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-95-175, 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 family of 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.

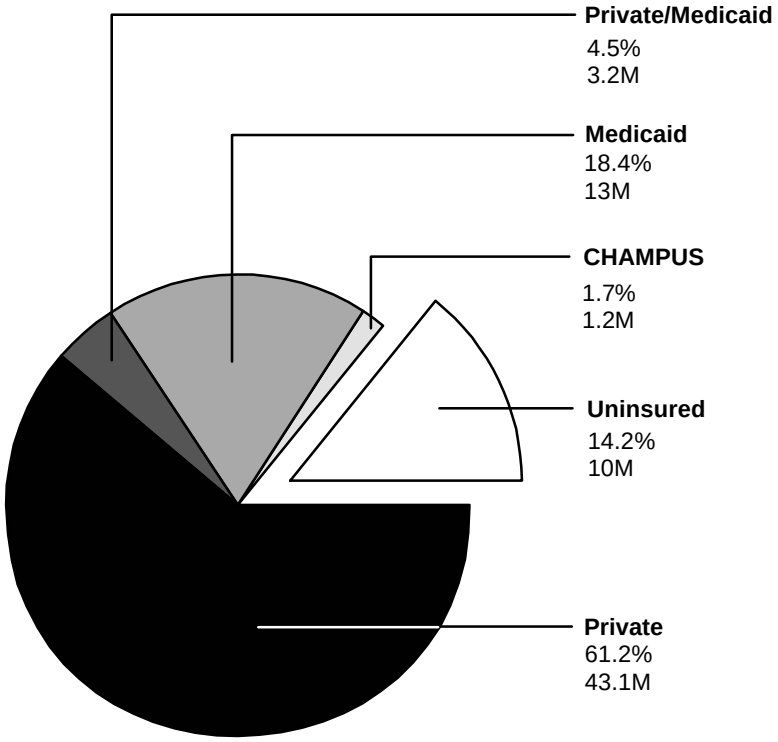
Among children whose parents are working, Medicaid continued to be an important source of insurance coverage. The Medicaid expansions in eligibility for low-income children not on welfare allowed more children of working parents to become insured through Medicaid—a trend that continued in 1994. But Medicaid 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 to federal mandate if they were from birth to 5 years old with family income at or below 133 percent of 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.

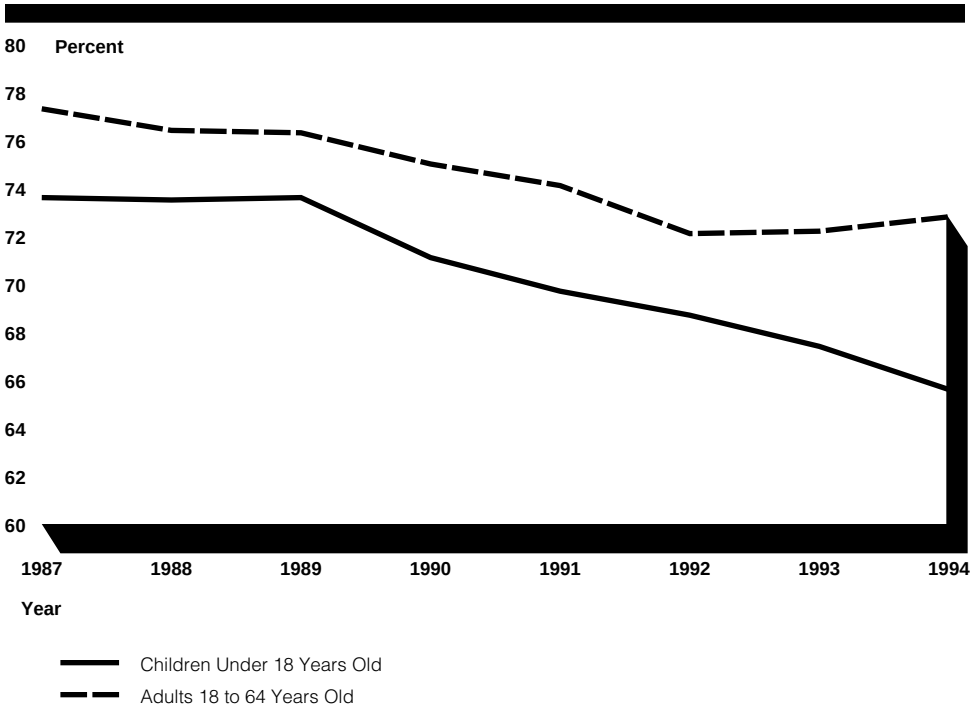
Health Insurance Coverage for Children at Lowest Reported Level Since 1987

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.)

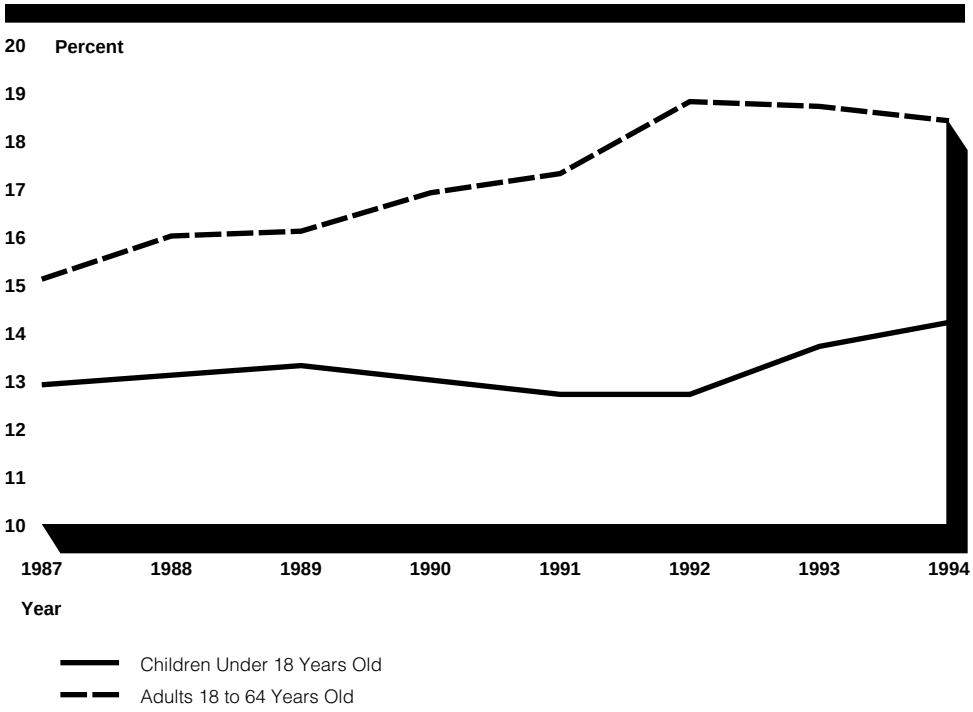
[10]These children might also have had other sources of coverage, such as Medicaid, in the same year.

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.

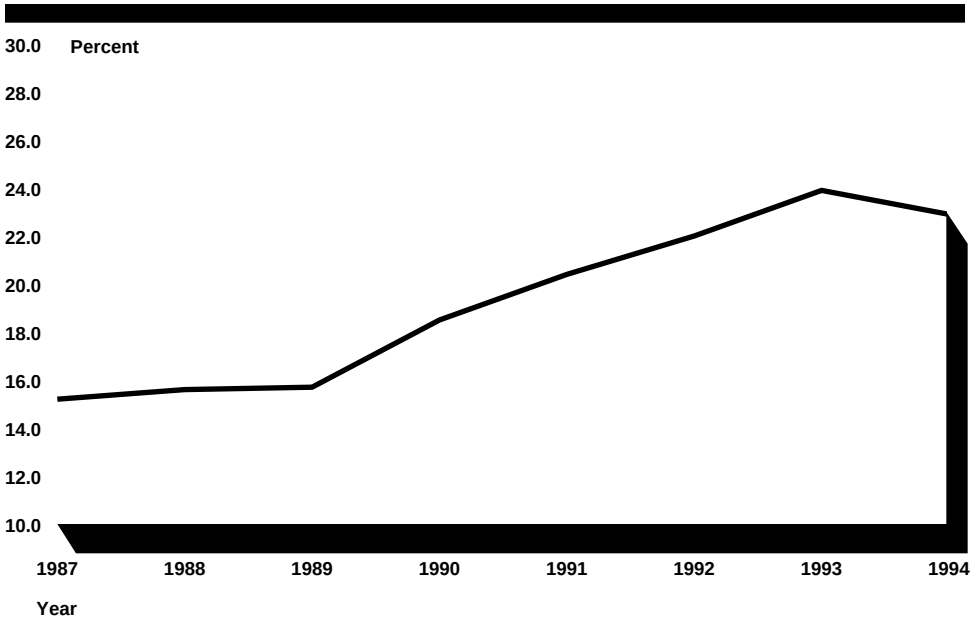
[d]Above near-poor families have incomes above 150 percent of the federal poverty level.

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.

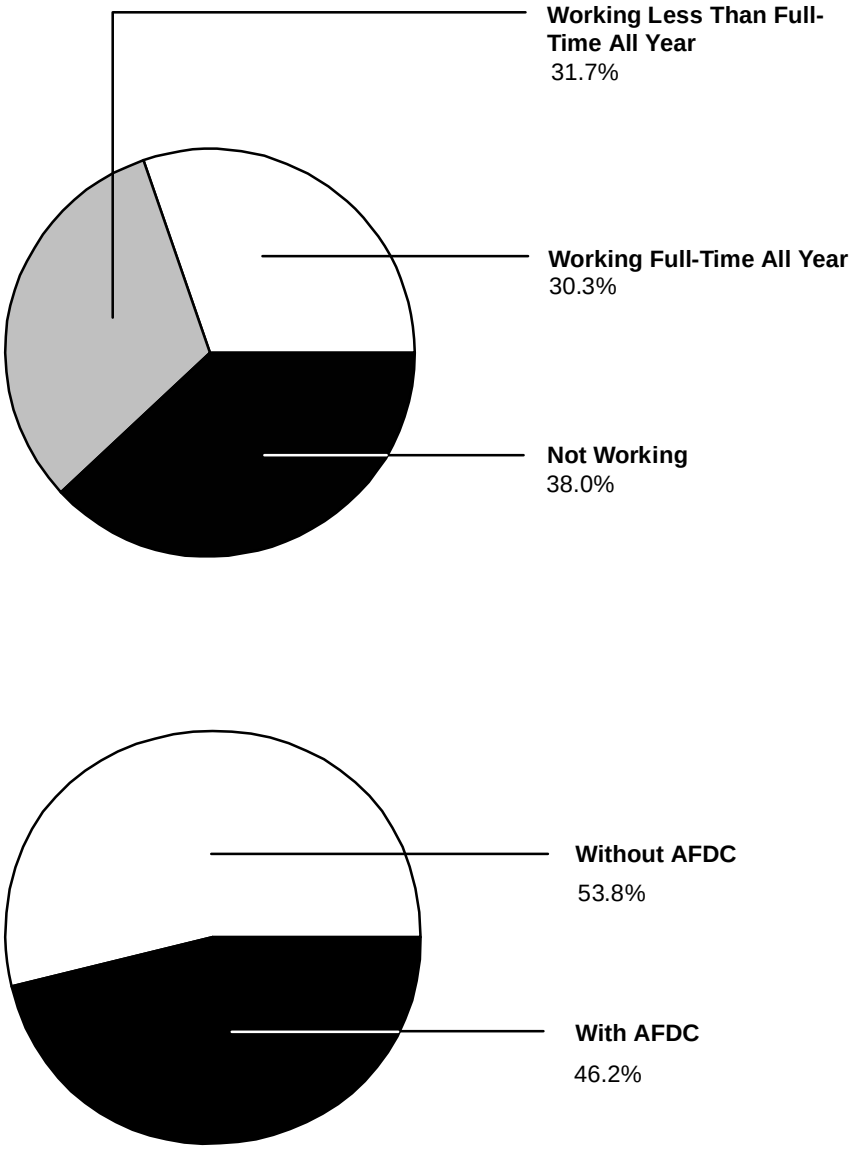
Figure 4: Estimated Medicaid Enrollment for Children Expanded Between 1989 and 1993, but Was Lower in 1994



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
Director, Health Systems Issues

Contents

Abbreviations

AFDC	Aid to Families With Dependent Children program
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CPS	Current Population Survey
HCFA	Health Care Financing Administration
HMO	health maintenance organization
WIC	Special Supplemental Food Program for Women, Infants, and Children

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	13[c]

(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.

Appendix II
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Medicaid and Children's Insurance (GAO/HEHS-96-50R, Oct. 20, 1995).

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

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995).

Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, Apr. 4, 1995).

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

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