purchased	7.7	7.2	-0.5	-7
Uninsured	13.3	13.5	+0.1	+1
Total	100	100		

Note: Column totals may not add to exactly 100 percent due to rounding. Percentages may not exactly compute due to rounding.

[a]Poor families have income at or below 100 percent of the federal poverty level.
[b]Statistically significant at the .05 level.
[c]Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
[d]Near-poor families have income between 101-150 percent of the federal poverty level.
[e]Above near-poor families have income above 150 percent of the federal poverty level.

PERCENT OF CHILDREN UNINSURED, BY STATE, 1993

Less Than 10 Percent

10-17 Percent

Above 17 Percent

PERCENT OF CHILDREN ON MEDICAID, BY STATE, 1993

Less Than 10 Percent

10-17 Percent

Above 17 Percent

COMPARISON OF CURRENT MEDICAID PROGRAM REQUIREMENTS TO CURRENT PROPOSALS IN THE HOUSE AND SENATE THAT AFFECT CHILDREN

FEDERAL FUNDING AND ITS GROWTH

Current Requirements

Medicaid services and associated administrative costs are jointly financed by the federal government and the states. The federal share of a state's payment for services varies. The federal matching payments are open-ended: that is, no limit exists on the amount a state may receive for expenditures allowable under its approved Medicaid state plan.

House

Beginning with fiscal year 1996, federal matching payments would be limited to a fixed allotment per state.

Senate

Beginning with fiscal year 1996, federal matching payments would be limited to a fixed allotment per state.

ELIGIBILITY FOR CHILDREN

Current Requirements

States must provide Medicaid to (1) families receiving benefits under the AFDC program and to AFDC-related groups not actually receiving cash payments, (2) pregnant women and children under age 6 in families with income under 133 percent of the federal poverty level, (3) children under age 19 born after September 30, 1983, with income under the federal poverty level, and (4) disabled children who receive benefits under the Supplemental Security Income program.

House

No requirement exits that requires states to provide Medicaid to any specific group of children. States must spend a minimum of 85 percent of what had been their average total program spending during fiscal years 1992 through 1994 on mandated services to mandated nondisabled persons under age 65 on services to low-income families. A similar provision exists for the low-income disabled. Funds set aside for low-income families would have to be spent on families with income below 185 percent of the federal poverty level that included a woman or child. A state could establish a lower

set-aside percentage if it could be determined and certified to the Secretary of the Department of Health and Human Services that the health care needs of that group (and any related performance goals in the state plan) could be met with a lower expenditure level.

Senate

Requires states to cover poor pregnant women and poor children up to and including age 12 and disabled individuals. The Medicaid program is limited to persons with income below 250 percent of the federal poverty level. For families with a pregnant woman or child and for disabled individuals, states must spend a minimum of 85 percent of actual fiscal year 1995 spending on members of those mandatory populations and for mandated services.

COVERED SERVICES FOR CHILDREN

Current Requirements

States are required to provide inpatient and outpatient hospital services; physician services; laboratory and X ray services; early and periodic screening, diagnostic and treatment services to individuals under 21; family planning services; rural health clinic service and federally qualified health center service; and services of nurse midwives, certified pediatric nurse practitioners, and certified family nurse practitioners to the extent that these individuals are authorized to practice under state law. States may offer additional services, such as dental services, prescription drugs, and care in intermediate facilities for the mentally retarded.

House

States are required to provide childhood immunizations.

Senate

States are required to provide childhood immunizations and prepregnancy family planning services and supplies, as selected by the states.

COST SHARING FOR FAMILIES OF CHILDREN

Current Requirements

States may not impose deductibles or coinsurance requirements for services to children or for pregnancy-related services. Pregnant women and infants in families with income over 150 percent of the federal poverty level and certain families receiving work-transition coverage after the loss of AFDC benefits may be charged

premiums or enrollment fees.

House

States are permitted to impose premiums, copayments, coinsurance, or deductibles pursuant to a public schedule. No premium could be imposed for families that include a pregnant woman or child or for families with income less than the federal poverty level. Cost-sharing for these families has to be nominal, except for cost-sharing designed to deter inappropriate emergency services use.

Senate

States are not permitted to impose fees, premiums, copayments, or other charges on services provided to individuals under age 18 or to services related to pregnancy and family planning.

PERFORMANCE OBJECTIVES AND REPORTING

Current Requirements

Each state's Medicaid program must be operated in accordance with a state plan for medical assistance, which describes the state's basic policies for eligibility, covered benefits, payments to providers, and administration. State plans must comply with all the requirements of federal law, be amended periodically to reflect changes in law, regulation, and policy, and be approved by the Health Care Financing Administration.

House

As part of the state plan, states will identify objectives and goals for providing health care services and the manner in which the plan is designed to meet the objectives and goals. Required goals and objectives include rates of childhood immunizations and reductions in infant mortality and morbidity.

Senate

As part of the state plan, states will identify objectives and goals for providing health care services and the manner in which the plan is designed to meet the objectives and goals. Required goals and objectives include rates of childhood immunizations, reductions in infant mortality and morbidity, and standards of care and access to services for children with special health care needs. In addition, the Congressional Budget Office must prepare and submit an annual report that analyzes the effects of changes in the Medicaid program on the health insurance status of children, the elderly, and the disabled.

COMPARISON OF FAMILY COST-SHARING PROVISIONS

Program	Family premium contri-bution	Income ranges-% of federal poverty level	Contri-bution per month per child	Percent enrolled	Copay-ments	Service and amount of copayment
Florida Healthy Kids Program	Yes	0-130 131-185 over 185	$5-20[a] $13-27[a] $43-49[a]	73 14 13	Yes	Prescription drugs, $3; eyeglass lenses, $10; refractions, $3; nonauthorized emergency room visits, $10
Minnesota Care Program	Yes	0-150 151-275	$4 $4-138[b]	N/A	No	None
New York Child Health Plus Program	Yes	0-159 160-222 over 222	0 $2.08 $54.71	87 13 <1	Yes	prescription drugs $1-3 inappropriate emergency room use $35
Pennsyl-vania Children's Health Insurance Program	Yes	0-184 185-235	0 $39.75-52.64	95 5	Yes	prescription drugs $5

[a]Premium contribution varies by locale or insurer.
[b]Premium contribution varies by income level within a specified range.

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