

CHILDREN'S STATISTICS

Prepared for Neera Tanden
Office of the First Lady

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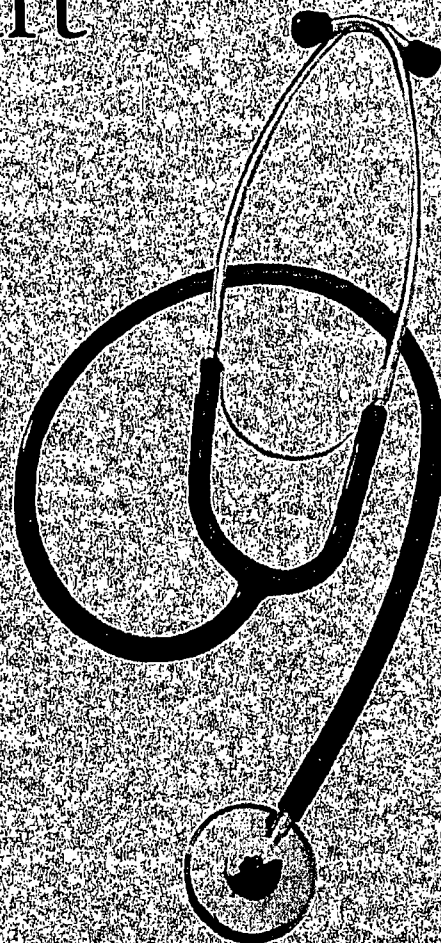
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Health Care

CHIP Check-Up:

A Healthy Start for Children



**A mid-term report on the State Children's Health Insurance Program
by the Children's Defense Fund**

CHIP Check-up: A Healthy Start for America's Children

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The information in this report is based on Children's Health Insurance Program (CHIP) plans submitted to HCFA or state statutes on CHIP passed by state legislatures as of April 30, 1998.

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May 12, 1998

IMPORTANT NOTE

The material used in this report was collected up through April 30, 1998. Since then new Children's Health Insurance Program legislation has been passed by both the Florida and Missouri legislatures, therefore the information in this report describing both Missouri and Florida does not represent the recently passed legislation.

Over the next several weeks we will be updating the CHIP Check-up: A Healthy Start for Children with the information from the approved legislation in Missouri and Florida, as well as, other states which enact CHIP legislation. Please check our web site at childrensdefense.org for updates.

Executive Summary:

CHIP Check-up: A Healthy Start for America's Children

Nine months ago, on August 5, 1997, President Clinton signed into law the largest funding expansion in children's health coverage since the adoption of Medicaid over 30 years ago. Investing \$48 billion in child health over 10 years, the Balanced Budget Act of 1997 created the State Children's Health Insurance Program (CHIP), which culminated an extraordinary, bipartisan effort by Congress and the White House and grassroots activity all across the country. This \$4 billion annual grant program now helps states cover uninsured children in low-wage, working families with incomes too high to qualify for Medicaid but too low to afford private coverage. Along with this unprecedented federal investment comes an enormous amount of state flexibility, so whether the legislation achieves its goals depends on state implementation.

This report looks at the 43 states that, by April 30, 1998, either completed state legislative activity around CHIP implementation or submitted plans to the Health Care Financing Administration (HCFA) for approval. They include 41 states adopting or proposing policies and two states that rejected CHIP implementation for 1998. Most states are implementing CHIP in a positive fashion that bodes well for the health of America's children. However, there are several areas of concern that will be important to monitor as the program unfolds.

Positive developments

- **Most states are acting boldly to help large numbers of uninsured children.** Of 41 states with CHIP plans, 20 states – nearly half – cover children up to or even above the general ceiling for CHIP, 200 percent of the federal poverty level (\$27,300 for a family of three).¹
- **Most states are basing covered benefits on children's unique health needs.** Among the 38 states that have made decisions about covered benefits, 25 states (66 percent) cover all or almost all Medicaid benefits.² Medicaid offers one of the country's very few health benefit packages developed with children in mind.

Many states have pursued creative approaches to gaining the advantages of building on Medicaid. Nine states are implementing so-called "Medicaid look-alike programs."³ With a Medicaid look-alike program, covered children do not receive any entitlement to coverage, but they do receive the Medicaid benefits package. States and parents also gain from using an existing administrative structure for new children, rather than creating an entirely new program in addition to Medicaid. (Of course, other states have chosen different routes to reach these goals, and some have done an excellent job.)

- **Most states forbid premiums and copays for the poorest CHIP children** —particularly those whose parents earn less than \$20,475 for a family of three, or 150 percent of the federal poverty level. Among 32 states with policies on premiums or copays for such children, 24 states (75 percent) exempt them from premiums, and 26 states (81 percent) bar copays.⁴

¹California; Connecticut; Georgia; Kansas; Kentucky; Maryland; Massachusetts; Michigan; Minnesota; Missouri; Nevada; New Jersey; New Mexico; New York; North Carolina; Pennsylvania; Rhode Island; Tennessee; Utah; Vermont.

²Alabama; Georgia; Idaho; Illinois; Indiana; Kansas; Louisiana; Maine; Maryland; Minnesota; Mississippi; Missouri; Nebraska; New Jersey; Ohio; Oklahoma; Oregon; Rhode Island; South Carolina; South Dakota; Tennessee; Texas; Vermont; Virginia; Wisconsin.

³Georgia; Kansas; Maine; Maryland; Massachusetts; Mississippi; New Jersey; Oregon; Virginia.

⁴These are states that cover any children with incomes between 100 and 150 percent of poverty. They include Illinois, Louisiana and South Dakota, which charge no covered children but cover children only up to 133% of poverty. In addition, the following states charge neither premiums or copays to covered children with family incomes at or below 150% of poverty: Connecticut, Idaho, Indiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Nebraska, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South

Worrisome trends

- **Slow start-up.** Few states have begun actually covering large numbers of new children. While such delays are understandable, it is unfortunate that more states did not rise to the challenge of covering uninsured children soon after federal money became available.
- **Some states are helping few children.** For example, nearly one in six uninsured children – almost 2 million – live in the three states that have done nothing more than cover teenagers with incomes below the poverty level, whose Medicaid coverage current federal law would soon require anyway.⁵
- **Some states are charging unaffordable amounts to low-wage, working families.** For example, nine states charge \$200 a year or more in premiums to low-wage, working families with two children eligible for CHIP.⁶ Nearly a third of all uninsured children, 3.4 million, live in these nine states. Because of financial barriers, many will not be enrolled in CHIP.
- **Some states are overreacting to fears that public subsidies will cause losses in employer coverage.** For example, 15 states will force uninsured children to wait for coverage between three and 12 months after losing insurance formerly provided through their parents' job.⁷
- **States face serious challenges combining Medicaid and non-Medicaid programs.** As many as 24 of 41 states (59%) implementing CHIP and described in this report eventually could simultaneously cover some children with Medicaid and others with a separate program.⁸ Coordinating these different programs is a vital but difficult task. For example, within each family, all children should be in the same program; children must not be forced to change doctors when family income changes and eligibility shifts between programs; and when working parents seek help for their children, they should encounter a simple system that is easy to use, without being bounced from agency to agency.

These issues are still in play in a number of task forces and state legislatures and numerous state agencies. Friends of children's health must remain focused on ensuring that this generation's new health care system for children meets children's needs. But it is not enough to enact good policies on paper. The ultimate test will be enrolling eligible children. Effective, committed action by all of us --government officials, civic and community organizations, service providers, advocates, religious congregations, private companies, parents, teachers and young people themselves-- is needed for the CHIP program to realize its potential.

Regional data. March 1997 Census Bureau data show some regional differences among uninsured children. For example, the South includes 34 percent of all children but 42 percent of all uninsured children. However, in each region of the country, the most important facts are the same: many children lack coverage; nine in ten uninsured children have working parents; roughly two-thirds have family incomes above the poverty line; and most live in two parent families. It is imperative that state officials make the most of this extraordinary opportunity to give these children a healthy start.

Carolina, Virginia, and Wisconsin; the following charge premiums but no copays: Georgia, Minnesota, Montana and Nevada; and the following charge copays but no premiums: New York and Utah.

⁵Alabama; Mississippi; Texas. Additional, future expansions may occur in these states.

⁶California; Colorado; Kentucky; Maine; Massachusetts; Nevada; New York; Tennessee; Wisconsin.

⁷California; Colorado; Connecticut; Kansas; Maine; Maryland; Michigan; Missouri; Montana; Nevada; New Jersey; North Carolina; Oregon; Utah; Wisconsin.

⁸Alabama; California; Colorado; Connecticut; Florida; Idaho; Illinois; Indiana; Iowa; Kentucky; Louisiana; Massachusetts; Michigan; Mississippi; Montana; Nevada; New Mexico; New York; North Carolina; Ohio; Pennsylvania; Texas; Utah; West Virginia.

Introduction

Nine months ago, on August 5, 1997, President Clinton signed into law the largest funding expansion in children's health coverage since the adoption of Medicaid over 30 years ago. Investing \$48 billion in child health over 10 years, the Balanced Budget Act of 1997 created the State Children's Health Insurance Program (CHIP), which culminated an extraordinary, bipartisan effort by Congress and the White House and grassroots activity all across the country. This \$4 billion annual grant program now helps states cover uninsured children in low-wage, working families with incomes too high to qualify for Medicaid but too low to afford private coverage. Along with this unprecedented federal investment comes an enormous amount of state flexibility, so whether the legislation achieves its goals depends on how states implement it.

On October 1, 1997, the first year's grants became available to states. More than seven months have passed, and most states' regular legislative sessions have ended. This is a good time to pause and take stock of how the states are doing.

This report finds that most states are implementing CHIP in a positive fashion that bodes well for the health of America's children. However, there are several areas of concern that will be important to monitor as the program unfolds.

We base our conclusions on an analysis of the 43 states that, by April 30, 1998, either completed state legislative activity around CHIP implementation or submitted plans to the Health Care Financing Administration (HCFA) for approval. They include 41 states adopting or proposing policies and two states that rejected CHIP implementation for 1998. This report does not examine state legislation adopted after April 30, 1998 or pending legislation not yet adopted.

Our report has several sections:

- First, a national overview of some of the most important trends in state CHIP implementation;
- Second, tables ranking the states on specific, critical policy decisions; and
- Third, regional tables providing information about uninsured children derived from the Census Bureau's March 1997 Current Population Survey.

Our analysis is based on state plans sent to HCFA and on state statutes. In some states, events have moved beyond these documents. Wherever possible, we have supplemented this analysis by seeking information from advocates and officials in the states. There is no guarantee that this process brought to our attention all important developments, however, so the following analysis may not fully reflect other policy changes that have taken place since the adoption of state statutes or the filing of state plans. For further information about the state policies we analyzed, see the methodological note that accompanies the tables.

A National Overview of CHIP Implementation

Many positive developments are apparent:

- **Most states are acting boldly to help large numbers of uninsured children.** Of 41 states proposing income eligibility standards, 20 states – nearly half – cover children up to or even above the general CHIP ceiling, 200 percent of the federal poverty level (\$27,300 for a family of three). Another eight states cover children up to 185 percent of poverty (\$25,253), one of the highest levels reached by states through Medicaid before CHIP. (See Table 2.) All but two states cover children through age 18, rather than end coverage at younger ages. (See Table 1a.)
- **Most states are basing covered benefits on children's unique health needs and building creatively on existing programs.** Typical commercial insurance was developed for working adults, not children. It often denies coverage of services that children need, like eyeglasses required to see the blackboard and hearing aids needed to hear the teacher in school. Among the 38 states that have made a decision about covered benefits, 25 (66 percent) used the Medicaid benefits package (with relatively small adjustments in a few cases). (See Table 1b.) Medicaid now serves more than one in four American children, and it has one of the country's very few health benefit packages developed with children in mind. It focuses heavily on preventive care for most children and authorizes comprehensive services when required by children with special health care needs.

Many states have pursued creative approaches to gaining the advantages of building on Medicaid. While the most important advantage of Medicaid is its child-friendly benefits, Medicaid has other attractive features as well: it is much easier for parents to work with a single program rather than multiple programs; Medicaid programs have existing statewide structures that consume only 4.2 percent of program expenditures, on average;¹ and Medicaid's role as each state's largest purchaser of children's health care gives the state the leverage to get better deals for the taxpayers while providing more comprehensive health care to children.

Against these practical concerns is the political argument against expanding any government "entitlement program." Nine states have addressed that concern by proposing or adopting so-called "Medicaid look-alike programs." (See Table 1b.)² Such a program offers

¹ By contrast, California officials expect that first-year administrative costs for that state's separate program could consume 25 percent or more of first year CHIP spending. Similarly, although Colorado proposes to expand its existing non-Medicaid program, rather than create a new one from scratch, during the first year it projects spending roughly as much state money on administration as on children's health coverage.

² In addition to the states categorized on this table as Medicaid look-alikes, Maryland plans to implement a Medicaid look-alike for higher-income children beginning in 1999; and Massachusetts provides Medicaid look-alike coverage for higher-income children without access to employer coverage.

children no entitlement. It does provide Medicaid benefits, using Medicaid's administrative structure, and often using Medicaid's networks of health plans and providers.³

Of course, other states have chosen different routes to reach these goals, and some have done an excellent job, without major Medicaid expansions. Connecticut, for example, provides good benefits and has taken significant steps, described below, to create a family-friendly system where parents seeking help for their children simply apply for assistance without worrying about the distinctions between different child health programs.

However, it is noteworthy that only nine of 41 states (22 percent) propose creating or expanding separate state programs with no Medicaid expansion.⁴ Four of these nine states are simply expanding previous state programs. (See Table 1b.)

- **Most states forbid cost-sharing for the poorest CHIP children** – particularly those whose parents earn less than \$20,475 for a family of three, or 150 percent of the federal poverty level. Among 32 states with policies on premiums and copayments that parents with incomes between 100 percent and 150 percent of poverty must pay, 24 states (75 percent) exempt these children from premiums, and 26 states (81 percent) exempt them from copayments.⁵ (See Tables 7 and 9.) Such cost-sharing policies help these children gain, not just an insurance card, but affordable access to care.
- **Some states are taking promising and innovative approaches to tough problems. For example:**
 - ◊ North Carolina has struck a balance between demands for personal responsibility from CHIP parents and the fact that many of these parents lack disposable income. North Carolina asks such parents with incomes above 150 percent of poverty to pay modest, annual enrollment fees -- \$50 per child. Such an annual, "up front" approach also avoids the administrative challenges and costs of assessing and collecting monthly premiums.
 - ◊ On another vexing issue – assuring that children do not fall between the cracks when a state uses two different programs to deliver health coverage – Connecticut simplifies Medicaid eligibility so all children through age 18 are eligible up to a single, common family income level; uses the same public name for both the separate program and Medicaid for children to minimize confusion; uses a single contractor for outreach to all uninsured children, whether they ultimately enroll in Medicaid or the separate program;

³ Of course, because it does not provide an entitlement, such an approach has two key disadvantages: it may put eligible, sick, low-income children on waiting lists rather than into doctor's offices; and states lose the federal government's guaranteed commitment to help pay program costs (even if, after CHIP allocations are exhausted, federal reimbursement is only at the standard Medicaid rate).

⁴ These include two states combining a separate state program with early Medicaid coverage of poor teenagers whose Medicaid coverage will soon be required under current federal law (so-called "Waxman children").

⁵ These include three states that charge no covered children but reach children only up to 133% of poverty.

and allows all families to mail their applications to the enrollment contractor, who makes sure they are processed by the appropriate agency.

◇ Utah has made the very practical proposal that joint CHIP/Medicaid applications should be processed first for Medicaid and later for CHIP. This is a feasible and easily administered approach to meeting the federal requirement that Medicaid-eligible children must be enrolled in Medicaid, rather than simply referred to Medicaid.

◇ Wisconsin apparently will use employers' wage withholding systems, rather than requiring monthly checks from the family, to collect premiums, with a higher expected rate of compliance and lower state administrative costs (albeit some potential for higher employer costs).

Some worrisome trends are important to monitor, however:

- **Slow start up.** Although CHIP funding was available in October 1997, most states will not implement new coverage of large numbers of children until July 1998 or even later. While such delays are understandable, it is unfortunate that more states did not rise to the challenge of very rapid CHIP implementation.⁶ Sick children forced to go without needed medical care for even short periods can experience, and doubtless have experienced, irreversible harm.
- **Some states are not yet acting to help large numbers of children.** Unfortunately, such states include large numbers of uninsured children. For example, nearly one in six uninsured children -- almost 2 million -- live in the three states -- Alabama, Mississippi, and Texas -- that stopped, for this year, at 100 percent of poverty. These states did no more than speed up the coverage of poor teenagers whose Medicaid coverage is already being phased in under current law. Two other states -- Wyoming and Washington -- made express legislative decisions not to implement CHIP in 1998. Washington's legislature turned down two opportunities to expand coverage, including one focused solely on uninsured children with special health care needs. Uninsured children in these states will suffer needless harm, as state officials turn away federal money available on generous terms to help uninsured children in low-wage, working families.
- **Some states are charging unaffordable amounts.** For example, nine states charge \$200 a year or more in premiums to low-wage, working families eligible for CHIP. (See Table 5.) Many such families will be unable to pay these premium costs. Altogether, 3.4 million uninsured children, or nearly a third of all uninsured children, live in these nine

⁶ Many states could have moved faster by (a) calling special legislative sessions and (b) at least as an interim measure, simply expanding existing programs, rather than creating new programs for children's health insurance.

states. Unless premium costs are reduced, many of these children will never benefit from CHIP, because they will not be enrolled.

- **Some states are overreacting to fears that private coverage will drop** because of expanded public help for uninsured children, a concern called “crowd-out.” Fifteen states will force at least some uninsured children to wait for coverage between three and 12 months after they lose insurance formerly provided through their parents’ employment. Another five states may deny coverage to uninsured children on the grounds that their parents should be able to pay the cost of coverage through work. (See Table 11.) Given the substantial, recent evidence that the original crowd-out claims may have been exaggerated,⁷ it is a shame that children will go without necessary health coverage because of these claims.
- **Some states are face challenges effectively combining Medicaid and non-Medicaid programs.** As many as 24 states surveyed in this report eventually may cover simultaneously some children with Medicaid and others with a separate program. In many of these states, different children in a single family can be in different programs with different health plans, based solely on their age; a change in family income can move a child from one program to the other, bouncing from one doctor to the next; parents may be asked to make complex calculations to ascertain the program for which their children may qualify so they can apply to the right agency; children denied coverage under a separate program because of likely Medicaid eligibility are sometimes simply referred to Medicaid, rather than enrolled in Medicaid, and can easily drop out of the application process when presented with long, complex forms and burdensome paperwork requirements. To achieve the basic purpose of the CHIP legislation and actually reach eligible children, states must create family-friendly systems that are easy for hard-working parents to use.

Two final points are important to keep in mind:

- **First, key issues are still in play in many states.** Legislatures and executive branch agencies in states like Arizona, Delaware, New Hampshire, North Dakota and the District of Columbia are still developing and debating their initial CHIP plans. Some state legislatures adopting CHIP bills delegated tremendous authority to administrative agencies to determine such fundamental matters as income eligibility, covered benefits, charges to

⁷ E.g., Thiede C.K., et al. (1997). Who Is Still Uninsured in Minnesota? Lessons From State Reform Efforts. *Journal of the American Medical Association*, 278, 1191-1195, finding that only 3 percent of MinnesotaCare enrollees had employer sponsored insurance before going on the program; Shenkman E., et al., (1997, Sept.) The Florida Healthy Kids Program: Are There Indications of Crowd Out? Institute for Child Health Policy, concluding that only 2 percent of children in Florida’s Healthy Kids program had previous employer coverage; Chollet, D.J., et al. Detering Crowd-Out in Public Insurance Programs: State Policies and Experiences, A Report from the Robert Wood Johnson Alpha Center, October 1997, finding that officials with experience running state health programs did not believe crowd-out was a serious problem for children’s health insurance programs or programs serving adults up to 200 percent of poverty.

low-income families, and even, in two states (Kentucky and New Mexico), whether Medicaid or a separate program should be used. In short, child health advocates must remain vigilant and engaged as this generation's new health care system for children is put in place.

- Second, the ultimate test will be enrolling eligible children. It is not enough to enact good policies on paper. Already, millions of uninsured children are eligible for Medicaid but are not enrolled. It will take a tremendous joint effort by all of us -- local, state, and federal government officials, private corporations, churches, mosques and synagogues, schools, day care providers, community organizations of all types, parents, teachers, and young people themselves -- to get the word out and get children into health care.

Regional information. The issue of uninsured children in low-wage, working families is very much alive in every section of the country. Although some of the particulars change from region to region -- for example, the South includes 34 percent of all children but 42 percent of all uninsured children -- the basic facts remain constant: a large number of children are uninsured; 90 percent of these children have working parents; two-thirds have parents who work full-time and year-round; most live in two parent families; two in three have family incomes above the poverty line; and the largest number of uninsured children are White, though a disproportionately high percentage of Black and Latino children are uninsured. It is imperative that state officials in every part of the country make the most of this once in a generation opportunity to give millions of children a healthy start in life.

A CHIP Check-Up: How have states done so far?

✓✓✓✓✓ = Highest rating
✓ = Lowest rating

State	Coverage	Affordability	Benefits	Family Friendliness
Alabama*	✓	✓	✓✓✓✓✓	✓✓✓
California	✓✓✓✓	✓	✓✓✓	✓
Colorado	✓✓✓	✓	✓✓	✓✓✓
Connecticut	✓✓✓✓	✓✓✓✓✓	✓✓✓✓	✓✓✓✓✓
Florida***	✓✓✓	✓	✓✓	✓
Georgia	✓✓✓✓	✓✓✓	✓✓✓✓	✓✓✓✓
Idaho	✓✓	✓✓✓✓	✓✓✓✓✓	✓✓✓
Illinois**	✓	✓✓✓	✓✓✓✓✓	✓✓✓✓✓
Indiana*	✓✓	✓✓✓✓	✓✓✓✓✓	✓✓✓
Iowa	✓✓✓	TBD	TBD	✓✓✓
Kansas	✓✓	TBD	✓✓✓✓✓	✓✓✓✓
Kentucky	✓✓✓✓	✓	TBD	TBD
Louisiana*	✓	✓✓✓	✓✓✓✓✓	✓✓✓✓✓
Maine	✓✓✓	✓✓✓✓	✓✓✓✓✓	✓✓✓✓
Maryland	✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓
Massachusetts**	✓✓✓✓	✓✓✓	✓	✓✓✓✓
Michigan	✓✓✓	✓✓✓✓✓	✓✓✓✓	✓✓✓✓
Minnesota	✓✓✓✓✓	N/A	✓✓✓✓✓	✓✓✓✓
Mississippi*	✓	✓	✓✓✓✓✓	✓✓✓✓✓
Missouri**	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓	✓✓✓✓✓
Montana	✓✓	✓✓	✓	✓✓
Nebraska	✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓
Nevada	✓✓✓	✓✓	✓✓	✓✓
New Jersey	✓✓✓	✓✓✓	✓✓✓✓	✓✓✓✓✓
New Mexico	✓✓✓✓✓	TBD	TBD	✓✓✓✓✓
New York**	✓✓✓✓✓	✓✓	✓	✓✓

State	Coverage	Affordability	Benefits	Family Friendliness
North Carolina	✓✓✓	✓✓✓	✓✓✓✓	TBD
Ohio*	✓✓	✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓
Oklahoma**	✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓
Oregon	✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓
Pennsylvania**	✓✓✓✓✓	✓✓✓✓✓	✓✓	✓✓
Rhode Island*	✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓
South Carolina	✓✓	✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓
South Dakota	✓	✓✓✓	✓✓✓✓✓	✓✓✓✓
Tennessee	✓✓✓✓	✓	✓✓✓✓✓	✓✓✓✓
Texas*	✓	✓	✓✓✓✓✓	✓✓✓
Utah	✓✓✓✓	✓✓✓	✓✓	✓✓✓
Vermont	✓✓✓✓✓	N/A	✓✓✓✓✓	✓✓✓✓✓
Virginia	✓✓✓	✓✓✓✓	✓✓✓✓✓	TBD
West Virginia	✓✓	TBD	✓✓✓	✓✓✓
Wisconsin	✓✓	✓✓✓✓	✓✓✓✓✓	✓✓✓✓

*Future expansions are under discussion.

**Legislative action is pending.

***Statute adopted after 4/30/98 is not incorporated into this analysis.

NOTES: (1) Ratings for coverage are based on maximum income eligibility, crowd-out policies, and age restrictions. (2) Ratings for affordability are based on the income level through which copayments and premiums are not charged and premium and copayment levels in specific income ranges. (3) Ratings for benefits are based on divergence from Medicaid services and limits on vision, hearing, dental, mental health, substance abuse, durable medical equipment, and rehabilitation therapy services. (4) Ratings for family friendliness are based on whether different children within a family can be split between programs, whether the same plans and providers serve multiple programs, whether children are enrolled in Medicaid when turned down by separate programs because of apparent Medicaid eligibility, whether multiple programs use the same application form and the same marketing and outreach program, whether applications are short and may be mailed in, and whether applicants must prove the value of family assets. (5) States marked N/A previously covered children through age 18 with family incomes up to and above 200% of poverty. Their affordability policies for comparatively higher-income CHIP children may not be comparable to other states. (6) Matters marked "TBD" are to be determined by state officials.

APPENDIX

TABLES

Table 1a
CHIP IMPLEMENTATION IN THE STATES: SUMMARY CHART

State	Eligibility & Structure		Premiums			Copayments:					Benefits
	Maximum age covered	Maximum % poverty covered	Maximum % poverty for no premium	for 2 children:		Maximum % poverty for no copays	Acute care physician visits		Prescriptions (generic)		Type
				Maximum annual premiums			100-149%	150-200%	100-149%	150-200%	
				100-149%	150-200%		100-149%	150-200%	100-149%	150-200%	
Alabama	18	100%	100%	n/a	n/a	100%	n/a	n/a	n/a	n/a	A
California	18	200%	100%	\$168	\$216	100%	\$5.00	\$5.00	\$5.00	\$5.00	C
Colorado	18	185%	100%	\$180	\$360	100%	\$2.00	\$5.00	\$1.00	\$3.00	C
Connecticut	18	300%	235%	\$0	\$0	185%	\$0.00	\$5.00	\$0.00	\$0.00	A/C
Florida**	18	185%	100%	\$180	\$180	100%	\$3.00	\$3.00	\$3.00	\$3.00	C
Georgia	18	200%	100%	\$180	\$180	200%	\$0.00	\$0.00	\$0.00	\$0.00	B
Idaho*	18	160%	160%	\$0	\$0	160%	\$0.00	\$0.00	\$0.00	\$0.00	A
Illinois*	18	133%	133%	\$0	n/a	133%	\$0.00	n/a	\$0.00	n/a	A
Indiana	18	150%	150%	\$0	n/a	150%	\$0.00	n/a	\$0.00	n/a	A
Iowa	18	185%	tbd	tbd	tbd	tbd	tbd	tbd	tbd	tbd	A/tbd
Kansas	18	200%	tbd	tbd	tbd	tbd	tbd	tbd	tbd	tbd	A
Kentucky	18	200%	100%	\$40	\$240	100%	tbd	tbd	tbd	tbd	tbd
Louisiana	18	133%	133%	\$0	n/a	133%	\$0.00	n/a	\$0.00	n/a	A
Maine	18	185%	150%	\$0	\$342	185%	\$0.00	\$0.00	\$0.00	\$0.00	A
Maryland	18	200%	200%	\$0	\$0	200%	\$0.00	\$0.00	\$0.00	\$0.00	A
Massachusetts*	18	200%	150%	\$0	\$240	150%	\$0.00	no limit*	\$0.00	no limit*	A/D
Michigan	18	200%	150%	\$0	\$60	200%	\$0.00	\$0.00	\$0.00	\$0.00	A/C
Minnesota	18	275-280%	n/a	n/a	n/a	275-280%	\$0.00	\$0.00	\$0.00	\$0.00	A
Mississippi	18	100%	100%	n/a	n/a	100%	n/a	n/a	n/a	n/a	A
Missouri*	18	300%	300%	\$0	\$0	300%	\$0.00	\$0.00	\$0.00	\$0.00	B
Montana	18	150%	100%	\$100	n/a	150%	\$0.00	n/a	\$0.00	n/a	D

Table 1a (cont)

State	Eligibility & Structure		Premiums			Copayments:					Benefits
	Maximum age covered	Maximum % poverty covered	Maximum % poverty for no premium	for 2 children:		Maximum % poverty for no copays	Acute care physician visits		Prescriptions (generic)		Type
				Maximum annual premiums 100-149%	150-200%		100-149%	150-200%	100-149%	150-200%	
Nebraska	18	185%	185%	\$0	\$0	185%	\$0.00	\$0.00	\$0.00	\$0.00	A
Nevada	18	200%	100%	\$50	\$200	150%	\$0.00	\$0.00	\$0.00	\$5.00	C
New Jersey	18	200%	150%	\$0	\$180	150%	\$0.00	\$5.00	\$0.00	\$1.00	A/B
New Mexico	18	235%	tbd	tbd	tbd	tbd	tbd	tbd	tbd	tbd	tbd
New York*	18	222%	150%	\$0	\$312	100%	\$2.00	\$2.00	\$1-\$3	\$1-\$3	D
North Carolina	18	200%	150%	\$0	\$100	150%	\$0.00	\$5.00	\$0.00	\$6.00	C
Ohio	18	150%	150%	\$0	n/a	150%	\$0.00	n/a	\$0.00	n/a	A
Oklahoma*	17	185%	185%	\$0	\$0	185%	\$0.00	\$0.00	\$0.00	\$0.00	A
Oregon	18	170%	170%	\$0	\$0	170%	\$0.00	\$0.00	\$0.00	\$0.00	A
Pennsylvania*	18	235%	200%	\$0	\$0	200%	\$0.00	\$0.00	\$0.00	\$0.00	C
Rhode Island	17	250%	185%	\$0	\$63	185%	\$0.00	\$5.00	\$0.00	\$2.00	A
South Carolina	18	150%	150%	\$0	n/a	150%	\$0.00	n/a	\$0.00	n/a	A
South Dakota	18	133%	133%	\$0	n/a	133%	\$0.00	n/a	\$0.00	n/a	A
Tennessee	18	200%	100%	\$564	\$786	100%	\$1.25	\$1.25	\$1.50	\$1.50	A
Texas	18	100%	100%	n/a	n/a	100%	n/a	n/a	n/a	n/a	A
Utah	18	200%	200%	\$0	\$0	100%	\$5.00	\$10.00	\$1.00	\$1.00	C
Vermont	18	300%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	A
Virginia	18	185%	150%	\$0	tbd	150%	\$0.00	tbd	\$0.00	tbd	A
West Virginia	18	150%	tbd	tbd	n/a	tbd	tbd	n/a	tbd	n/a	A/C
Wisconsin	18	185%	150%	\$0	\$891	185%	\$0.00	\$0.00	\$0.00	\$0.00	A

* Legislative action pending that may affect eligibility and other matters.

** Recently adopted statutes not incorporated into this analysis.

Legislative reduction of coverage to 150% of poverty effective 7/1/98.

* Total family costs, including premiums and copayments, capped at 5% of family income.

NOTES: 1) Matters marked "tbd" are to be determined by state officials. 2) In the benefits column, letters indicate the following: A = Medicaid benefits; B = Medicaid benefits, minus a few select services; C = Commercial benefit structure; D = Major gaps in benefits. States with more than one designation expanded Medicaid and created a separate program with different benefits for different income groups. The first designation refers to the Medicaid expansion, the second to the separate program. 3) In columns describing premiums and copayments, "100%" represents minimum, mandatory Medicaid eligibility for children, which for most children amounts to 100% of the the federal poverty level. 4) The following states are not included in these listings because neither final legislative action nor submission of a CHIP state plan has occurred: Alaska, Arizona, Arkansas, Delaware, District of Columbia, Hawaii, New Hampshire, North Dakota. 5) Washington and Wyoming legislatures rejected CHIP implementation for 1998. 6) Premiums and copayments are estimated for those states who set these fees based on a percentage of costs or income.

Table 1b
Program Used to Expand Coverage

Basic approach	Specific Approach	States
Medicaid expansion only	Initial implementation of CHIP. Later implementation may or may not be a further Medicaid expansion.	AL, ID, IL, IN,* LA, MD,** OH, TX (8 states)
	Apparently final action	MN, MO, NE, OK, RI, SC, SD, TN, VT, WI (10 states)
Separate state program only	Expansion of previous programs	CO, NY, PA (3 states)
	Creation of new programs	MT, NV, NC, UT (4 states)
Combination of Medicaid and separate programs	The separate program is combined with a <i>Medicaid expansion that is solely for poor teenagers</i> (i.e., early coverage of Waxman children)	CA, FL (2 states)
	The separate program is combined with a <i>Medicaid expansion that simplifies eligibility</i> . Within a family, children are no longer divided among programs based simply on age.	CT, IA, MI, MA*** (4 states)
	Medicaid is combined with a separate program that is a <i>Medicaid look-alike</i> . Children receive no entitlement, but they have Medicaid benefits, both programs have the same administrative agency and perhaps providers and plans, and the difference may be invisible to parents.	GA, KS, ME, MS,† OR, VA, NJ (7 states)
	<i>Other approach</i> (Medicaid under age 6, separate program for older children)	WV (1 state)
Agency delegated authority to determine structure		KY, NM (2 states)

*Medicaid expansion sunsets after 1 year. Legislature must decide how to proceed.

**Medicaid look-alike between 185 and 200 percent of poverty slated to begin 7/99.

***Medicaid look-alike covers children 150-200% of poverty without access to employer coverage.

†Medicaid look-alike only. No Medicaid expansion. Legislature may change approach in future.

Table 1C
State Children's Health Insurance Program: State Progress as of April 30, 1998

STATE	Plan submitted to HCFA	Plan approved by HCFA	State law enacted implementing CHIP	Legislature rejected implementation in 1998	Legislative work ongoing in 1998
Alabama	X	X			X
Alaska					X
Arizona					
Arkansas					
California	X	X	X		
Colorado	X	X	X		
Connecticut	X	X	X		
Delaware					X
District of Columbia					
Florida	X	X			X
Georgia			X		
Hawaii					
Idaho	X				
Illinois	X	X			X
Indiana	X		X		
Iowa			X		
Kansas			X		
Kentucky			X		
Louisiana			X		
Maine			X		
Maryland	X		X		
Massachusetts	X		X		X
Michigan	X	X	X		
Minnesota	X		X		
Mississippi			X		
Missouri	X	X			X
Montana	X				
Nebraska			X		
Nevada	X				
New Hampshire					
New Jersey	X	X	X		
New Mexico			X		
New York	X	X			X
North Carolina			X		
North Dakota					
Ohio	X	X	X		
Oklahoma	X				
Oregon	X				
Pennsylvania	X				X
Rhode Island	X				
South Carolina	X	X			
South Dakota			X		
Tennessee	X				
Texas	X				
Utah	X		X		
Vermont	X				
Virginia			X		
Washington				X	
West Virginia			X		
Wisconsin	X		X		
Wyoming				X	
TOTAL	28	12	25	2	9

Table 2

ELIGIBILITY: MAXIMUM FAMILY INCOME

State	Maximum % poverty covered	State rank
Connecticut	300%	1
Missouri	300%	1
Vermont	300%	1
Minnesota	275-280%	4
Rhode Island*	250%	5
New Mexico	235%	6
Pennsylvania	235%	6
New York	222%	8
California	200%	9
Georgia	200%	9
Kansas	200%	9
Kentucky	200%	9
Maryland	200%	9
Massachusetts	200%	9
Michigan	200%	9
Nevada	200%	9
New Jersey	200%	9
North Carolina	200%	9
Tennessee*	200%	9
Utah	200%	9
Colorado	185%	21
Florida	185%	21
Iowa	185%	21
Maine**	185%	21
Nebraska	185%	21
Oklahoma	185%	21
Virginia	185%	21
Wisconsin	185%	21
Oregon	170%	29
Idaho#	160%	30
Indiana* **	150%	31
Montana	150%	31
Ohio*	150%	31
South Carolina	150%	31
West Virginia**	150%	31
Illinois*	133%	36
Louisiana*	133%	36
South Dakota	133%	36
Alabama*	100%	39
Mississippi*	100%	39
Texas*	100%	39

* Additional, future expansions under discussion.

** State statute authorizes eligibility changes.

Legislative reduction of coverage to 150% of poverty effective 7/1/98.

* Tennessee has no income limit on coverage for children but subsidies end above 200% of poverty.

NOTES: In Minnesota, children ages 0-2 qualify up to 280% of poverty. Children of other ages qualify up to 275% of poverty.

Table 3
AFFORDABILITY: MAXIMUM INCOME
WITH NO FAMILY PREMIUM PAYMENT

State	Maximum % poverty for no premium	State rank
Missouri	300%	1
Connecticut	235%	2
Maryland*	200%	3
Pennsylvania	200%	3
Utah	200%	3
Nebraska	185%	6
Oklahoma	185%	6
Rhode Island	185%	6
Oregon	170%	9
Idaho	160%	10
Indiana	150%	11
Maine	150%	11
Massachusetts	150%	11
Michigan	150%	11
New Jersey	150%	11
New York	150%	11
North Carolina	150%	11
Ohio	150%	11
South Carolina	150%	11
Virginia	150%	11
Wisconsin	150%	11
Illinois	133%	22
Louisiana	133%	22
South Dakota	133%	22
Alabama	100%	25
California	100%	25
Colorado	100%	25
Florida	100%	25
Georgia	100%	25
Kentucky	100%	25
Mississippi	100%	25
Montana	100%	25
Nevada	100%	25
Tennessee	100%	25
Texas	100%	25

* Cost-sharing policies subject to change after first year.

NOTES: Iowa, Kansas, New Mexico and West Virginia leave this determination to state agencies or elected officials. Minnesota and Vermont had programs in place that determine the income level at which premiums would be charged and CHIP implementation in these states affects higher income levels only. Accordingly, these states are not included in this table.

Table 4
AFFORDABILITY: MAXIMUM ANNUAL PREMIUMS FOR
CHILDREN WITH FAMILY INCOMES OF 100-149% OF POVERTY

State	Maximum annual premiums for family with 2 children	State rank
Connecticut	\$0	1
Idaho	\$0	1
Illinois	\$0	1
Indiana	\$0	1
Louisiana	\$0	1
Maine	\$0	1
Maryland	\$0	1
Massachusetts	\$0	1
Michigan	\$0	1
Missouri	\$0	1
Nebraska	\$0	1
New Jersey	\$0	1
New York	\$0	1
North Carolina	\$0	1
Ohio	\$0	1
Oklahoma	\$0	1
Oregon	\$0	1
Pennsylvania	\$0	1
Rhode Island	\$0	1
South Carolina	\$0	1
South Dakota	\$0	1
Utah	\$0	1
Virginia	\$0	1
Wisconsin	\$0	1
Kentucky	\$40	25
Nevada	\$50	26
Montana	\$100	27
California	\$168	28
Colorado	\$180	29
Florida	\$180	29
Georgia	\$180	29
Tennessee	\$564	32

NOTES: 1) In states that set premiums and copays based on a percentage of costs or income, estimated amounts are listed.
2) Alabama, Texas, and Mississippi are excluded from this chart because they do not cover children with incomes above 100% of poverty. 3) Minnesota and Vermont are excluded from this chart because their expanded coverage is aimed at higher income children.
4) Iowa, Kansas, New Mexico, and West Virginia all delegate decisions in this area to state officials and so are also excluded.

Table 5

**AFFORDABILITY: MAXIMUM ANNUAL PREMIUMS FOR
CHILDREN WITH FAMILY INCOMES OF 150-200% OF POVERTY**

State	Maximum annual premiums for family with 2 children	State rank
Connecticut	\$0	1
Idaho	\$0	1
Maryland	\$0	1
Missouri*	\$0	1
Nebraska	\$0	1
Oklahoma	\$0	1
Oregon	\$0	1
Pennsylvania	\$0	1
Utah	\$0	1
Michigan	\$60	10
Rhode Island	\$63	11
North Carolina	\$100	12
Florida	\$180	13
Georgia	\$180	13
New Jersey	\$180	13
Nevada	\$200	16
California	\$216	17
Kentucky	\$240	18
Massachusetts	\$240	18
New York	\$312	20
Maine	\$342	21
Colorado	\$360	22
Tennessee	\$786	23
Wisconsin	\$891	24

* Subject to future changes.

NOTES: 1) In states that set premiums and copays based on a percentage of costs or income, estimated amounts are listed. 2) States excluded from Table 4 are excluded here for the same reasons. 3) Illinois, Indiana, Louisiana, Montana, Ohio, and South Carolina are excluded because they do not cover children with incomes over 150% of poverty.

Table 6

**AFFORDABILITY: MAXIMUM FAMILY INCOME WITHOUT
COPAYMENTS FOR CHILDREN**

State	Maximum % poverty without copayments	State rank
Missouri	300%	1
Minnesota	275-280%	2
Georgia	200%	3
Maryland*	200%	3
Michigan	200%	3
Pennsylvania	200%	3
Connecticut	185%	7
Maine	185%	7
Nebraska	185%	7
Oklahoma	185%	7
Rhode Island	185%	7
Wisconsin	185%	7
Oregon	170%	13
Idaho	160%	14
Indiana	150%	15
Massachusetts	150%	15
Montana	150%	15
Nevada	150%	15
New Jersey	150%	15
North Carolina	150%	15
Ohio	150%	15
South Carolina	150%	15
Virginia	150%	15
Illinois	133%	24
Louisiana	133%	24
South Dakota	133%	24
Alabama	100%	27
California	100%	27
Colorado	100%	27
Florida	100%	27
Kentucky	100%	27
Mississippi	100%	27
New York	100%	27
Tennessee	100%	27
Texas	100%	27
Utah	100%	27

* Cost-sharing policies subject to change after first year.

NOTES: This table excludes the states excluded from Table 3 with one exception: Minnesota is included here, since children affected by the state's CHIP plan have no copayments.

Table 7

**AFFORDABILITY: MAXIMUM PHYSICIAN VISIT COPAYMENTS
FOR CHILDREN WITH FAMILY INCOMES OF 100-149% OF POVERTY**

State	Copayment for acute care physician visits	State rank
Connecticut	\$0.00	1
Georgia	\$0.00	1
Idaho	\$0.00	1
Illinois	\$0.00	1
Indiana	\$0.00	1
Louisiana	\$0.00	1
Maine	\$0.00	1
Maryland	\$0.00	1
Massachusetts	\$0.00	1
Michigan	\$0.00	1
Minnesota	\$0.00	1
Missouri	\$0.00	1
Montana	\$0.00	1
Nebraska	\$0.00	1
Nevada	\$0.00	1
New Jersey	\$0.00	1
North Carolina	\$0.00	1
Ohio	\$0.00	1
Oklahoma	\$0.00	1
Oregon	\$0.00	1
Pennsylvania	\$0.00	1
Rhode Island	\$0.00	1
South Carolina	\$0.00	1
South Dakota	\$0.00	1
Virginia	\$0.00	1
Wisconsin	\$0.00	1
Tennessee	\$1.25	27
Colorado	\$2.00	28
New York	\$2.00	28
Florida	\$3.00	30
California	\$5.00	31
Utah	\$5.00	31

NOTES: 1) In states that set premiums and copayments based on a percentage of costs or income, estimated amounts are listed.
 2) States excluded from Table 4 are excluded from this table, except that (a) Minnesota is included as explained in Table 6 and (b) Kentucky is excluded because state officials are delegated authority to set copayment policies.

Table 8

**AFFORDABILITY: MAXIMUM PHYSICIAN VISIT COPAYMENTS
FOR CHILDREN WITH FAMILY INCOMES OF 150-200% OF POVERTY**

State	Copayment for acute care physician visits	State rank
Georgia	\$0.00	1
Idaho	\$0.00	1
Maine	\$0.00	1
Maryland*	\$0.00	1
Michigan	\$0.00	1
Minnesota	\$0.00	1
Missouri	\$0.00	1
Nebraska	\$0.00	1
Nevada	\$0.00	1
Oklahoma	\$0.00	1
Oregon	\$0.00	1
Pennsylvania	\$0.00	1
Wisconsin	\$0.00	1
Tennessee	\$1.25	14
New York	\$2.00	15
Florida	\$3.00	16
California	\$5.00	17
Colorado	\$5.00	17
Connecticut	\$5.00	17
New Jersey	\$5.00	17
North Carolina	\$5.00	17
Rhode Island	\$5.00	17
Utah	\$10.00	23
Massachusetts	no limit**	24

* Cost-sharing policies subject to change after first year.

** Total family costs, including premiums and copayments, capped at 5% of family income.

NOTES: 1) In states that set premiums and copayments based on a percentage of costs or income, estimated amounts are listed. 2) States excluded from Table 5 are excluded here, except that Minnesota and Kentucky are as described in Table 7.

Table 9

**AFFORDABILITY: MAXIMUM PRESCRIPTION DRUG COPAYMENTS
FOR CHILDREN WITH FAMILY INCOMES OF 100-149% OF POVERTY**

State	Copayment for prescriptions (generic)	State rank
Connecticut	\$0.00	1
Georgia	\$0.00	1
Idaho	\$0.00	1
Illinois	\$0.00	1
Indiana	\$0.00	1
Louisiana	\$0.00	1
Maine	\$0.00	1
Maryland	\$0.00	1
Massachusetts	\$0.00	1
Michigan	\$0.00	1
Minnesota	\$0.00	1
Missouri	\$0.00	1
Montana	\$0.00	1
Nebraska	\$0.00	1
Nevada	\$0.00	1
New Jersey	\$0.00	1
North Carolina	\$0.00	1
Ohio	\$0.00	1
Oklahoma	\$0.00	1
Oregon	\$0.00	1
Pennsylvania	\$0.00	1
Rhode Island	\$0.00	1
South Carolina	\$0.00	1
South Dakota	\$0.00	1
Virginia	\$0.00	1
Wisconsin	\$0.00	1
Colorado	\$1.00	27
Utah	\$1.00	27
Tennessee	\$1.50	29
New York	\$1-\$3	30
Florida	\$3.00	31
California	\$5.00	32

NOTES: 1) In states that set premiums and copayments based on a percentage of costs or income, estimated amounts are listed.
2) This table excludes the states excluded in Table 7.

Table 10

**AFFORDABILITY: MAXIMUM PRESCRIPTION DRUG COPAYMENTS
FOR CHILDREN WITH FAMILY INCOMES OF 150-200% OF POVERTY**

State	Copayment for prescriptions (generic)	State rank
Connecticut	\$0.00	1
Georgia	\$0.00	1
Idaho	\$0.00	1
Maine	\$0.00	1
Maryland	\$0.00	1
Michigan	\$0.00	1
Minnesota	\$0.00	1
Missouri	\$0.00	1
Nebraska	\$0.00	1
Oklahoma	\$0.00	1
Oregon	\$0.00	1
Pennsylvania	\$0.00	1
Wisconsin	\$0.00	1
New Jersey	\$1.00	14
Utah	\$1.00	14
Tennessee	\$1.50	16
Rhode Island	\$2.00	17
New York	\$1-\$3	18
Colorado	\$3.00	19
Florida	\$3.00	19
California	\$5.00	21
Nevada	\$5.00	21
North Carolina	\$6.00	23
Massachusetts	no limit*	24

* Total family costs, including premiums and copayments, capped at 5% of family income.

NOTES: 1) In states that set premiums and copayments based on a percentage of costs or income, estimated amounts are listed.

2) This table excludes the states excluded from Table 8.

Table 11
Crowd-out provisions

Policy	States
12 month waiting period	NJ (1 state)
6 month waiting period	CT, KS,* MD, MI, MO, NV, NC,* , ** OR, WI (9 states)
3 month waiting period	CA, CO, ME, MT, UT (5 states)
Denial of coverage if access to employer insurance (various qualifications – e.g., Indiana requires the access to be affordable)	IN, MI, MN, RI, WI (5 states)
State will monitor. If crowd-out becomes a serious problem, certain measures will be taken.	CA, MO, FL, OR (4 states)
Obligations imposed on employers and/or insurers	CA, IN, MD, WI (4 states)
Subsidize employer coverage	MA, MD, NY, NC (4 states)
Other approaches	NY, VT (2 states)

*Unlike other states with waiting periods, these make no exceptions for children losing coverage because of lay-offs or other factors outside the family's control.

**Six month waiting period during first six months of program. After that, 60 day waiting period.

TABLE 12

Children Through Age 18 and Health Coverage in 4 Regions of the U.S.

Uninsured children by region

	total number of children (in millions)	% of all U.S. children in each region	% of all uninsured children in each region	number of uninsured children in each region (in millions)	% of children in each region who are uninsured
Northeast	13,772	18.4	15.4	1,739	12.6
Midwest	17,731	23.7	14.8	1,674	9.4
South	25,749	34.4	42.4	4,794	18.6
West	17,647	23.6	27.4	3,093	17.5
National	74,899	100.1	100	11,300	15.1

Privately insured children by region

	% of all U.S. children in each region	% of all children who lack private insurance	number of children who lack private insurance (in millions)	% of children in each region who lack private insurance
Northeast	18.4	16.8	4,222	30.7
Midwest	23.7	17.3	4,346	24.5
South	34.4	39.4	9,913	38.5
West	23.6	26.5	6,657	37.7
National	100.1	100	25,137	33.6

Work status of parent(s)

	Percent of uninsured children with a working parent	Percent of uninsured children with a full time, full year working parent
Northeast	91.9	64.3
Midwest	93.8	65.0
South	90.7	67.7
West	93.7	65.7
National	92.1	66.2

Note: Children without parents are excluded from the above chart.

Race

	% of all uninsured children who are:		Black	White
	Black	White	% uninsured	% uninsured
Northeast	25.6	67.2	19.3	10.8
Midwest	18.1	78.8	13.9	8.8
South	28.2	68.7	20.4	17.9
West	6.6	82.6	21.8	17.5
National	20.4	73.7	19.2	14.1

Note: For the above chart, Hispanic children were included within Black and White race categories. Children of other racial/ethnic groups were not included due to small sample sizes.

Race & Hispanic status

	% of all uninsured children who are			Non-Hispanic		
	Non-Hispanic		Hispanic	Black	White	Hispanic
	Black	White		% uninsured	% uninsured	% uninsured
Northeast	22.8	45.1	25.2	19.4	8.3	26.0
Midwest	18.1	67.3	11.6	14.0	7.9	23.2
South	27.8	45.9	23.2	20.4	14.6	32.9
West	6.4	34.8	48.8	22.1	11.2	29.1
National	19.7	45.9	28.8	19.1	10.7	29.3

Two-parent families

	Percent of uninsured children in 2-parent families
Northeast	57.0
Midwest	53.6
South	57.8
West	67.5
National	59.7

Note: Data in the above chart is revised from original national numbers. Adolescent householders are now excluded.

Income

	Percent of all uninsured children in families with incomes of:			Children in families with incomes of		
	< 100%	100-199%	200% & up	< 100%	100-199%	200% & up
	% uninsured	% uninsured	% uninsured	% uninsured	% uninsured	% uninsured
Northeast	29.7	33.6	36.6	19.2	22.2	7.6
Midwest	30.0	31.2	38.8	17.6	14.2	5.8
South	35.4	37.7	26.9	28.2	28.5	9.6
West	36.6	35.6	27.8	27.4	26.8	9.1
National	34.0	35.6	30.4	24.5	23.9	8.1

SOURCE: March 1997 Current Population Survey, health coverage in 1996. Calculations by the Children's Defense Fund, 4/98. NOTE: Southern states are those listed in the Census Bureau's Region 3: AL, AR, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV.

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National Report

The New York Times

New Effort Aims to Enroll Children in Insurance Plans

By ROBERT PEAR

WASHINGTON, Feb. 22 — Alarmed at an increase in the number of people without health insurance, President Clinton will announce on Tuesday that he is establishing a national toll-free telephone number to enroll children in Medicaid and in a separate new health program for people under the age of 19.

The phone number is 877-KIDS-NOW (877-543-7669). Callers will be automatically connected to the Medicaid agency or the health department of the state they are calling from. They may then obtain free or low-cost health insurance for their children. Many states allow families to apply by mail.

In August 1997, Congress created the Children's Health Insurance Program, and in December 1997, Mr. Clinton ordered a major effort to locate and sign up millions of children who were eligible for Medicaid. But the erosion of health insurance coverage has continued, as poor families, the Clinton Administration and state officials have not fully exploited the potential of the two programs.

On Tuesday, the President and leaders of the National Governors' Association will announce steps to reverse that trend.

Gov. Thomas R. Carper of Delaware, a Democrat who is chairman of the association, and Gov. Michael O. Leavitt of Utah, a Republican, said the special telephone line could help millions of families.

The Census Bureau says that at least 10.7 million children lack health insurance. The White House says that half of them are eligible for Medicaid or the new insurance program, but have not enrolled in either.

The White House has enlisted businesses and broadcasters in a campaign to increase enrollment.

Kmart will put the toll-free telephone number on its shopping bags, diaper boxes and pharmaceutical products. The General Motors Corporation will put labels with the number on child safety seats. NBC, ABC, Black Entertainment Television and Univision, the Spanish-language network, will run television and radio advertisements publicizing the number. And the Federal Government will run radio spots in 45 states.

Changes in Federal welfare policy, including the landmark law that Mr. Clinton signed in August 1996, have increased the number of poor people without health insurance, experts on health policy say.

The number of welfare recipients has plunged 35 percent since the measure was signed into law. Children are often eligible for Medicaid after they lose cash assistance, but many parents do not know that their children may still qualify for Medicaid, and state officials do not always assess eligibility.

Jonathan M. Stein, a lawyer at Community Legal Services in Philadelphia, said: "State and Federal Governments have failed to carry out Federal laws that mandate a continuation of Medicaid coverage for most families leaving welfare. In Pennsylvania, tens of thousands of

been continued on Medicaid, but have been erroneously terminated, without any active intervention by the Federal Government."

Federal officials said they were looking into the situation.

Even though the Federal Government is establishing one telephone number for its campaign to "insure kids now," the eligibility criteria vary widely by state. For example, information posted on the Internet says a child in a family of three may qualify for insurance under New York's Child Health Plus program if the family has an income under \$31,980 a year. But the comparable figures are \$40,950 for Connecticut; \$13,650 for Texas and Mississippi; and \$27,300 in New Jersey, Florida and California.

The number of people without health insurance increased an average of 1 million a year in the last decade and now exceeds 43 million, after a sharp rise in 1997.

The increases occurred even though the Government has a wide safety net intended to guarantee

A national toll-free number with access to health agencies.

medical assistance for low-income families, including these provisions:

Under Federal law, if a family loses welfare because of increased earnings from employment, the family is supposed to remain eligible for Medicaid for six months "without any reapplication" for benefits. Moreover, the state is supposed to offer another six months of Medicaid to most such families.

Under Federal Medicaid rules, a state must "continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible." Thus, Federal courts have said, if a family loses cash assistance, the state may not automatically end Medicaid coverage, but must, on its own initiative, determine whether the family might qualify for Medicaid on some other ground.

Under the 1996 welfare law, states must provide Medicaid to anyone who would have qualified for welfare under the eligibility rules in effect in July 1996. States may adopt new, more restrictive eligibility standards for welfare, but many families ineligible for cash assistance under those standards will be eligible for Medicaid.

The latest data from the Census Bureau, issued in September, show trends that worry many health policy experts.

The proportion of children with no health insurance of any kind increased to 15 percent in 1997, from 13.8 percent in 1995, when many states began cutting their welfare rolls. The proportion of poor children with no health insurance rose to 23.6 percent in 1997, from 21.4 percent in 1995.

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TUESDAY, FEBRUARY 23, 1999

PRIVATE HEALTH INSURANCE COVERAGE FOR CHILDREN: A SURVEY OF 450 EMPLOYERS

by

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and
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Maternal and Child Health Policy Research Center**

and

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February 1999



**MATERNAL & CHILD HEALTH
POLICY RESEARCH CENTER**

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INTRODUCTION

The majority of American children receive their health insurance coverage through employer-sponsored plans. In 1997, 59.7 percent of children, approximately 42.8 million nationwide, had employer-sponsored coverage.¹ However, rates of employer-based coverage for children differ considerably, depending on various child, family, and employer characteristics, as Table 1 shows. Adolescents, children in higher income families, children living in the Northeast and the Midwest, children with a parent working full-time, and children with a parent employed in a public agency or large private firm were more likely than other children to have employer-based coverage.² Among the children without employer-based coverage in 1997, almost two-thirds had another source of coverage (most often Medicaid), and more than a third were uninsured.³

In the period between 1987 and 1994 there had been a steady decline in the proportion of children who obtained health insurance through their parents' employer, but since 1994 the trend has leveled off and may be reversing, as shown in Figure 1.⁴ Improvements in the economy and a drop in the rate of medical price inflation resulting from managed care both contributed to the decline in premium rate increases for employer-based coverage.⁵ Another factor may have been that, during this same period, the proportion of the premium paid by employers – for family as well as single coverage – began increasing.⁶

In 1993, 73.6 percent of small employers (10-99 employees), 94.6 percent of medium employers (100-999 employees), and 96.7 percent of large employers (1,000+ employees)

¹ Special tabulations from the March 1998 Current Population Survey prepared by the Employee Benefit Research Institute, November 1998.

² Fronstin P: Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey. *Employee Benefit Research Institute Issue Brief*. No. 192, December 1997.

³ Nationwide in 1997, 20.5% children had Medicaid coverage, 7.3% children had private non-employer-based coverage, and 15.0% were uninsured. Special tabulations from the March 1998 CPS prepared by the Employee Benefit Research Institute, November 1998.

⁴ The percentage of children with employer-sponsored coverage declined from 66.7% in 1987 to 58.1% in 1994. Fronstin P.: Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey. *Employee Benefit Research Institute Issue Brief*. No.192, December 1997.

⁵ Ginsburg P and Pickreign J: Tracking Health Care Costs: An Update. *Health Affairs*. 16(4):151-155, July/August 1997.

⁶ Ginsburg P and Gabel J: Tracking Health Care Costs: What's New in 1998? *Health Affairs*. 17(5):141-146, September/October 1998.

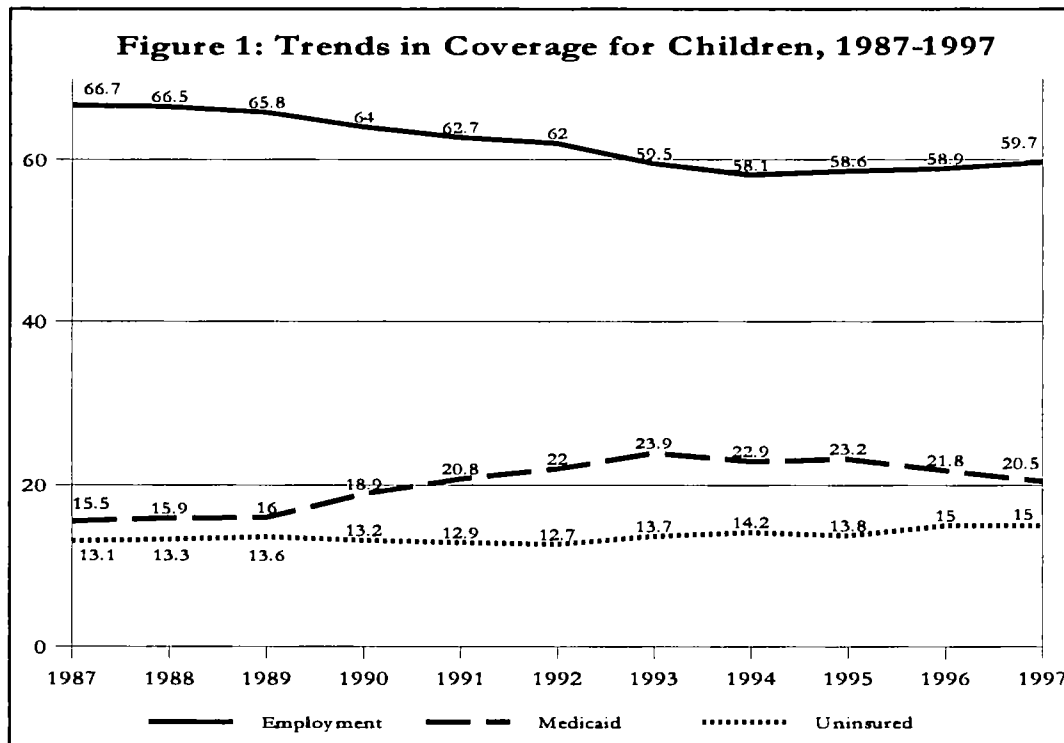
Table One:
Characteristics of Children with Employer-Based
Health Insurance Coverage in 1996

<u>Characteristics</u>	<u>Number (in millions)</u>	<u>Percent (%)</u>
All Children Under 18	41.9	58.9
Infant	2.0	51.4
1-5	11.4	56.9
6-12	16.8	60.0
13-17	11.7	60.8
Family Income		
Below 100% of poverty	1.8	11.7
100%-199% of poverty	7.5	46.9
200%-399% of poverty	18.4	77.2
400% or more of poverty	14.2	87.5
Region		
Northeast	8.2	62.6
Midwest	11.3	66.9
South	13.2	54.1
West	9.2	54.4
Employer of Family Head		
Self	3.1	46.0
Public	7.0	75.8
Private	31.4	65.5
Under 10 workers	2.2	37.9
10-99 workers	7.2	55.4
100-999 workers	8.3	72.8
1000 or more workers	13.7	77.1
Labor Force Status of Family Head		
Year-round, full-time workers	38.1	72.6
Part-year or part-time workers	1.6	3.8
Non-workers	0.5	6.4

Source: Fronstin, P. Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey. *Employee-Benefit Research Institute Issue Brief*. No. 192, December 1997.

offered health insurance to employees.⁷ Still, in the same year, close to one quarter of employers failed to offer health insurance coverage to the families of their employees.⁸

In this report, we present the results of our 1998 survey of 450 employers. Following a discussion of the methodology, we present an executive summary and then an in-depth discussion of three topics on children's health insurance coverage: employer perspectives and employee decisions, premium contributions and scope of coverage, and future directions.



Source: Fronstin P. and Pierron B: Expanding Health Insurance for Children: Examining the Alternatives. *Employee Benefit Research Institute Issue Brief*. No. 187, July 1997.

Fronstin P.: Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey. *Employee Benefit Research Institute Issue Brief*. No. 192, July 1997.

Special tabulations from the March 1998 Current Population Survey prepared by the Employee Benefit Research Institute, November 1998.

⁷ Center for Disease Control and Prevention: *Employer-Sponsored Health Insurance*. DHHS Publication No. 98-1017, Hyattsville, Maryland, December 1997.

⁸ General Accounting Office: *Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases*. GAO/HEHS-97-35, Washington, D.C., February 24, 1997.

METHODOLOGY

This employer survey of dependent health care coverage was implemented and administered by Lake Snell Perry & Associates. The survey was conducted by telephone using professional interviewers and concluded in September 1998.

The survey was designed to collect nationally representative information on employer attitudes, premium contributions, benefits, cost-sharing, and future directions with respect to dependent health insurance. Since the survey was about health insurance policies affecting children, it was important to discover the attitudes of employers who actually offer this coverage and to learn more about the nature of that coverage. Therefore, to be eligible for this survey, employers had to provide employees with health insurance coverage for their dependent children.

A total of 450 employers were randomly phoned. The sample was restricted to employers whose Standard Industrial Codes (SIC codes) denote blue-collar, clerical and sales, and professional and technical employee types. Government employers were excluded.

To allow for analysis by company size, 150 small (10-99 employees), 150 medium (100-999 employees), and 150 large (1,000 or more employees) companies were surveyed. Employers with fewer than 10 employees were not included in this survey because they are generally difficult to reach and include in a survey. For results based on the total sample, the proportions of employers of different sizes were weighted to approximate their actual nationwide proportions as calculated by the Bureau of Labor Statistics.

To analyze the responses, a variety of characteristics were examined. These included: company size (small, medium, and large); predominant employee type (professional and technical, clerical and sales, and blue collar and service); average employee annual salary (\$13,000 - \$27,000 and \$28,000 and over); and region (Northeast, Midwest, South, and West).

The responses have a margin of error of approximately +/- 4.6 percentage points. Due to the small number of interviews in the survey, analysis is restricted to categories with sufficient cell sizes to permit reliable interpretation.

EXECUTIVE SUMMARY

Following are the key findings from a nationally representative survey of 450 employers, concluded in September 1998, regarding health insurance coverage for dependent children of employees.

- **The vast majority of employers in the survey believe that providing employees health insurance coverage for their children is simply “the right thing to do.”** The larger the employer, the more likely they are to have positive attitudes toward providing health insurance coverage for employees’ dependent children.
- **One in five employees elects not to take coverage for their children even when it is offered by the employer.** Most employers explain that dependent coverage is declined because the employee already has this coverage through a spouse. However, small and medium employers and those with lower salaried workers are more likely than other employers to report that their employees decline dependent coverage because it is too costly.
- **Employers report that most of their employees with dependent children participate in either an Health Maintenance Organization (HMO) or a Preferred Provider (PPO) plan.** Very few are enrolled in Point of Service (POS) or Fee-for-Service plans. HMOs are much more prevalent in the West than in other regions of the country.
- **Half of employers characterize the services covered under the health insurance plan that families generally select as being similar to our description of a “minimum” basic benefits package.** The larger the employer, the greater the likelihood that more services are offered than those in the “minimum” plan. Employees in a PPO tend to have coverage for more services than those in an HMO.
- **One out of five employers characterizes the cost-sharing policies in their health insurance plan as being similar to our description of a “common” cost-sharing arrangement.** Most employers, however, report that the plan used by most of their employees with children is more generous, imposing less cost-sharing than this basic example. Larger employers are more likely than small employers to impose lower cost-sharing.

- **Employers contribute less toward the coverage for their employees' dependent children than for their employees.** Employers, on average, contribute only about 60 percent of the cost of dependent coverage, compared with 80 percent for their employees' coverage. Almost one in five employers contributes nothing to the cost of coverage for their employees' dependent children.
- **About one in four employers reports that a year from now employees will pay more for their children's coverage and one in five predicts more dependents will be enrolled in HMOs.** Most employers believe, however, that a year from now, the medical services and procedures that their plan covers for dependent children will remain the same.
- **When asked, a majority of employers express interest in possibly expanding their health insurance plan to offer more parent education programs, preventive visits to identify and treat developmental and behavioral problems, and mental health counseling and support for children and their families.** Almost half of employers also express an interest in creating adolescent clinics for treatment of mental and physical problems common to this age group.

A detailed description of these findings can be found on the following pages.

FINDINGS IN DETAIL

I. EMPLOYER PERSPECTIVES AND EMPLOYEE DECISIONS REGARDING HEALTH COVERAGE FOR CHILDREN

Providing Coverage for Dependent Children is "the Right Thing to Do"

Nearly all employers believe providing health insurance coverage for the dependent children of their employees is important. As Table Two illustrates, 93 percent of employers surveyed say the statement "providing employees with affordable and comprehensive coverage for their children is simply the right thing for an employer to do" describes their company's view well. This is true regardless of company size, geographic location, industry type, and other key characteristics. Few employers indicate that providing coverage for children is unimportant. In fact, only 10 percent say they feel providing employees with health insurance for their children is not very important because employees will be hardworking and productive regardless of the health insurance benefits provided their children.

Table Two:
Employer Attitudes about Providing Health Insurance for Dependent Children

	<u>Describes Company's Views</u>			
	<u>Very Well</u>	<u>Pretty Well</u>	<u>Not Too Well</u>	<u>Not Well At All</u>
Providing employees with affordable and comprehensive coverage for their children is simply the right thing for an employer to do	63%	30%	3%	3%
Providing employees with health insurance coverage for their children is a growing financial burden for the company	10	26	25	36
Providing employees with health insurance coverage for their children is not very important because employees will be hardworking and productive regardless of the insurance benefits we provide their children	3	7	17	71
Providing employees with health insurance coverage for their children is really something the state or federal government is better equipped to do	3	5	19	69

Equally significant, nearly all employers indicate that responsibility for providing coverage to the children of employees is something that should remain with employers, and not be shifted to the government. Only eight percent of employers indicate that providing employees with health insurance coverage for their children is really something that the state or federal government is better equipped to do. Employers' resistance to a larger state role in insuring employees' children is echoed in another survey finding. When asked if they would drop health coverage for employees' dependent children if publicly subsidized health insurance was made available for uninsured children from families with low and moderate incomes, almost nine in 10 (86%) say their company would not drop coverage. Only 12 percent say they would definitely (7%) or possibly (5%) drop coverage.

Dependent Coverage – a Growing Financial Burden for Some Employers

Employers' commitment to covering their employees' children is all the more compelling because, for a significant minority of employers in the survey, providing coverage for dependent children is a growing financial burden. Thirty-six percent of employers say the statement "providing employees with health insurance coverage for their children is a growing financial burden for the company" describes their company's view well. Six in 10 (61%) say this describes their company's view not too well or not at all, indicating that this is not a major issue for their company.

As Table Three demonstrates, small and medium employers are more likely than large employers to report that meeting the expense of dependent coverage is increasingly difficult. Roughly 40 percent of small and medium employers say the statement "providing health insurance coverage for their employees' children is a growing financial burden for the company" describes their company's position very or pretty well. In contrast, 30 percent of large employers say that the statement describes their company very or pretty well.

As might be expected, employers who view insuring dependent children as a growing

Table Three:
Employer Perceptions About Growing Financial Burden of Providing Dependent Coverage by Company Size

	<u>Describes Company's Views</u>			
	<u>Very Well</u>	<u>Pretty Well</u>	<u>Not Too</u>	<u>Not At All</u>
Total	10%	26%	25%	36%
<u>Company Size</u>				
Small	14	25	20	39
Medium	8	32	25	33
Large	9	21	29	36

financial burden are more likely to say they would considering dropping dependent coverage if publicly subsidized health insurance coverage became available. Twenty percent of those who say their resources are stretched by dependent care would consider dropping dependent coverage, compared with only seven percent of those who feel less financial pressure.

Some Employees Decline Coverage for Dependent Children

Even though an overwhelming majority of employers say they feel it is imperative to offer health insurance to dependent children, not all employees take advantage of this benefit. Employers, on average, report that one in five (19%) employees does not obtain health insurance coverage for their dependents.

Table Four: Reasons Employees Decline Dependent Coverage by Selected Variables		
	Coverage by Spouse	Coverage Too Costly
Total	62%	22%
Company Size		
Small	51	20
Medium	57	32
Large	81	14
Average Annual Salary		
\$13,000-\$27,000	52	28
\$28,000 or higher	71	17
Employee Type		
Professional/Technical	70	22
Clerk/Sales	59	25
Blue Collar	60	21
Region		
Northeast	62	13
Midwest	66	21
South	59	29
West	61	29

Employers offer two main reasons why employees elect not to obtain coverage, as shown in Table Four. The majority, almost two-thirds, say employees who decline coverage do so because their children get coverage through a spouse's health plan. The second most common reason, cited by almost one quarter of employers, is cost.

Reasons that employees decline coverage for their dependents vary by company size, salary levels, employee type, and region. Large employers, those paying annual salaries of \$28,000 or higher, and those with a mostly professional and technical workforce are much more likely than other employers to report that employees who decline family coverage do so because their children are already covered through a spouse's employer. Firms that report their employees decline dependent coverage because of cost are more likely to be small and medium employers, and those employers paying average salaries of \$13,000-

\$27,000. Take-up rates also vary by region. Employers in the Northeast are much less likely to cite cost as a reason for declining coverage for dependent children than employers in other regions.

Not surprisingly, the extent of employer premium contributions impacts the percent of employees who decline coverage for their dependent children – the more generous the premium contribution, the less likely employees are to decline coverage. As demonstrated in Table Five, employers who contribute 51 to 75 percent of the cost for coverage of dependent children report that only 15 percent of employees decline coverage, and the proportion is even lower among employers who contribute 76 to 100 percent of the cost. Conversely, employers who contribute less than 25 percent of the cost for coverage of dependent children report that a full third of their employees decline this coverage.

Table Five:
Employees Declining Dependent Coverage by Employer Premium Contributions for Dependent Coverage

	<u>Declining Coverage</u>
Total	19%
<u>Percent of Employer Contribution for Dependent Coverage</u>	
0% to 25%	32
26% to 50%	26
51% to 75%	15
76% to 100%	10

Table Six:
Plan Type in Which Most Full-Time Employees with Dependents Participate by Selected Variables

	<u>HMO</u>	<u>PPO</u>
Total	37%	40%
<u>Company Size</u>		
Small	31	41
Medium	41	41
Large	37	38
<u>Region</u>		
Northeast	42	30
Midwest	27	47
South	28	50
West	58	29

Employees with Dependent Children Choose HMOs and PPOs

Employees with dependent children who do elect to obtain health insurance coverage tend to enroll in either an health maintenance organization (HMO) or a preferred provider organization (PPO), as shown in Table Six. Employers report that four out of 10 of their full-time employees with dependent children participate in a PPO and almost as many participate in an HMO. Few employees with dependents participate in a point of service (POS) plan (11%) or a fee-for-service plan (8%).

Plan type varies by region and company size. Employers in the West and Northeast are much more likely to report that their families are enrolled in an HMO compared to employers in the South and Midwest, where PPOs are the more predominant plan. Employees in large and medium-sized companies are slightly more likely to be enrolled in an HMO than employees in small companies.

II. PREMIUM CONTRIBUTIONS AND SCOPE OF COVERAGE FOR CHILDREN

Employers Contribute Less for Dependent Children Than for Employee Coverage

On average, employers contribute a much smaller percentage toward health insurance coverage for their employees' dependent children than for their employees. Employers report that while they contribute an average of 81 percent of the cost of health insurance coverage for their employees, they contribute only 61 percent of the cost of health insurance for their employees' children.

As shown in Table Seven, contributions for children's coverage vary by size of company, average salary of employees, and region. Specifically, large employers tend to contribute more towards children's coverage than either medium or small employers. In addition, employers with higher income employees are likely to contribute more toward the cost of coverage for employees' children than those with lower income employees. Regional variations in employer contributions for dependents are also significant; employers in the North and Midwest contribute more to the insurance coverage of their employees' dependents than employers in the West and South. These marked variations are not found in the contributions employers make towards the coverage of their employees.

Table Seven:
Employer Premium Contributions for
Dependents and Employees
by Selected Variables

	<u>Dependents</u>	<u>Employees</u>
Total	61%	81%
Company Size		
Small	56	83
Medium	58	79
Large	70	81
Average Annual Salary		
\$13,000-\$27,000	57	80
\$28,000 +	64	83
Region		
Northeast	69	84
Midwest	67	81
South	51	78
West	55	82

Some Employers Contribute Nothing to the Cost of Dependent Coverage; Others Contribute 100 Percent

Overall, 17 percent of employers surveyed contribute nothing toward the cost of coverage for dependent children; the same share contribute 100 percent. Those contributing nothing to the coverage of dependent children are more likely to say their contribution since 1995 has stayed the same (63% versus 47% for the entire sample). This finding suggests that most of those employers have contributed nothing for many years, and that this is not a recent change in contribution policy. Though the sample is too small to draw conclusions, the 17 percent of employers that contribute nothing toward the coverage of dependent children are more likely to be small employers (55%), have blue collar employees (43%), and pay average salaries of \$13,000-\$27,000 (56%).

It is interesting to note that while large employers, on average, contribute more to the cost of coverage for employees' children, it is small employers who are most likely to contribute the full cost of dependent coverage. Three in 10 small employers (29%) cover the whole cost of dependent coverage, compared with nine percent of medium and 14 percent of large employers. However, as already noted, small employers are also the most likely to make no contribution at all to the cost of this coverage – leaving employees to shoulder the full costs themselves. In short, it seems that a sizable group of small employers tend to take an “all-or-nothing” approach to contributing for coverage of their employees' children.

Employer Premium Contributions for Dependent Coverage Have Remained the Same or Increased Since 1995

Employers were asked if the percentage amount they now contribute for the health insurance coverage of employees' dependent children has increased, stayed the same, or decreased since 1995. Almost half of employers (47%) report their premium contribution for dependents has stayed the same, while an almost equal proportion (44%) report that their contribution has increased sharply (10%) or somewhat (34%). Only five percent say their contribution has decreased.

Large employers are more likely to report that since 1995 their contribution for the coverage of dependent children has increased (54%) than medium (37%) and small employers (41%). More than half of employers with white collar workers report their contribution has

increased since 1995 (55%), compared with fewer employers with blue collar workers (43%) and clerk/sales employees (36%).

When it comes to premium contributions for employees, a slightly more positive picture emerges. Overall, more than half of all employers (51%) report that their contribution for employees' health insurance coverage has increased either sharply (14%) or somewhat (37%) since 1995. Forty-one percent report that it has stayed the same and only six percent report the amount has decreased.

Half of All Employers Equate Their Health Insurance Benefits for Children with a "Basic" Plan

The specific details of what is and is not covered by any insurance plan are complex and varied, and thus difficult to determine in a survey. Rather than ask employers to describe their own plan, respondents were read the following plan description and asked to compare it with their own:

The health plan covers doctor visits, inpatient and outpatient hospital services, lab tests and x-rays, 20 outpatient mental health visits per year, 14 inpatient mental health days per year, 20 outpatient substance-abuse treatment visits per year, 14 inpatient substance-abuse treatment days per year, and home health care when it occurs instead of hospitalization.

The plan presented for comparison was intended to represent a minimum basic benefits package.

Half the employers surveyed say the benefits covered in this plan are roughly equivalent to theirs, and over a third say their plan covers even more, as shown in Table Eight. Yet, one in 10 employers says the package they provide employees and their children offers fewer services than the basic benefit plan.

The benefits that employers provide vary by company type and other factors. Most notably, the larger a company, the more likely it is to offer a broader package of benefits. More than half of employers with over 1,000 employees say their plan covers more services than the basic plan described. In addition, employers who pay a higher average annual salary appear to offer benefits packages with greater service coverage. Employers in the West appear to offer plans with relatively fewer services than those in other regions of the country.

Plan type also makes a difference. According to employers, those whose employees' families participate predominantly in a PPO are much more likely to have a plan that covers services additional to those covered in the basic benefit plan, as compared with those employers whose families are mostly enrolled in an HMO.

Table Eight:
Scope of Insurance Benefits Offered by Employers
Compared to Basic Plan Benefits
by Selected Variables

	More Services	About the Same Services	Fewer Services
Total	36%	51%	10%
Company Size			
Small	19	55	19
Medium	34	58	7
Large	54	41	4
Employee Type			
Professional/Technical	38	54	5
Clerical/Sales	31	51	12
Blue Collar	37	49	12
Average Annual Salary			
\$13,000-\$27,000	32	49	15
\$28,000 +	38	56	5
Region			
Northeast	38	49	8
Midwest	32	55	11
South	41	49	8
West	30	52	16
Plan Type			
HMO	27	60	11
PPO	39	47	9

Most Employers Report Their Cost-Sharing Requirements are Less Than Those in a "Basic" Plan

While half of employers say the plan in which most of their employees participate has a scope of benefits about the same as the basic comparison plan, when it comes to cost-sharing, a

majority say their plan is more generous. Employers compared the plan that most of their employees are in with this common cost-sharing arrangement:

The plan requires a single annual family deductible of \$600. It requires separate deductibles for hospital, mental health, and substance-abuse treatment. It also has a co-insurance rate of 80%/20%, or a copayment requirement of \$20 for most services. Its coinsurance requirement for mental health services is 50%/50%..

As shown in Table Nine, almost three-quarters (72%) of employers say their plan's cost-sharing arrangement is more generous than this basic plan, including four in 10 who report theirs is much more generous. Two in 10 say their plan is about as generous and only five percent say their plan is less so. Employers with mostly white collar workers have more favorable arrangements than those with mostly blue collar or, in particular, sales and clerical workers. Employers who contribute more toward the premium cost of dependent coverage also have a plan with a more generous cost-sharing system than those who pay less.

**Table Nine:
Cost-Sharing Requirements Compared to Basic
Plan by Selected Variables**

	Much More <u>Generous</u>	Somewhat More <u>Generous</u>	About as/Less <u>Generous</u>
Total	40%	32%	26%
Company Size			
Small	25	31	41
Medium	41	35	23
Large	55	29	14
Employee Type			
Professional/Technical	53	32	14
Clerk/Sales	32	26	40
Blue Collar	38	35	24
Average Annual Salary			
\$13,000-\$27,000	33	32	32
\$28,000 +	44	34	21

There is, however, one difference in the pattern. Whereas PPOs tend to cover more services than HMOs, PPOs are no more generous than HMOs in terms of their cost-sharing arrangements.

III. FUTURE DIRECTIONS IN HEALTH COVERAGE FOR CHILDREN

Some Employers Foresee Shifting More of the Cost of Dependent Coverage to Employees

In addition to asking about current arrangements for coverage of employees' dependents, employers were asked about possible changes in the year to come. As Table Ten shows, seven in 10 employers expect to make no change in their premium contribution for dependent coverage, suggesting most will continue to contribute 61 percent (on average) of the premium charge. However, a quarter say a year from now they will contribute less – and thus their employees will have to contribute more – toward dependent coverage. Yet, most of these employers expect their contribution to decrease only somewhat (25%) rather than sharply (1%).

Projected employer premium decreases do not appear to differ much by employer and plan characteristics. There are some exceptions, however. Employers with predominantly professional/technical employees (35%) and employers in the West (36%) are more likely than other types of employers to want to decrease premium contributions for dependents. For families in the West, where employer

Table Ten:
Anticipated Changes in Employer Premium Contributions for Dependent Coverage by Selected Variables

	Current Premium Contribution	Change in Next Year—		
		Increase	Stay Same	Decrease
Total	61%	3%	68%	26%
Company Size				
Small	56%	5	71	23
Medium	58%	3	67	28
Large	70%	2	67	27
Employee Type				
Professional/Technical	60%	3	63	35
Clerk/Sales	56%	7	66	21
Blue Collar	64%	1	72	24
Average Annual Salary				
\$13,000-\$27,000	57%	3	68	27
\$28,000 +	64%	3	68	26
Plan Type				
HMO	55%	4	68	25
PPO	58%	3	67	27
Region				
Northeast	69%	3	71	23
Midwest	67%	5	70	22
South	51%	2	69	26
West	55%	2	59	36

contributions to dependent coverage are already lower than in other regions of the country, purchasing employer-based coverage for children in the future would be especially burdensome.

As Table Eleven demonstrates, expected changes in employer premium contributions apparently are not associated with current contribution levels. Employers who now pay a quarter or less of the premium cost for employees' children are no more likely to increase or decrease their contribution than those who now pay three-quarters or more. Among employers who do intend to make such changes, those who currently only contribute between a quarter to a half of the premium cost are somewhat more likely than other employers to move in a generous direction.

Some Employers Foresee More Dependent Children in HMOs

The majority of employers do not anticipate changes in the number of dependent children enrolled in HMOs (see Table Twelve). However, two in 10 employers do expect this number to increase within the next year – usually only slightly (18%) rather than sharply (2%). Large and medium employers are more likely than small employers to expect increased HMO

Table Eleven:
Anticipated Changes in Employer Premium Contributions for Dependents by Current Employer Contribution

	<u>Increase</u>	<u>Stay the Same</u>	<u>Decrease</u>
Total	3	68	26
Percent of Premium Now Paid by Employer			
0% to 25%	6	69	26
26% to 50%	9	69	19
51% to 75%	1	68	28
76% to 100%	2	70	24

Table Twelve:
Anticipated Changes in the Number of Dependent Children Enrolled in HMOs

	<u>Increase</u>	<u>Stay the Same</u>	<u>Decrease</u>
Total	20%	68%	3%
Company Size			
Small	15	72	3
Medium	21	67	3
Large	21	65	3
Current Plan Type			
HMO	27	62	3
PPO	13	72	4

enrollment among their employees' dependent children. Employers who say most of their employees with dependent children are already enrolled in HMOs are twice as likely to foresee an increase in the number of children enrolled in HMOs in the next year as those who currently say most of their employees with dependents are now in PPOs.

Employers Anticipate Few if Any Benefit Changes in Dependent Coverage

Most employers (88%) expect no changes in the scope of services their plan covers for children in the coming year, and none expect these benefits to be reduced. A small proportion (7%) anticipate services will actually increase. In short, most say the status quo will prevail; this finding holds true across all key variables. Moreover, there are no significant differences resulting from the level of service currently offered by an employer's plan (in relation to the comparison plan).

Employers Express Some Interest in New Pediatric Benefits

The survey asked employers about their potential interest in offering new pediatric services not typically available in the health insurance plans that employers currently offer. As illustrated in Table Thirteen, they were asked to rate their interest in four different types of pediatric services on a 0 to 10 scale.

The survey results indicate that employers are most interested in programs designed to diagnose children's developmental and behavioral problems in the early stages; over half, in fact, are very interested in this service. Those expressing the most interest in enhanced preventive services are small or medium employers and those with a professional workforce. More than half of employers are also interested in expanded mental health coverage. In general, interest levels do not vary across groups. Parenting education classes is another new pediatric benefit that four out of 10 employers are enthusiastic about, particularly employers with professionals and blue collar employees. A third of employers also expressed substantial interest in adolescent clinics. These employers are more likely to be small and also have professional or blue collar employees.

Table Thirteen:
Potential Interest in Preventive Services for Children

	Average Score (0-10)	Very Interested (7-10)	Somewhat Interested (4-6)	Uninterested (0-3)
Offering preventive care visits with specially trained staff so that a child's developmental and behavior problems can be identified and treated before they become more serious	6.0	53%	27%	21%
Expanding mental health coverage so that children and their families can receive counseling and support even before a problem becomes a diagnosed mental illness	5.6	41	34	26
Providing new parent education programs to help families care for infants and children	5.4	41	32	27
Creating teenager-friendly clinics where teens could go to get treatment for the mental and physical problems common to their age group	4.8	31	38	31

DISCUSSION

Employers continue to play a major role in providing health insurance to children despite previous declines in the rates of employer-sponsored coverage and recent expansions in Medicaid and other types of public coverage. In 1997, 60 percent of all children in the United States obtained their health insurance coverage through their parents' employers.

Our survey of 450 employers revealed a strong commitment to insure employees' children, but a markedly different level of premium contributions for employees versus employees' children— 81 percent versus 61 percent. This disparity in premium contributions was even more pronounced among small firms and those in the South. Our survey also found that almost 20 percent of US firms that offer health insurance coverage for employees' families actually contributed nothing to the premium.

Not surprisingly, the financial burden imposed on families to pay for their share of the premium is substantial. In 1997, the average annual HMO premium rate for American families was \$5,143, while the average for individuals was \$1,769.⁹ Employees required to pay 40 percent of the family premium would be charged \$2,057, whereas those required to pay 20 percent of the employee premium would be charged \$354 -- more than a five-fold difference. The premium obligation for a family earning \$40,000 would represent as much as 20 percent of its income.

Affordability of employer-based health insurance coverage for families with children is clearly an important issue that needs careful examination. Various options could be considered to encourage employers to increase their premium contributions and to equalize the level of financial support for employee and family premiums. One approach is to establish large health insurance purchasing cooperatives for small firms and those with low-wage workers. Such group purchasing arrangements have the advantage of being able to offer lower cost and more comprehensive coverage than would otherwise be available in the insurance market.¹⁰ Another approach is to modify the tax exclusion for employment-based health insurance coverage. This could be accomplished either by only allowing tax exemptions for those employers that contribute 75 percent or more to health insurance for employees and their

⁹ Hoescht Marion Roussel: *Managed Care Digest Series*. Kansas City, Missouri, December 14, 1998.

¹⁰ Curtis R: *Resource Manual: Implementing Healthplan Purchasing Cooperatives*. Washington, D.C.: Institute for Health Policy Solutions. 1995.

families or by capping the tax exemption for firms that offer less than 75 percent. A third, complimentary strategy, might be to provide refundable, income-adjusted tax credits to families who are required to pay more than 25% of the premium share for employer-based family coverage.

Our employer survey also revealed that a sizable group of employees elect not to take the health insurance coverage offered for their children because they are already covered through a spouse. Twelve percent of employees reportedly decline coverage for this reason. Since the majority of American families now have two working parents, the issue of shifting responsibility for employer-based coverage onto spouses is an important one. According to the General Accounting Office, employers are implementing a variety of strategies to discourage employees from taking family coverage. These include providing financial incentives to employees who refuse family coverage, allowing only employees who are the primary wage earners to access family coverage, establishing multiple premium rates based on the number of dependents covered, and offering flexible benefit options to substitute for health insurance coverage (e.g., child care subsidies).¹¹ Financial incentives to discourage family coverage constitute serious threats to future improvements in employer-sponsored health insurance coverage for children. Congress and businesses together should examine alternative strategies to develop a more equitable distribution of responsibility for insuring children in families with two working parents. Research should also be conducted to assess the extent to which employers are adopting policies to discourage employees from purchasing health insurance coverage for their families.

The health insurance benefit packages offered by half of the employers in our survey can be described as basic. While routine medical services apparently are covered, other services important to children -- such as prescription drugs, physical therapy, occupational therapy, speech therapy, and dental care -- are not. Although the basic benefit plan includes mental health treatment services, coverage is available for only a very limited number of visits. Given that between 15-20 percent of children in the United States have an existing chronic or special health care need, the scope of employer benefit packages for children is critical to a large segment of working families.¹² Families with children who have special health care needs may

¹¹ General Accounting Office: *Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases*. Washington, D.C.: GAO, February 1997.

¹² Newacheck PW, Strickland B, Schonkoff JP, et al. An epidemiologic profile of children with special health care needs. *Pediatrics*. 1998; 102:117-123. Westbrook LE, Silver EJ, Stein REK: Implications for estimates of disability in children. A comparison of definitional components. *Pediatrics*. 1998; 101:1025-1030.

have limited resources to purchase health services not covered in their insurance plans, given that they have already expended a substantial amount on premium charges and probably copayment or coinsurance charges as well. Employers should consider the service requirements of their employees' children in structuring their benefit plans. Similarly, public programs, most importantly the Title V Program for Children with Special Health Care Needs, should consider expanding the focus of their efforts to include children in moderate and middle income families.

Given the current scope of benefits typically offered in employer-sponsored health insurance plans, a surprisingly high level of interest was expressed by employers in our survey in expanding pediatric benefits. The benefits that we specifically asked employers about were parent education programs, enriched preventive care visits with specially trained staff to address early childhood development concerns, expanded mental health counseling and support for children without diagnosed mental illness, and adolescent clinics. Clearly, translating employer interest in expanded pediatric benefits into reality will take a substantial commitment and new investment. Employers are, however, in the enviable position to negotiate improved services -- defining new benefit requirements or establishing financial incentives to achieve comprehensive coverage for their employees' children.



February 9, 1999

Employed But Not Insured:

A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance

by Jocelyn Guyer and Cindy Mann

I. Overview

States now offer health care coverage to uninsured children in low-income working families through Medicaid and, in some states, through newly established child health programs. The parents who head these families, however, remain at high risk of being uninsured. More than 5.4 million low-income working parents were uninsured in 1997 according to the U.S. Census Bureau data analyzed in this report.⁽¹⁾

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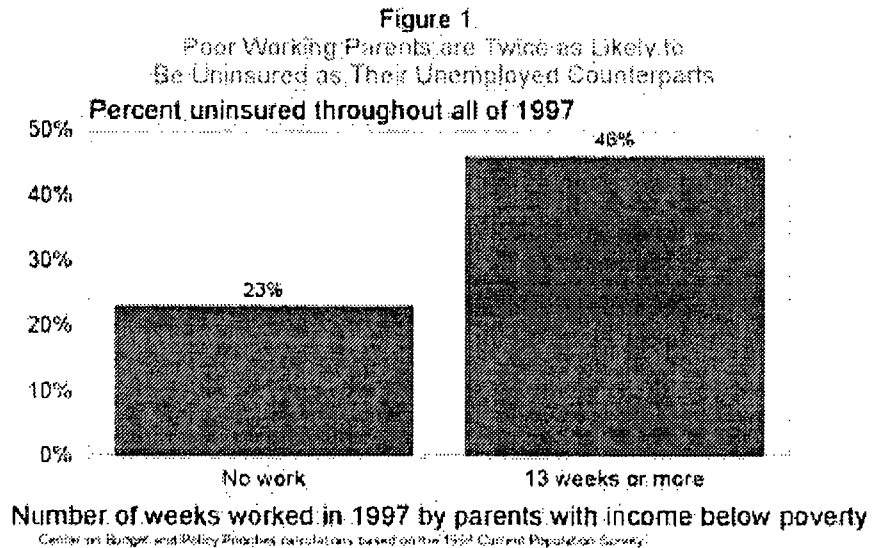
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- Nationwide, more than one out of three working parents (34.5 percent) with income below 200 percent of the poverty level (\$27,300 a year for a family of three in 1998) were uninsured.
- The uninsured rate among working parents with income below 100 percent of the federal poverty level (\$13,650 a year for a family of three) is even higher. Nationwide, close to half (46 percent) of all poor working parents are uninsured.
- Working poor parents are twice as likely to be uninsured as their unemployed counterparts. In 1997, some 23 percent of poor parents who had no earnings throughout the year were uninsured compared to 46 percent of poor parents who worked for 13 weeks or more during the year.

Unless action is taken, the number of uninsured working parents is likely to grow. More and more low-income parents are joining the workforce at the same time that employer-based coverage for low-wage workers is declining. Although states generally provide Medicaid to parents who are

receiving welfare, including parents combining welfare and work, few states cover low-income working parents who have no current or recent attachment to the welfare system. As a result, most parents who are supporting their families through part-time or full-time work are ineligible for Medicaid even if they work at jobs that pay very low wages and that do not offer health care coverage.⁽²⁾



- Some 43 states do not cover working parents who earn enough to bring them just to the poverty level (\$13,650 a year for a family of three).
- In half the states, working parents are ineligible for Medicaid if their earnings exceed 59 percent of the poverty level (\$7,992 a year for a family of three).
- In nine states (shown in Figure 2), working parents are ineligible for Medicaid if their earnings reach 37 percent of the poverty level — \$5,051 a year for a family of three. In these states, parents who earn \$7 an hour are ineligible for health care coverage through Medicaid if they work more than eight to 13 hours a week.
- For example, in Texas parents

who earn \$7 an hour are ineligible for coverage if they work more than 12 hours a week. Parents in Texas who earn the federal minimum wage of \$5.15 an hour are ineligible if they work more than 19 hours a week.

- Only seven states — Delaware, Hawaii, Massachusetts, Minnesota, Oregon, Rhode Island and Vermont — and the District of Columbia have Medicaid earnings thresholds that are at

least equal to the poverty level (\$13,650 a year for a family of three).⁽³⁾ The District of Columbia, Minnesota, Rhode Island, and Vermont cover parents with income at or above 150 percent of the poverty level.

- In addition, some 21 states fail to cover parents in two-parent families to the same extent that they cover parents in single-parent families. In these states, working parents in two-parent families will be ineligible for Medicaid at even lower incomes levels than those that apply to parents in single-parent families.

While the Medicaid earnings thresholds for working parents vary widely among the states, this is not a report about "good" versus "bad" states. For example, all of the states listed in Figure 2 have recently expanded coverage for low-income *children* — some quite substantially — and many are looking for ways to also cover their parents. Few states provide Medicaid more broadly to low-income working parents because, until recently, federal Medicaid law generally limited coverage to parents who were receiving welfare or who recently had left welfare.⁽⁴⁾

Figure 2

States with Particularly Limited Medicaid Coverage for Low-Income Working Parents

In these states, how many hours a week can a parent who is seeking Medicaid work and still be eligible?

	At a job that pays \$7 an hour	At a job that pays \$5.15 an hour
Alabama	8 hours	11 hours
Arkansas	8 hours	11 hours
Louisiana	9 hours	12 hours
West Virginia	11 hours	15 hours
Texas	12 hours	16 hours
Indiana	12 hours	17 hours
Virginia	13 hours	17 hours
Florida	13 hours	18 hours
Idaho	13 hours	18 hours

Note: Based on the earnings threshold for parents in three-person families that do not receive welfare.

Parents Already Enrolled in Medicaid May Be Able to Retain Medicaid Coverage at Somewhat Higher Income Levels

The earnings thresholds noted here apply to low-income working parents in three-person families who are applying for Medicaid. As discussed later in this report, parents may be able to retain Medicaid at somewhat higher income levels if they are enrolled in Medicaid under these more restrictive thresholds and then increase their earnings. For example, parents who have been on welfare and Medicaid and then increase their earnings to a level that would make them ineligible for Medicaid if they were first applying for coverage can retain Medicaid coverage for a limited period of time under "Transitional Medical Assistance" rules.

This restriction no longer operates under federal law. As a result of a provision in the 1996 federal welfare law that delinked Medicaid eligibility from eligibility for welfare, states have a new option to expand coverage more broadly to low-income working parents. Because the option to expand is through Medicaid, the federal government will provide states with federal Medicaid matching payments that will finance anywhere from 50 percent to 77 percent of the cost of such an expansion (with the exact portion depending on each state's federal Medicaid matching rate). Rhode Island and the District of Columbia already have used this option to expand coverage to more low-income working parents along with their children, and Missouri and Wisconsin recently adopted parent coverage expansions through federal Medicaid waivers. Every state can now take advantage of the new federal option — and federal Medicaid matching payments — to provide this critical support to low-income working families.

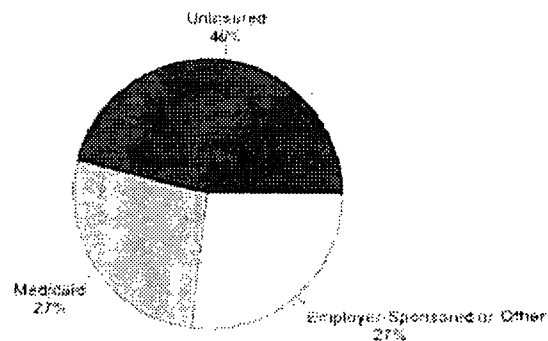
II. Data on Uninsured Parents

In 1997, according to Census Bureau data, there were 15.8 million working parents whose family income was below 200 percent of the poverty level — \$27,300 a year for a family of three. More than a third of these parents — 5.4 million parents — were uninsured throughout all of 1997.

Among the 4.9 million working parents with income below 100 percent of the poverty level in 1997, about a quarter were covered through Medicaid and another quarter were insured through employer-sponsored or "other" coverage (including other sources of private coverage and the military's health insurance program). The single largest group of working poor parents — 46 percent — were uninsured throughout all of 1997.

Tables 1 and 2 provide state-specific estimates of the number and percentage of working parents who were uninsured in each state during the mid-1990s. Table 1 shows estimates of the uninsured rate among working parents with income below 200 percent of the poverty level, while Table 2 shows such estimates for working parents with income below 100 percent of the poverty level. Because the state-level Census data are based on small samples, particularly for the less populated states, these data generally should not be used to compare uninsured rates across states. The data do, however, give a sense of the magnitude of the problem in each state.⁽⁵⁾

Figure 3
Close to Half of All Working Poor Parents are Uninsured



Health Insurance Status of Working Poor Parents, 1997

Source: CBPP calculations based on March 1996 Current Population Survey data

Low-income working parents are at high risk of being uninsured because, as described in more detail below, they have limited access to publicly-funded coverage and, at the same time, they often are not offered coverage through their employers. In 1996, only 43 percent of workers making \$7 or less per hour were offered health insurance coverage by their employers.⁽⁶⁾ In contrast, among workers making more than \$15 an hour, 93 percent were offered coverage. Moreover, not all low-wage workers who are offered coverage can afford to purchase that coverage, particularly as more of the cost of coverage has been shifted on to employees in recent years. Between 1988 and 1996, the cost to employees of purchasing coverage for themselves increased at an average annual rate of 18.3 percent and the cost of purchasing family coverage over this same period grew at an average annual rate of 11.9 percent.⁽⁷⁾

Table 1

**Working Parents in Families with Income Below 200 Percent of Poverty
Lacking Health Insurance, Mid-1990s**

	Number of working parents below 200% of poverty	Number without health insurance	Percent without health insurance	90 Percent Confidence Interval*	
				Low	High
United States	16,060,000	5,410,000	33.7%	32.3%	35.1%
Alabama	274,000	78,000	28.6%	18.4%	38.8%
Alaska	34,000	12,000	34.5%	22.6%	46.3%
Arizona	412,000	187,000	45.5%	36.6%	54.4%
Arkansas	248,000	86,000	34.7%	26.2%	43.3%
California	2,226,000	901,000	40.5%	36.1%	44.8%
Colorado	181,000	56,000	31.1%	18.8%	43.4%
Connecticut	120,000	27,000	22.1%	8.2%	36.0%
Delaware	35,000	12,000	33.0%	19.2%	46.7%
District of Columbia	20,000	5,000	27.4%	12.9%	41.9%
Florida	859,000	328,000	38.1%	32.1%	44.2%
Georgia	494,000	216,000	43.7%	33.9%	53.5%
Hawaii	73,000	6,000	8.0%	1.1%	14.9%
Idaho	101,000	37,000	37.0%	27.9%	46.1%
Illinois	609,000	142,000	23.4%	17.1%	29.6%
Indiana	293,000	70,000	24.0%	13.4%	34.6%
Iowa	190,000	44,000	23.1%	13.6%	32.6%
Kansas	167,000	42,000	25.4%	15.4%	35.5%
Kentucky	267,000	105,000	39.4%	28.7%	50.1%
Louisiana	321,000	115,000	35.9%	26.3%	45.6%
Maine	73,000	26,000	35.9%	23.4%	48.4%
Maryland	207,000	64,000	30.8%	16.9%	44.6%
Massachusetts	222,000	58,000	26.1%	16.1%	36.1%
Michigan	432,000	111,000	25.7%	18.2%	33.1%
Minnesota	234,000	51,000	21.6%	11.2%	32.0%

Mississippi	255,000	78,000	30.8%	22.2%	39.3%
Missouri	308,000	96,000	31.3%	19.8%	42.7%
Montana	78,000	19,000	24.2%	16.4%	32.1%
Nebraska	102,000	20,000	19.5%	10.0%	29.1%
Nevada	88,000	30,000	33.9%	21.6%	46.2%
New Hampshire	49,000	14,000	29.0%	14.2%	43.7%
New Jersey	303,000	109,000	36.0%	26.8%	45.3%
New Mexico	162,000	78,000	48.1%	39.0%	57.2%
New York	960,000	333,000	34.7%	29.3%	40.0%
North Carolina	415,000	137,000	33.1%	24.8%	41.4%
North Dakota	39,000	8,000	21.1%	11.4%	30.7%
Ohio	569,000	130,000	22.9%	16.3%	29.5%
Oklahoma	268,000	85,000	31.7%	22.8%	40.6%
Oregon	194,000	47,000	24.1%	13.6%	34.7%
Pennsylvania	549,000	128,000	23.4%	16.8%	29.9%
Rhode Island	33,000	8,000	23.1%	9.1%	37.2%
South Carolina	254,000	87,000	34.2%	22.9%	45.5%
South Dakota	43,000	8,000	18.8%	9.7%	27.9%
Tennessee	415,000	106,000	25.5%	16.3%	34.8%
Texas	1,639,000	798,000	48.7%	43.6%	53.7%
Utah	163,000	33,000	20.1%	12.4%	27.7%
Vermont	39,000	9,000	23.0%	13.3%	32.8%
Virginia	356,000	99,000	27.7%	17.1%	38.3%
Washington	262,000	65,000	24.8%	13.0%	36.7%
West Virginia	135,000	44,000	32.6%	23.4%	41.9%
Wisconsin	247,000	41,000	16.7%	7.0%	26.4%
Wyoming	41,000	14,000	33.7%	24.3%	43.1%

*There is a 90 percent chance that the actual uninsured rate among working parents below 200 percent of the poverty level, if it were determined from a survey of all households, would fall in the range defined by the low-end and high-end estimates of the 90 percent confidence interval. The confidence interval is higher in states with smaller sample sizes.

Source: CBPP tabulations of Census Bureau's March Current Population Survey data from 1996-98. Data are for 1995 - 1997. Based on parents living with children between the ages of 18 and 65 in families with income below 200 percent of poverty and in which the parents worked a combined total of more than 13 weeks a year. Due to rounding error, the uninsured rate presented in column 4 may not equal the quotient of columns 2 and 3.

Table 2
Working Parents in Poor Families Lacking Health Insurance, Mid-1990s

	Number of working poor parents	Number without health insurance	Percent without health insurance	90 Percent Confidence Interval	
				Low	High*
United States	4,818,000	2,222,000	46.1%	43.5%	48.8%
Alabama	81,000	32,000	39.5%	18.9%	60.2%
Alaska	8,000	3,000	36.1%	12.2%	60.0%
Arizona	148,000	93,000	62.6%	48.2%	77.1%
Arkansas	64,000	39,000	61.1%	43.9%	78.2%

California	794,000	379,000	47.8%	40.4%	55.2%
Colorado	37,000	16,000	42.4%	12.7%	72.0%
Connecticut	35,000	13,000	36.4%	4.0%	68.7%
Delaware**	7,000	3,000	45.1%	12.6%	77.6%
District of Columbia**	6,000	2,000	38.6%	10.3%	66.9%
Florida	266,000	140,000	52.6%	41.4%	63.8%
Georgia	134,000	72,000	54.0%	35.1%	72.9%
Hawaii	19,000	3,000	15.6%	0.0%	34.1%
Idaho	35,000	19,000	53.0%	37.1%	68.9%
Illinois	178,000	57,000	31.8%	19.2%	44.4%
Indiana	73,000	35,000	48.2%	22.7%	73.6%
Iowa	56,000	18,000	32.0%	12.9%	51.2%
Kansas	40,000	16,000	41.0%	19.3%	62.7%
Kentucky	101,000	54,000	53.9%	36.3%	71.4%
Louisiana	95,000	52,000	54.4%	36.4%	72.3%
Maine	18,000	11,000	59.9%	34.2%	85.7%
Maryland	51,000	20,000	38.6%	9.3%	68.0%
Massachusetts	59,000	18,000	30.6%	10.2%	50.9%
Michigan	124,000	42,000	33.7%	18.6%	48.8%
Minnesota	47,000	14,000	30.0%	3.7%	56.4%
Mississippi	87,000	36,000	41.7%	25.6%	57.7%
Missouri	83,000	32,000	38.4%	14.8%	62.1%
Montana	25,000	9,000	35.4%	20.2%	50.6%
Nebraska	22,000	5,000	20.6%	0.0%	41.7%
Nevada	25,000	14,000	55.7%	29.3%	82.2%
New Hampshire**	10,000	5,000	47.6%	9.3%	86.0%
New Jersey	63,000	30,000	48.4%	26.6%	70.2%
New Mexico	63,000	38,000	60.7%	46.2%	75.1%
New York	300,000	118,000	39.4%	29.5%	49.3%
North Carolina	120,000	59,000	49.3%	32.8%	65.7%
North Dakota	13,000	4,000	28.2%	9.4%	47.0%
Ohio	159,000	55,000	34.7%	20.7%	48.6%
Oklahoma	88,000	40,000	45.3%	28.8%	61.7%
Oregon	58,000	20,000	34.3%	13.3%	55.3%
Pennsylvania	136,000	53,000	38.9%	23.7%	54.1%
Rhode Island**	9,000	5,000	54.2%	23.8%	84.6%
South Carolina	69,000	28,000	41.2%	18.4%	63.9%
South Dakota	13,000	4,000	28.4%	8.5%	48.3%
Tennessee	110,000	36,000	32.8%	13.9%	51.8%
Texas	573,000	362,000	63.1%	54.9%	71.3%
Utah	31,000	13,000	41.7%	20.8%	62.6%
Vermont	10,000	3,000	32.1%	10.8%	53.5%
Virginia	95,000	36,000	38.2%	15.6%	60.8%

Washington	68,000	24,000	35.2%	10.9%	59.4%
West Virginia	37,000	22,000	58.8%	40.1%	77.6%
Wisconsin	62,000	15,000	24.1%	2.0%	46.1%
Wyoming	11,000	5,000	48.6%	29.4%	67.8%

*There is a 90 percent chance that the actual uninsured rate among working parents below 100 percent of the poverty level, if it were determined from a survey of all households, would fall in the range defined by the low-end and high-end estimates of the 90 percent confidence interval. The confidence interval is higher in states with smaller sample sizes.

**Figures are based on a sample size that falls below the minimum recommended by the Census Bureau for reliable estimates.

Source: CBPP tabulations of Census Bureau's March Current Population Survey data from 1996-98. Data are for 1995 - 1997. Based on parents between the ages of 18 and 65 living with children in families with income below 100 percent of poverty and in which the parents worked a combined total of more than 13 weeks a year. Due to rounding error, the uninsured rate presented in column 4 may not equal the quotient of columns 2 and 3.

End Notes:

1. The national estimates of the number and percentage of uninsured working parents in this report are based on calculations done by the Center on Budget and Policy Priorities using data from the U.S. Census Bureau's March 1998 Current Population Survey. In this report, "low-income" is defined as having income below 200 percent of the federal poverty level (\$27,300 a year for a family of three). The term "working parent" includes household heads and their spouses between the ages of 18 and 65 who lived with children and who worked a combined total of more than 13 weeks during the year. The data show that poor parents who work more than 13 weeks during the year work an average of 28.4 hours during each work week.

2. In general, this report considers the basic Medicaid income eligibility rules that apply to low-income families with children in each state. Pregnant women, disabled parents, and parents who are themselves under the age of 19 may be eligible for Medicaid at higher income levels than the levels presented in this report. A small number of states also cover parents through "medically needy" eligibility categories at somewhat higher income levels, although in practice states with medically needs categories generally use them primarily to cover people with high medical bills. Appendix B provides additional details on the Medicaid eligibility categories for families with children and describes the methodology for identifying the state-specific earnings thresholds for working parents included in this report.

3. Maine also extends Medicaid to single parents with earnings up to 100 percent of the poverty level, but it only covers parents in two-parent families if one of the parents is incapacitated or the principal wage earner works fewer than 100 hours a month. As noted later in this report, Missouri and Wisconsin have adopted but not yet implemented Medicaid expansions for parents.

4. The one exception is that states have had the option to provide coverage to families with children with income somewhat above welfare income eligibility thresholds without regard to whether they were eligible for welfare under what is known as the "medically needy" eligibility category. In most states, however, this category is used primarily to offer partial coverage to families that have high medical bills relative to their incomes and that "spend down" to the medically needy income eligibility levels. States also have had the opportunity to vary from federal law by seeking a waiver from the federal government. Delaware, Hawaii, Massachusetts, Minnesota, Oregon and Vermont have expanded coverage for parents through waivers.

5. State estimates of the number and percentage of uninsured working parents are based on calculations done by the Center on Budget and Policy Priorities using U.S. Census Bureau data from the March 1998, March 1997 and March 1996 Current Population Surveys. In developing the estimates in Tables 1 and 2, the Center used a standard strategy employed by researchers and others of pooling CPS data for a three-year period to increase the accuracy of state-specific estimates of uninsured rates. A three-year average of CPS data is used in the new child health insurance program (CHIP) to allocate the federal child health block grant funds among states.

6. Philip F. Cooper and Barbara Steinberg Schone, *More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996*, Health Affairs, 16(6) (1997), pp. 142-149. The percentage of workers with wages at or below \$7 per hour who have "access" to employer-based coverage is somewhat higher (55 percent in 1996) because some low-wage workers are offered coverage through the employer of a family member.

7. Ellen O'Brien and Judith Feder, *How Well Does the Employment-Based Health Insurance System Work for Low-Income Families?*, Kaiser Commission on Medicaid and the Uninsured, September 1998.



February 9, 1999

Employed But Not Insured

Part II

by Jocelyn Guyer and Cindy Mann

III. State Medicaid Coverage for Parents

In virtually all states, Medicaid eligibility rules for working parents are much more restrictive than the rules that apply to their children. In general, to be eligible for Medicaid, parents must have income and resources that fall below a state's Medicaid income and resource thresholds for the state's family coverage category. To date, states generally have set these thresholds at the same levels as the income and resource thresholds that they use to determine eligibility for cash welfare. As a practical matter, this means that most parents can enroll in Medicaid only if they have income and resources low enough to qualify for welfare.

Moreover, some 21 states restrict Medicaid coverage to parents in single-parent families and to parents in a small portion of two-parent families. In these states, parents in two-parent families who work are even less likely to qualify for Medicaid than parents in single-parent households.

In contrast, all states provide health care coverage through Medicaid (and, in some states, through separate child health insurance programs) to children at significantly higher income levels, and eligibility for children generally does not depend on whether they are part of a single-parent or a two-parent family. In addition, 40 states have dropped the resource test for children applying for Medicaid.

State Medicaid Earnings Thresholds for Parents

Table 3 shows how much an uninsured parent in a three-person family who is applying for Medicaid can earn on a monthly or annual basis and still be found eligible for coverage in each state. Table 4 shows how many hours a week such a parent can work and still be found eligible for Medicaid. Both tables look at *gross* income before taxes and other work-related expenses are taken into account.

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How to Read Tables 3 and 4

Table 3 shows how much a working parent in a three-person family can earn and still be found eligible for Medicaid. For example, it shows that in Florida a parent in a three-person family can earn no more than \$391 a month and still be found eligible for Medicaid. On an annual basis, such a parent can earn no more than \$4,704 a year in Florida, an amount that is equivalent to 34 percent of the poverty level.

Table 4 provides the same information, but it is presented in terms of the number of hours a parent can work and still be found eligible for Medicaid. For example, in Alabama a parent in a three-person family can work no more than eight hours a week at a job that pays \$7 an hour and be found eligible for coverage. If the parent is employed at a job that pays the federal minimum wage of \$5.15 an hour, he or she can work no more than 11 hours a week and still be found eligible for coverage in Alabama.

Both Tables 3 and 4 show the thresholds applicable to parents who are applying for Medicaid, who are not on welfare, whose only source of income is from earnings, and who do not pay child care expenses out-of-pocket. If parents have income from sources other than earnings, lower income eligibility thresholds than those presented in Tables 3 and 4 might apply. At the same time, if they pay out-of-pocket for child care expenses, they may be eligible for Medicaid at higher income levels because child care costs (generally up to a capped amount) are deducted from gross earnings. See Appendices B and C for a detailed description of the methodology used to compile the data for these tables and for additional state-specific information.

The earnings thresholds presented in Table 3 are a function of a state's Medicaid "net" or "countable" income standard and the disregards it allows for families with earnings.⁽¹⁾ When states define what counts as income for purposes of determining Medicaid eligibility, under federal law they must at a minimum "disregard" (i.e., not count) \$90 of a Medicaid applicant's monthly earnings to account for certain work-related expenses. The law, however, allows states to disregard more than the required minimum of \$90. Higher disregards, in effect, raise the state's earnings threshold for working families. For example, a state with a Medicaid net or countable income standard of \$500 a month could decide to disregard \$200 in earnings. If it does so, the earnings threshold for a working parent in that state would be \$700 (\$500 + \$200 earnings disregard = \$700, the state's countable income standard). There is wide variation among states with respect to both their net or countable income standards and their earnings disregard policies.

Table 3

How Much Can a Working Parent Who is Applying for Medicaid Earn and Still Be Eligible for Coverage?

*(Based on a 3-person family with one wage earner.
Assumes that the family's only source of income is earnings.)*

	Monthly Earnings Threshold	Annual Earnings Threshold	Earnings Threshold as a Percent of the Federal Poverty Level
Alabama	\$253	\$3,036	22%
Alaska	\$1,181	\$14,172	83%
Arizona	\$584	\$7,011	51%
Arkansas	\$255	\$3,060	22%
California	\$864	\$10,368	76%
Colorado	\$510	\$6,120	45%

Connecticut*	\$866	\$10,392	76%
Delaware**	\$1,228	\$14,730	108%
District of Columbia	\$2,275	\$27,300	200%
Florida	\$392	\$4,704	34%
Georgia	\$513	\$6,156	45%
Hawaii**	\$1,309	\$15,708	100%
Idaho	\$406	\$4,872	36%
Illinois*	\$597	\$7,164	52%
Indiana	\$377	\$4,524	33%
Iowa	\$1,063	\$12,750	93%
Kansas	\$493	\$5,916	43%
Kentucky	\$615	\$7,380	54%
Louisiana	\$263	\$3,156	23%
Maine	\$1,227	\$14,724	108%
Maryland*	\$523	\$6,276	46%
Massachusetts**	\$1,513	\$18,156	133%
Michigan	\$548	\$6,576	48%
Minnesota**	\$3,128	\$37,538	275%
Mississippi	\$457	\$5,484	40%
Missouri	\$381	\$4,572	33%
Montana	\$833	\$10,000	73%
Nebraska*	\$490	\$5,880	43%
Nevada	\$1,020	\$12,240	90%
New Hampshire	\$686	\$8,235	60%
New Jersey	\$533	\$6,396	47%
New Mexico	\$702	\$8,424	62%
New York	\$666	\$7,992	59%
North Carolina	\$634	\$7,608	56%
North Dakota	\$845	\$10,140	74%
Ohio	\$972	\$11,664	85%
Oklahoma	\$426	\$5,112	37%
Oregon**	\$1,138	\$13,650	100%
Pennsylvania	\$804	\$9,648	71%
Rhode Island	\$2,194	\$26,333	193%
South Carolina	\$658	\$7,896	58%
South Dakota	\$796	\$9,546	70%
Tennessee	\$766	\$9,192	67%
Texas*	\$364	\$4,368	32%
Utah*	\$657	\$7,884	58%
Vermont**	\$1,797	\$21,564	158%
Virginia	\$380	\$4,560	33%
Washington	\$1,090	\$13,080	96%
West Virginia	\$342	\$4,104	30%

Wisconsin	\$737	\$8,844	65%
Wyoming	\$789	\$9,468	69%
Median state	\$666	\$7,992	59%

Unless otherwise noted, the earnings thresholds presented in this table are based on the income standards and earnings disregards used by states under their family coverage categories. States marked with an "*" have not yet established a family coverage category and base their earnings thresholds on the state's medically needy eligibility rules. States marked with "**" have expanded coverage to low-income working parents under a waiver of federal law and the table is based on the eligibility rules that apply to parents under the waiver. See Appendices B and C for additional information.

Table 4

How Many Hours Can a Parent Who is Applying for Medicaid Work and Still Be Eligible for Coverage?

*(Based on a 3-person family with one wage earner.
Assumes that the family's only source of income is earnings.)*

	At a \$7 an hour job, can a parent work full time?	If no, how many hours a week can a parent work?	At the federal minimum wage (\$5.15 per hour), can a parent work full time?	If no, how many hours a week can a parent work?
Alabama	NO	8	NO	11
Alaska	NO	39	YES	
Arizona	NO	19	NO	26
Arkansas	NO	8	NO	11
California	NO	28	NO	39
Colorado	NO	17	NO	23
Connecticut*	NO	29	NO	39
Delaware **	YES		YES	
District of Columbia	YES		YES	
Florida	NO	13	NO	18
Georgia	NO	17	NO	23
Hawaii**	YES		YES	
Idaho	NO	13	NO	18
Illinois*	YES	20	NO	27
Indiana	NO	12	NO	17
Iowa	NO	35	YES	
Kansas	NO	16	NO	22
Kentucky	NO	20	NO	28
Louisiana	NO	9	NO	12
Maine	YES		YES	
Maryland*	NO	17	NO	23
Massachusetts**	YES		YES	
Michigan	NO	18	NO	25
Minnesota**	YES		YES	
Mississippi	NO	15	NO	20
Missouri	NO	13	NO	17
Montana	NO	27	NO	36

Nebraska*	NO	16	NO	22
Nevada	NO	34	YES	
New Hampshire	NO	23	NO	36
New Jersey	NO	18	NO	24
New Mexico	NO	23	NO	31
New York	NO	22	NO	30
North Carolina	NO	21	NO	28
North Dakota	NO	28	NO	38
Ohio	NO	32	YES	
Oklahoma	NO	14	NO	19
Oregon**	NO	38	YES	
Pennsylvania	NO	27	NO	36
Rhode Island	YES		YES	
South Carolina	NO	22	NO	29
South Dakota	NO	26	NO	36
Tennessee	NO	25	NO	34
Texas*	NO	12	NO	16
Utah*	NO	22	NO	29
Vermont**	YES		YES	
Virginia	NO	13	NO	17
Washington	NO	36	YES	
West Virginia	NO	11	NO	15
Wisconsin	NO	24	NO	33
Wyoming	NO	26	NO	35
Median state	NO	21	NO	28

Unless otherwise noted, the earnings thresholds presented in this table are based on the income standards and earnings disregards used by states under their family coverage categories. States marked with an "*" have not yet established a family coverage category and base their earnings thresholds on medically needy eligibility rules. The states marked with "**" have expanded coverage to low-income working parents under a waiver of federal law and the table is based on the eligibility rules that apply to parents under the waiver. See Appendices B and C for additional information. Some states have minimum wage levels that are higher than the federal level.

In some states, somewhat higher earnings thresholds for ongoing Medicaid coverage apply to parents who first qualify under the thresholds shown in Tables 3 and 4 and who then find a job or increase their earnings. States have adopted these more generous eligibility rules for parents already enrolled in Medicaid in order to allow them to increase their earnings without losing ongoing coverage. In some states, these more generous rules for calculating financial eligibility for Medicaid recipients are time-limited. The earnings thresholds that states use to determine the ongoing eligibility of a parent who already is enrolled in Medicaid are shown in Tables 6 and 7 in Appendix A.

Missouri and Wisconsin Have Approved, But Not Yet Implemented, Expansions of Coverage for Low-Income Working Parents

This report is based on the earnings thresholds for parents that are currently in place in the states. However, both Missouri and Wisconsin have adopted expansions in Medicaid for low-income working parents that they plan to implement later in 1999. Wisconsin has expanded Medicaid to parents with income up to 185 percent of the poverty level and then will allow them to remain enrolled until their income reaches 200 percent of the poverty level. Missouri's expansion, which is slated for implementation later this month, covers parents with income up to 100 percent of the poverty level and certain non-custodial parents with income up to 125 percent of the poverty level.

In addition, all states are required by federal law to provide up to twelve months of "Transitional Medical Assistance" to parents enrolled in Medicaid who lose their eligibility for ongoing coverage due to earnings.⁽²⁾ Twelve states have received waivers to extend TMA for longer than 12 months.⁽³⁾

Both the provision of time-limited TMA and the use in selected states of more generous eligibility rules for parents already enrolled in Medicaid assure that these parents can increase their earnings somewhat without losing health care coverage, at least for a period of time. These rules are an important source of coverage for some low-income working parents, especially those entering or re-entering the low-wage job market after a period of unemployment. However, these rules provide Medicaid at somewhat higher income levels only to those parents who were unemployed or whose incomes were so low that they could qualify for coverage under the much more restrictive rules that generally apply to applicants. They are not a substitute for covering low-income parents more broadly, and they raise equity issues because they do not help low-income parents who consistently have been working at low-wage jobs.

Medicaid for Parents in Two-Parent Families

Until recently, states could not cover parents in two-parent families to the same extent that they covered parents in single-parent families unless they had a waiver of standard federal rules allowing them to do so. Under these rules, which relate back to the old AFDC program, parents in two-parent families can qualify for Medicaid only if one of the two parents in the family is incapacitated or "unemployed" which is defined as working fewer than 100 hours a month. In August of 1998, the U.S. Department of Health and Human Services issued a regulation allowing states to effectively drop the 100-hour rule limitation for two-parent families without having to secure a federal waiver.⁽⁴⁾ States that have waivers or that take advantage of the flexibility offered by the new regulation can provide Medicaid to parents in two-parent families to the same extent that they offer coverage to parents in single-parent families.

Table 5 shows which states provide Medicaid to parents in two-parent families to the same extent as they provide coverage to parents in single-parent families. As of the fall of 1998, 29 states and the District of Columbia had dropped the limitations on covering parents in two-parent families.⁽⁵⁾ In the remaining 21 states, low-income working parents in single-parent families will have greater access to Medicaid than parents in two-parent families. For example, Pennsylvania provides coverage to a

mother with two children who earns the minimum wage and works up to 36 hours a week, as shown in Table 3. But, as a result of the 100-hour rule limitation, Pennsylvania does not cover the parents in a two-parent family if the principal wage earner (either the husband or the wife) works at the minimum wage more than 100 hours a month (or an average of 23 hours a week).

**Additional States Are Planning to Improve
Coverage of Two-Parent Families**

In the process of gathering information for Table 5, the Center was informed by a number of states that they plan to eliminate the 100-hour rule sometime in 1999. Thus, the number of states that provide coverage to parents in two-parent families on the same terms that they make coverage available to single-parent families may increase noticeably in the next several months.

Table 5

**Which States Cover Two-Parent Families to the Same Extent as
Single-Parent Families?**

(States cover two-parent families to the same extent as single-parent families if they have eliminated the "100 hour rule," a requirement that the principal wage earner in a two-parent family work fewer than 100 hours per month.)

**Cover two-parent families to the same extent as
single-parent families?**

Alabama	No
Alaska	No
Arizona	Yes
Arkansas	No
California	New applicants — No; Recipients - Yes
Colorado	No
Connecticut	New applicants — No; Recipients — Yes
Delaware **	Yes
District of Columbia	Yes
Florida	No
Georgia	Yes
Hawaii **	Yes
Idaho	Yes
Illinois *	Yes
Indiana	Yes
Iowa	Yes
Kansas	Yes
Kentucky	No
Louisiana	No
Maine	No
Maryland *	Yes
Massachusetts **	Yes
Michigan	Yes

Minnesota **	Yes
Mississippi	Yes
Missouri	Yes
Montana	Yes
Nebraska *	No
Nevada	Yes
New Hampshire	No
New Jersey	No
New Mexico	Yes
New York	Yes
North Carolina	Yes
North Dakota	No
Ohio	Yes
Oklahoma	No
Oregon	Yes
Pennsylvania	No
Rhode Island	Yes
South Carolina	Yes
South Dakota	Yes
Tennessee	No
Texas	Yes
Utah	No
Vermont **	Yes
Virginia	Yes
Washington	Yes
West Virginia	No
Wisconsin	No
Wyoming	No

Unless otherwise noted, the information presented in this table is based on a state's rules for two-parent families under its family coverage category. States marked with an "*" have not yet established a family coverage category, but do have a medically needy category and the information in this table is based on their medically needy eligibility rules. States marked with "**" have expanded coverage to low-income working parents under a waiver of federal law and the table is based on the eligibility rules that apply to parents under the waiver. See Appendices B and C for additional information.

IV. States Have a New Opportunity to Expand Medicaid to Cover More Low-Income Working Parents

The low earnings thresholds that operate to exclude many low-income working parents from Medicaid coverage and the limitations on covering parents in two-parent families result from the historic link between Medicaid and the now-repealed Aid to Families with Dependent Children (AFDC) program. Until 1996, federal Medicaid law largely limited states to covering low-income parents who received or who had recently received welfare under the AFDC program. A few states, such as Massachusetts, Minnesota, and Vermont, secured special waivers of federal Medicaid law from the Health Care Financing Administration, which administers Medicaid on the federal level, allowing them to provide Medicaid to low-income parents not on welfare. The waiver process, however, often involved lengthy and

complex negotiations with HCFA, including a guarantee that any increase in federal Medicaid spending that might result from a state's proposed expansion in coverage would be fully offset by federal savings generated by other changes in state Medicaid policies.

When the federal welfare law was enacted in August of 1996 and the AFDC program was repealed, eligibility for Medicaid was "delinked" from eligibility for welfare. Under current federal law, a parent's receipt of welfare does not determine his or her eligibility for Medicaid. In place of the link between welfare and Medicaid eligibility, federal law established a new family coverage category. Under this category, *at a minimum*, states must cover parents who meet the income and resource standards and conform to certain of the family composition rules that they used in their AFDC programs on July 16, 1996. States can, however, expand eligibility for families with children under the new category beyond these minimum standards, and, as discussed above, states can eliminate the restrictive family composition rules that limit coverage for parents in two-parent families.

The 1996 federal welfare law thus created a new opportunity for states to cover a broader group of low-income working parents. The new option is available to all states without the need to secure a waiver. Moreover, the federal government will finance anywhere from 50 percent to 77 percent of the cost of expanding Medicaid to low-income working parents, with the exact portion determined by each state's regular Medicaid matching rate (see Table 8 in Appendix D).⁽⁶⁾

How Does the Parent Expansion Option Relate to the New Child Health Insurance Program (CHIP)?

The Balanced Budget Act of 1997 created a child health block grant that can be used by states to expand Medicaid for children or to establish or expand separate child health insurance programs. Although there are some limited exceptions, the child health block grant funds generally cannot be used to provide health care coverage to parents.

States that are interested in providing health care to all members of low-income families — not just to the children in these families — can do so by combining the Medicaid parent expansion option discussed here with the opportunities created by the child health block grant to expand coverage for children. For example, a state could expand Medicaid to cover both the parents and the children in low-income working families and receive the enhanced federal matching payments available under the child health law for the children's coverage. Wisconsin, which will soon implement an expansion of coverage to parents and children with income below 185 percent of the poverty level under an 1115 waiver, has adopted this approach. Alternatively, a state could elect to expand Medicaid to some of the parents whose children are eligible for coverage under the state's Medicaid program. In Rhode Island, children are eligible for Medicaid up to 250 percent of the poverty level and parents are now eligible if their incomes are below 185 percent of the poverty level.

Although the new opportunity is an option to expand Medicaid for families with children, not just for parents, states have long had broad flexibility to expand Medicaid to cover children in low-income working families. Moreover, the new child health block grant created by the Balanced Budget Act of 1997 further encouraged states to expand coverage for children by making enhanced federal payments available for such coverage. The option created by the 1996 federal welfare law is significant, therefore, because for the first time it allows states to expand Medicaid to low-income

working parents without securing a federal waiver.

States Also Can Relax or Eliminate Their Resource Test for Parents

Along with meeting a state's income test, a parent seeking Medicaid generally must also meet a resource test. As with their income test, states have broad flexibility to design their resource test for parents. If a state has not taken advantage of this flexibility to expand or eliminate its resource limit, a parent seeking Medicaid is generally ineligible for coverage if she has more than \$1,000 in resources (not counting part of the value of the family's car and a small number of other items).

Several states have already adopted more generous resource rules. For example, Ohio and Oklahoma have eliminated the Medicaid resource test for parents. Other states, such as Kansas, have elected to disregard the full value of a family's car when evaluating whether a parent meets their Medicaid resource test.

Rhode Island and the District of Columbia already have taken advantage of the parent expansion opportunity. As a result of these expansions, low-income working parents can be employed full-time at jobs that pay up to \$12 an hour in Rhode Island and up to \$13 an hour in the District of Columbia and be eligible for Medicaid.

- **District of Columbia** — In October 1998, the District of Columbia created a new program call "DC Healthy Families" that provides Medicaid to families with children with income up to 200 percent of the poverty level (\$27,300 for a family of three), including the parents in these families. Under the District's new program, families with children are eligible for coverage regardless of whether they are headed by a single parent or by two parents. Moreover, the District does not require families to meet a resource test in order to be eligible for coverage.
- **Rhode Island** — In November, 1998, Rhode Island expanded Medicaid to families with children with net or countable income up to 185 percent of the poverty level (\$25,252 for a family of three). Since the state already had covered children at even higher income levels, this expansion served to extend Medicaid to some, although not all, of the parents of children already covered under Medicaid in Rhode Island. As in the District of Columbia, parents do not need to meet an asset test in order to be eligible for Medicaid under the expansion, nor is coverage limited to single-parent families.

Missouri and Wisconsin also have decided to expand Medicaid to a broader group of low-income working parents in recent months, joining the ranks of states such as Delaware, Hawaii, Massachusetts, Minnesota, Oregon, and Vermont that have used the 1115 waiver process to cover parents at higher income levels (see box in Chapter 3 for details). In both states, the parent expansions are part of larger health care expansions designed to provide support to low-income families trying to get by in the low-wage job market.

V. Conclusion

Until recently, states have had little opportunity under federal law to provide Medicaid to low-income working parents without regard to whether they were receiving or had recently received welfare. As a result, uninsured parents seeking to support their families by working at low-wage jobs are largely ineligible for coverage through Medicaid if they work more than a few hours each week. Indeed, parents who work enough to bring their families' income up to the federal poverty level are ineligible for Medicaid in all but a handful of states. At the same time, low-income parents often do not have access to employer-sponsored health care coverage through their jobs. Given their limited access to Medicaid and to employer-sponsored coverage, low-income parents are uninsured at high rates.

However, as this report illustrates, some states have taken advantage of federal Medicaid matching payments to provide coverage to low-income working parents more broadly. In these states, low-income parents can work full time without fear of being uninsured. As the result of the provision in the 1996 federal welfare law that delinked TANF and Medicaid eligibility, all states now have the opportunity to provide health care coverage to low-income working parents through Medicaid without seeking a federal waiver.

Until more states seize upon the new opportunity, the number of uninsured low-income parents is likely to grow as changes in welfare programs and the strong economy result in more parents working at low-wage jobs do not offer health insurance. By taking advantage of the new option, states can lower dramatically the number of uninsured parents in their state and provide critical support to low-income working families.

End Notes:

1. The income eligibility thresholds shown in these tables vary from (and are generally higher than) the net or countable income eligibility thresholds states will commonly report as their Medicaid income thresholds for families with children. The thresholds reported here provide information on the total amount of earnings a family can have and still be eligible for Medicaid, while net or countable income thresholds indicate the total amount of income a family can have and still be eligible for Medicaid *after certain deductions are taken into account*.
2. States must provide six months of TMA without regard to how much a family earns, and an additional six months as long as the family's gross earnings less child care expenses are below 185 percent of the poverty level.
3. Jan Kaplan, *Transitional Medicaid Assistance* (Washington, D.C., Welfare Information Network, December 1997).
4. Federal Register, Volume 63, Number 152, August 7, 1998.
5. Two additional states — California and Connecticut — have eliminated the 100-hour rule requirement for two-parent families already enrolled in Medicaid, but have retained the rule for adults in two-parent families applying for coverage.
6. For a detailed discussion of how the 1996 federal welfare law changes make it possible for states to expand coverage to low-income working parents, see Guyer and Mann, *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-Income Working Parents*, Center on Budget and Policy Priorities, August 20, 1998.



February 9, 1999

Employed But Not Insured

Appendices

by Jocelyn Guyer and Cindy Mann

Appendix A:

State-Specific Earnings Thresholds for Working Parents Who Already Are Enrolled in Medicaid

Table 6

How Much Can a Working Parent Already Enrolled in Medicaid Earn and Still Retain Eligibility for Coverage?			
<i>(Based on a 3-person family with one wage earner. Assumes that the family's only source of income is earnings.)</i>			
	Monthly Earnings Threshold	Annual Earnings Limit Threshold	Earnings as a % of the Federal Poverty Level
Alabama	\$253	\$3,036	22%
Alaska	\$1,778	\$21,340	125%
Arizona	\$584	\$7,011	51%
Arkansas	\$637	\$7,650	56%
California	\$1,788	\$21,456	157%
Colorado	\$510	\$6,120	45%
Connecticut *	\$1,138	\$13,656	100%
Delaware **	\$1,228	\$14,730	108%
District of Columbia	\$2,275	\$27,300	200%
Florida	\$804	\$9,648	71%
Georgia	\$513	\$6,156	45%
Hawaii **	\$1,309	\$15,708	100%
Idaho	\$406	\$4,872	36%
Illinois*	\$597	\$7,164	52%
Indiana	\$377	\$4,524	33%
Iowa	\$1,063	\$12,750	93%
Kansas	\$762	\$9,140	67%
Kentucky	\$615	\$7,380	54%
Louisiana	\$263	\$3,156	23%
Maine	\$1,227	\$14,724	108%
Maryland *	\$523	\$6,276	46%

Massachusetts **	\$1,513	\$18,156	133%
Michigan	\$548	\$6,576	48%
Minnesota **	\$3,128	\$37,538	275%
Mississippi	\$457	\$5,484	40%
Missouri	\$381	\$4,572	33%
Montana	\$833	\$10,000	73%
Nebraska *	\$490	\$5,880	43%
Nevada	\$434	\$5,205	38%
New Hampshire	\$686	\$8,235	60%
New Jersey	\$533	\$6,396	47%
New Mexico	\$702	\$8,424	62%
New York	\$1,067	\$12,809	94%
North Carolina	\$634	\$7,608	56%
North Dakota	\$625	\$7,496	55%
Ohio	\$972	\$11,664	85%
Oklahoma	\$426	\$5,112	37%
Oregon **	\$1,138	\$13,650	100%
Pennsylvania	\$804	\$9,648	71%
Rhode Island	\$2,194	\$26,333	193%
South Carolina	\$668	\$8,016	59%
South Dakota	\$796	\$9,546	70%
Tennessee	\$766	\$9,192	67%
Texas *	\$364	\$4,368	32%
Utah *	\$657	\$7,884	58%
Vermont **	\$1,797	\$21,564	158%
Virginia	\$380	\$4,560	33%
Washington	\$1,090	\$13,080	96%
West Virginia	\$342	\$4,104	30%
Wisconsin	\$737	\$8,844	65%
Wyoming	\$789	\$9,468	69%
Median state	\$686	\$8,235	60%

Unless otherwise noted, the earnings thresholds presented in this table are based on the income standards and earnings disregards used by states under their family coverage categories to determine the ongoing eligibility of a parent who has been working for 12 months or more. States marked with an "*" have not yet established a family coverage category and base their earnings thresholds on their medically needy eligibility rules. States marked with "**" have expanded coverage to low-income working parents under an 1115 waiver and the table is based on the eligibility rules that apply to parents under the waiver. See Appendices B and C for additional information.

Table 7

How Many Hours Can a Parent Already Enrolled in Medicaid Work and Still Retain Eligibility for Coverage?

*(Based on a 3-person family with one wage earner.
Assumes that the family's only source of income is earnings.)*

At a \$7 an hour job,	If no, how many hours	At the federal minimum wage	If no, how many hours
------------------------------	------------------------------	------------------------------------	------------------------------

	can a parent work full time?	a week can the parent work?	(\$5.15 per hour), can a parent work full time?	can a parent work at \$5.15 an hour?
Alabama	NO	8	NO	11
Alaska	YES		YES	
Arizona	NO	19	NO	26
Arkansas	NO	21	NO	29
California	YES		YES	
Colorado	NO	17	NO	23
Connecticut *	NO	38	YES	
Delaware **	YES		YES	
District of Columbia	YES		YES	
Florida	NO	27	NO	36
Georgia	NO	17	NO	23
Hawaii **	YES		YES	
Idaho	NO	13	NO	18
Illinois*	NO	20	NO	27
Indiana	NO	12	NO	17
Iowa	NO	35	YES	
Kansas	NO	25	NO	34
Kentucky	NO	20	NO	28
Louisiana	NO	9	NO	12
Maine	YES		YES	
Maryland *	NO	17	NO	23
Massachusetts **	YES		YES	
Michigan	NO	18	NO	25
Minnesota **	YES		YES	
Mississippi	NO	15	NO	20
Missouri	NO	13	NO	17
Montana	NO	27	NO	36
Nebraska *	NO	16	NO	22
Nevada	NO	14	NO	19
New Hampshire	NO	23	NO	31
New Jersey	NO	18	NO	24
New Mexico	NO	23	NO	31
New York	NO	35	YES	
North Carolina	NO	21	NO	28
North Dakota	NO	21	NO	28
Ohio	NO	32	YES	
Oklahoma	NO	14	NO	19
Oregon **	NO	38	YES	
Pennsylvania	NO	27	NO	36
Rhode Island	YES		YES	

South Carolina	NO	22	NO	30
South Dakota	NO	26	NO	36
Tennessee	NO	25	NO	34
Texas *	NO	12	NO	16
Utah *	NO	22	NO	29
Vermont **	YES		YES	
Virginia	NO	13	NO	17
Washington	NO	36	YES	
West Virginia	NO	11	NO	15
Wisconsin	NO	24	NO	33
Wyoming	NO	26	NO	35
Median state	NO	23	NO	31

Unless otherwise noted, the earnings threshold presented in this table are based on the income standards and earnings disregards used by states under their family coverage categories to determine the ongoing eligibility of a parent who has been working for 12 months or more. States marked with an "*" have not yet established a family coverage category and base their earnings threshold on their medically needy eligibility rules. States marked with "**" have expanded coverage to low-income working parents under an 1115 waiver and the table is based on the eligibility rules that apply to parents under the waiver. See Appendices B and C for additional information. Some states have minimum wage levels that are higher than the federal level.

Appendix B:

Methodology Used to Develop Tables with State-Specific Information on Medicaid Eligibility Rules for Parents

This Appendix describes the methodology used to develop the tables in this report that provide state-specific information on Medicaid eligibility rules for parents. It applies to Tables 3 through 5, which appear in the body of the report, as well as to Tables 6 and 7, which appear in Appendix A.

General Information

The tables with state-specific information about Medicaid eligibility rules for parents in this report are based on the eligibility rules that apply to a three-person family that is not on welfare and that has one working parent.

Technically, the Medicaid rules described in these tables are used to determine the eligibility of families with children, not just parents. However, since most children also are eligible for Medicaid under other eligibility categories (e.g., poverty level eligibility categories for children) at higher income levels than are presented in these tables, the thresholds and rules noted in these tables relate primarily to parents.

When eligibility rules for income vary within a state, the tables display the rules that apply in the sub-state area with the largest number of Medicaid beneficiaries.

In many states, parents have more than one route to Medicaid eligibility. Unless otherwise specified, the tables display the eligibility rules used under a state's "family coverage" category (i.e., the "delinking" or "section 1931" eligibility category based on a state's July 16, 1996 AFDC income, resource, and family composition rules that replaced the automatic eligibility link between Medicaid and cash welfare when the 1996 federal welfare law was enacted). There are two circumstances under which the information in the tables is not based on the rules that apply to the family coverage category.

- *"Medically needy category"* — Some states, identified by an "*" in the tables, have not yet fully implemented the requirement in the 1996 federal welfare law to delink TANF and Medicaid eligibility, but do have a "medically needy" eligibility category for families with children that can be used to cover parents and other caretaker relatives who are ineligible for or who elect not to be on TANF. The medically needy eligibility category for families with children is an optional Medicaid eligibility category that covers families who have income and resources below state-established medically needy thresholds or who fall below these thresholds after they "spend down" their "excess" income and resources on medical bills. Traditionally, the medically needy eligibility category has been used by states primarily for people with high medical bills, but, in some states, it also can serve as a source of coverage for other parents if their income and resources are below medically needy thresholds even when medical bills are not taken into account.

Note that the coverage available to a parent who is eligible for Medicaid under a medically needy eligibility category is not identical to the coverage that would be available to them if their state had established a family coverage category. For example, families that lose their eligibility for coverage under the family coverage category due to their earnings are eligible for up to a year of Transitional Medical Assistance. TMA, however, is not available to families that lose eligibility for a medically needy category due to earnings.

- *1115 waiver* — Some states, identified with "***" have expanded Medicaid to parents under a section 1115 Medicaid waiver. Whenever the information in the tables is based on an 1115 waiver, this is specifically noted because the terms of the Medicaid coverage available to parents under a waiver may vary from what is available to them under a state's regular Medicaid program. For example, parents covered under an 1115 waiver expansion may pay premiums or other cost-sharing charges, may receive a somewhat narrower set of benefits, and may face requirements that they be uninsured at the time they seek Medicaid or for a period of time prior to seeking coverage. They also typically will not be eligible for up to a year of Transitional Medical Assistance when they lose eligibility for Medicaid under 1115 waiver expansion rules (unlike their counterparts who lose eligibility for Medicaid under the family coverage category due to earnings or child support income).

State-specific notes that appear in Appendix C describe any important

differences in the terms of the coverage available under a state's 1115 waiver expansion versus its regular Medicaid program. If an 1115 waiver state also has established a Medicaid family coverage category as part of its regular Medicaid program that covers a subset of parents at lower income levels than its waiver rules, the state-specific notes in Appendix C describe the income standard used under the state's family coverage category.

Background Information on Specific Tables

Tables 3 and 4

Tables 3 and 4 provide information on how much a working parent who *applies* for Medicaid can earn and still be found eligible for coverage. Table 3 presents the information in terms of dollar limits on earnings and Table 4 presents it in terms of how many hours a week a parent can work. Both tables take into account how states treat a family's earnings when evaluating their application for Medicaid. For example, many states disregard \$90 in earnings each month for each wage earner when determining a family's countable income to account for expenses associated with working. Thus, a state that covers a working parent in a three-person family with countable income below \$600 a month would extend coverage to a parent with gross earnings of \$690 a month ($\$690 - \$90 = \$600$, the state's countable income threshold of \$600 a month). A number of states, however, have adopted significantly more generous disregards of earnings and these are reflected in Tables 3 and 4.

The earnings thresholds presented in these tables do not take into account other possible disregards or deductions a family might receive, the most significant of which is the deduction for child care expenses. A parent who pays out-of-pocket for child care costs is likely to be eligible for Medicaid at somewhat higher gross earnings levels than are presented in the table. At the same time, a parent with income from sources other than earnings may be eligible for Medicaid at lower income levels than those identified in these tables because the parent may not be able to take full advantage of a state's earnings disregard policy.

Note that states generally define a person applying for Medicaid as someone who has not been enrolled in Medicaid in one of the four previous months.

Table 5

Table 5 shows whether or not a state covers two-parent families to the same extent that it covers single-parent families by eliminating the so-called "100-hour" rule. The 100-hour rule, which is a remnant of the old AFDC system, restricts Medicaid coverage to two-parent families in which the principal wage earner works fewer than 100 hours a month. As a result of a regulation issued by the Department of Health and Human Services on August 7, 1998, all states now have the option to effectively drop the 100-hour rule and to provide Medicaid to

two-parent families on the same terms that it is available to single-parent families. Even prior to the regulation, a majority of states had statewide waivers that gave them the option to dispense with the 100-hour rule requirement when determining a family's eligibility for Medicaid.

Tables 6 and 7

Tables 6 and 7, which appear in Appendix A, display how much a working parent in a three-person family who is enrolled in Medicaid can earn and still retain eligibility for ongoing coverage, with Table 6 presenting the information in terms of a dollar limit and Table 7 presenting it in terms of how many hours a week such a parent can work. They differ from Tables 3 and 4 because they are based on the gross earnings thresholds that relate to parents who already are enrolled in Medicaid and then find a job or have increased earnings, as opposed to working parents who are applying for Medicaid.

As with Tables 3 and 4, Tables 6 and 7 reflect a state's earnings disregard policies, as well as the state's countable income threshold for parents enrolled in Medicaid. They do not take into account other disregards or deductions that parents can receive, and they assume that all income is from earnings.

More specifically, Tables 6 and 7 show the gross earnings eligibility thresholds that apply to a parent already enrolled in Medicaid who has been working for twelve months or more. Parents already enrolled in Medicaid, but who have been working for fewer than twelve months, may be eligible for regular Medicaid at different gross earnings levels than those displayed in Tables 6 and 7 because some states offer Medicaid beneficiaries a different earnings disregard for a time-limited period. For example, many states disregard \$30 plus one-third of remaining earnings for the first four months that a parent works.

Also note that Tables 6 and 7 display how much a parent can earn and retain ongoing Medicaid coverage as opposed to time-limited coverage under Transitional Medical Assistance. Under federal law, families who lose their eligibility for regular Medicaid under the family coverage category because of an increase in earnings or the lapse of an earnings disregard policy are eligible for six months of Transitional Medical Assistance and for an additional six months if the family's gross income (less child care expenses) is below 185 percent of the poverty level. (Twelve states have received waivers to extend TMA for longer than 12 months.) States also must provide four months of transitional coverage to a family who loses Medicaid due to child support income.

Source of Information

For most states, the information in these tables on Medicaid eligibility rules are based on a survey on the implementation of the Medicaid provisions included in the 1996 federal welfare law conducted by the State Policy Documentation Project,

a joint project of the Center for Law and Social Policy and the Center on Budget and Policy Priorities. Responses to the survey were verified by officials in most states in the fall of 1998. In states for which verified survey results were not available, the Center has confirmed the information included in this table directly with state officials. The only exception is that in Virginia state officials did not verify or comment on the information included in these tables.

Since states continue to examine and revise their coverage of families with children under the family coverage category, it is possible that some of the information in this table may have changed since it was confirmed by state officials in late 1998.

Appendix C:

Additional State-Specific Information on Medicaid Eligibility Rules for Parents

These state-specific notes are designed to supplement the tables in this report that provide information about each state's Medicaid eligibility rules for parents (Table 3 - Table 7) by explaining relevant details about a state's coverage of parents. For example, they indicate when a state has an additional route to Medicaid coverage for parents through a medically needy eligibility category or through a continued linkage of Medicaid eligibility to receipt of cash assistance. Throughout this Appendix, the phrase "gross earnings" is used in situations where a state's earnings disregard policies have been taken into account.

Arkansas also has a medically needy eligibility category that provides coverage to a family of three with countable income below \$275 per month.

California also has a medically needy eligibility category that provides coverage to a family of three with countable income below \$934 per month.

Connecticut has not yet fully implemented the delinking of TANF and Medicaid as of the fall, 1998. As a result, applicants are most likely to be evaluated for Medicaid eligibility under the state's medically needy eligibility rules unless they also are seeking TANF coverage. Once a family is on Medicaid, it remains eligible for coverage as long as it meets medically needy eligibility criteria or TANF income and resource eligibility rules. A working parent in a three-person family receiving TANF retains eligibility for coverage until the parent's gross earnings reach \$1,138 per month or 100 percent of the poverty level. As a result, as noted in Tables 6 - 7, once a parent is on Medicaid, she continues to remain eligible for coverage until her gross earnings reach \$1,138 per month.

Delaware extends Medicaid to all uninsured adults, including parents, with countable income (gross income less a \$90 earnings and other disregards) at or below 100 percent of the poverty level under an 1115 waiver. These are the income thresholds reflected in Tables 3 - 4 and Tables 6 - 7. There are some

differences in the coverage available to parents under this 1115 waiver versus the coverage available to them if they qualify for regular Medicaid under the state's delinking category. Under the 1115 waiver expansion, an adult must be fully uninsured in order to be eligible and coverage does not start until the adult has enrolled in a managed care plan. In contrast, under the family coverage category, parents can be enrolled in Medicaid if they have insurance from another source and Medicaid will cover services not covered by the private plan. Also, they can receive services on a fee-for-service basis until they are enrolled in a managed care plan. In Delaware, a working parent in a three-person family with no child care expenses who applies for Medicaid is eligible for coverage under the delinking category if her gross earnings fall below \$427 per month. Once on Medicaid, she remains eligible for coverage under the delinking category until her gross earnings reach \$942 per month.

Hawaii covers parents with gross income up to 100 percent of the poverty level under an 1115 Medicaid waiver, as noted in Tables 3 - 7. The poverty level in Hawaii is set at \$1,309 per month, a level that is different from that of other states. Hawaii also has a medically needy eligibility category that covers a family of three with countable income up to \$712 a month. It has not established a delinking Medicaid eligibility category.

Illinois has not yet implemented the requirement to delink TANF and Medicaid eligibility and does not have a family coverage category as of the fall, 1998. The state provides Medicaid to non-TANF families with children through its medically needy eligibility category, at the levels noted in Tables 3 - 4 and Tables 6 - 7. It also provides Medicaid to all TANF recipients. (State law requires that persons receiving TANF also receive Medicaid.) In order to initially qualify for TANF, a three-person family must have gross earnings below \$466 per month and to remain on welfare a family must have gross earnings below \$1,128 per month.

Indiana also provides Medicaid to all TANF recipients. Under its TANF program, Indiana has established a special "zero-grant" status for families on welfare who increase their earnings to the point that they no longer are eligible for cash benefits, but who nevertheless have income below 100 percent of the poverty level. Families in this zero-grant status are still considered TANF recipients and so, under Indiana rules, are eligible for Medicaid. Thus, some parents with income up to 100 percent of the poverty level are eligible for Medicaid in Indiana, but they are eligible up to this income level only if they recently have received cash welfare benefits and if they are willing to continue to be classified as TANF recipients (and have the TANF time limits continue to run) even after they have stopped receiving cash welfare benefits.

Iowa also has a medically needy eligibility category that provides coverage to a family of three with countable income below \$566 per month.

Louisiana also has a medically needy eligibility category that provides coverage to a family of three with countable income below \$699 a quarter; this translates into countable income below \$233 per month.

Maryland has not yet established a family coverage category as of fall, 1998.

Instead it provides coverage to families who are not on cash assistance through its medically needy eligibility category, at the levels noted in Tables 3 - 4 and Tables 6 - 7. In addition, it provides Medicaid to all TANF recipients. In general, a working single parent with two children is income-eligible for TANF when applying for assistance if her gross earnings fall below \$484 a month. She remains income-eligible for TANF (and Medicaid) as long as her gross earnings remain below \$523 per month.

Massachusetts covers all families with children with gross income below 133 percent of the poverty level under an 1115 Medicaid waiver; these are the income levels noted in Tables 3 - 4 and Tables 6 - 7. Some parents, including those who are pregnant, disabled, or working for an employer that offers family coverage that meets specified conditions (e.g., the employer-sponsored coverage must meet benefit and cost-sharing standards, as well as a requirement that the employer cover 50 percent or more of the cost of the coverage) may be eligible for publicly-funded coverage at higher income levels. Also, the state provides Medicaid to all TANF recipients.

Michigan also has a medically needy eligibility category that provides coverage to a family of three with countable income below \$532 a month.

Minnesota offers subsidized health care coverage to uninsured parents and other caretaker relatives with gross income at or below 275 percent of the poverty level under "MinnesotaCare," the state's 1115 waiver program. These are the incomes levels noted in Tables 3 - 4 and Tables 6 - 7. Once enrolled in MinnesotaCare, parents and other caretaker relatives can remain enrolled even if their income exceeds 275 percent of the poverty level if they are willing to pay the full cost of coverage. The parents who are covered as a result of this waiver face some additional restrictions on their eligibility for coverage that do not apply to their counterparts who are eligible under Minnesota's family coverage category. (The delinking category generally covers a parent in a three-person family applying for coverage if the parent has gross earnings of up to \$826 per month. As recipients, the family can retain regular coverage under the family coverage category if its gross earnings are at or below \$621 per month). To qualify for MinnesotaCare, families cannot have had employer-subsidized health coverage within the last 18 months through their current employer, cannot have had any other type of health coverage within the last four months, and cannot currently have access to employer-subsidized insurance coverage for which the employer covers 50 percent or more of the cost. Adults enrolled in MinnesotaCare also have benefit restrictions and cost-sharing that do not apply to adults enrolled under the state's family coverage category.

Minnesota also has a medically needy category that provides coverage to a family of three with countable income below \$709 per month.

Mississippi also provides Medicaid to all of its TANF recipients. Since it provides a disregard of 100 percent of earnings for six months to employed TANF recipients, this means that some parents at higher gross earnings levels than noted in Tables 6 - 7 may be able to qualify for Medicaid for a limited period, but only if they also are receiving welfare.

Missouri has received initial approval from HCFA under an 1115 waiver to provide coverage to uninsured custodial parents with countable income at or below 100 percent of the poverty level. Since this waiver is not expected to be implemented until later in February 1999, the new income levels are not reflected in Tables 3 - 4 and Tables 6 - 7. Under the 1115 waiver, the state also would cover uninsured non-custodial parents with countable income below 125 percent of the poverty level who are current in paying their child support, as well as uninsured non-custodial parents actively participating in Missouri's Parents' Fair Share program. In order to qualify for coverage under the 1115 waiver expansion, parents must have been uninsured for a period of six months (with some exceptions). Once enrolled in Medicaid as part of an expansion group, parents receive a narrower set of benefits than their counterparts who are covered under the state's delinking Medicaid eligibility category and will have cost-sharing obligations not applicable to their counterparts enrolled in the state's delinking Medicaid eligibility category. Finally, the 1115 waiver will allow Missouri to extend Transitional Medical Assistance for an additional two years to parents who otherwise would be uninsured, assuring that families who lose their ongoing Medicaid eligibility under the state's delinking category may be eligible for up to three years of transitional coverage.

Nebraska has not established a family coverage category as of the fall, 1998. Instead it provides coverage to families who are not receiving cash assistance through its medically needy eligibility category at the levels noted in Tables 3 - 4 and Tables 6 - 7. Due to budgeting rules that breakdown the family unit into as many distinct units as possible and then aggregate the income thresholds for each of these distinct units to create a new family income threshold, parents may be eligible for Medicaid under Nebraska's medically needy category at higher income levels than presented in this report depending on their individual circumstances, including the number of children that they have and the age of their children. In addition, Nebraska provides Medicaid to all TANF recipients. In general, a parent in a three-person family is income-eligible for TANF if her gross earnings fall below \$668 a month. A parent who is eligible for TANF can elect to receive only Medicaid, but any months in which the parent receives Medicaid count against the family's TANF time limit.

New Hampshire also provides Medicaid to its TANF recipients who may be eligible for TANF (and, hence Medicaid) at higher gross earnings levels than those noted in Tables 3 - 4 and Tables 6 - 7. In addition, the state has a medically needy category that provides coverage to a family of three with countable income below \$652 per month.

New York also has a medically needy category that provides coverage to a family of three with countable income below \$867 a month.

North Carolina also has a medically needy category that provides coverage to a family of three with countable income below \$367 a month.

North Dakota also has a medically needy category that provides coverage to a family of three with countable income below \$505 a month.

Ohio has an earnings disregard for recipients reflected in Tables 6 - 7 that is reduced after 18 months. Under the \$90 earnings disregard policy that goes into effect after 18 months, the gross earnings threshold for a working parent in a three-person family is \$451 per month.

Oklahoma also has a medically needy category that provides coverage to a family of three with countable income below \$412 a month.

Oregon covers non-elderly adults, including parents, with gross income below 100 percent of the federal poverty level poverty under an expansion adopted as part of an 1115 Medicaid waiver. This is the income level presented in Tables 3 - 4 and Tables 6 - 7. The parents who are covered as a result of the 1115 waiver expansion pay premiums of \$6 to \$28 a month that are not applicable to their counterparts who are eligible under Oregon's family coverage category. (The delinking category generally covers a working parent in a three-person family if the parent has gross earnings below \$808 per month).

Oregon also has a medically needy category that provides Medicaid coverage to a family of three with countable income below \$615 a month. In addition, it provides Medicaid to all TANF recipients.

Pennsylvania also has a medically needy category that provides coverage to a family of three with countable income below \$2,800 over a six-month period; this translates into countable income below \$467 per month.

Tennessee also provides Medicaid to all parents who are receiving TANF. Since it has more generous earnings disregard policies under TANF than under its family coverage category, this means that some parents receiving TANF may be able to qualify for Medicaid at a higher gross earnings level than noted in Tables 3 - 4 for a limited period of time.

In addition, a parent who can initially qualify for Medicaid under the state's family coverage category is guaranteed a slot in TennCare, the state's special health insurance program operated under a Medicaid 1115 waiver, when the parent loses eligibility for Medicaid under the delinking category. Premiums are required once the parent's income reaches 100 percent of the poverty level.

Utah also provides Medicaid to all of its TANF recipients who may be eligible for TANF benefits (and, hence, Medicaid) at higher gross earnings levels than the levels noted in Tables 3 - 4 and Tables 6 - 7.

Texas has not established a delinking Medicaid eligibility category as of the fall, 1998; instead it provides coverage to families who are not on cash assistance through its medically needy eligibility category at the levels noted in Tables 3 - 4 and Tables 6 - 7. Texas also provides Medicaid to all TANF recipients. Beginning in April of 1999, the state plans to provide Transitional Medicaid Assistance to families with income below TANF limits in the state's medically needy eligibility category whose new or increased earnings or child support causes the family's income to exceed the TANF limits.

Vermont covers most adults, including parents, with countable income below 150 percent of the poverty level under an expansion it enacted as part of an 1115 Medicaid waiver. This is the income level noted in Tables 3 - 4 and Tables 6 - 7. The parents who are covered under this expansion have restrictions on their eligibility for coverage that do not apply to their counterparts who are eligible under Vermont's delinking Medicaid category for families with children. (This regular category generally covers a parent with two children if she has gross earnings below about \$997 per month, although this eligibility threshold varies depending on the area of the state in which a family resides). For example, adults covered under the 1115 waiver expansion generally must have resided in the state and have been fully uninsured for at least 12 months before they are eligible for coverage. The benefit package that they receive also is not identical to the package available to regular Medicaid beneficiaries and they pay an enrollment fee of up to \$20 and cost-sharing for specific services.

Vermont also has a medically needy category that provides coverage to a family of three with countable income below \$825 a month.

Virginia also has a medically needy category that provides coverage to a family of three with countable income below \$358 a month.

West Virginia has a medically needy category that provides coverage to a family of three with countable income below \$290 a month.

Wisconsin received approval from the Health Care Financing Administration on January 22, 1999 to implement "BadgerCare," a program that will expand Medicaid to families with children, including the parents in these families, up to 185 percent of the poverty level under an 1115 waiver. Once enrolled, families will retain eligibility for coverage until their incomes reach 200 percent of the poverty level. The expansion will be financed with a mixture of state funds, premiums from families, federal child health funds and Medicaid funds. Families with income above 150 percent of the poverty level will pay premiums to participate in the program.

Appendix D:

Federal Medicaid Matching Rates for Fiscal Year 1999

Table 8

Federal Medicaid Matching Rates for Fiscal Year 1999	
State	Federal Medicaid Matching Rate
Alabama	69.27
Alaska	59.80

American Samoa	50.00
Arizona	65.50
Arkansas	72.96
California	51.55
Colorado	50.59
Connecticut	50.00
Delaware	50.00
District of Columbia	70.00
Florida	55.82
Georgia	60.47
Guam	50.00
Hawaii	50.00
Idaho	69.85
Illinois	50.00
Indiana	61.01
Iowa	63.32
Kansas	60.05
Kentucky	70.53
Louisiana	70.37
Maine	66.40
Maryland	50.00
Massachusetts	50.00
Michigan	52.72
Minnesota	51.50
Mississippi	76.78
Missouri	60.24
Montana	71.73
Nebraska	61.46
Nevada	50.00
New Hampshire	50.00
New Jersey	50.00
New Mexico	72.98
New York	50.00
North Carolina	63.07
North Dakota	69.94
Northern Mariana Islands	50.00
Ohio	58.26
Oklahoma	70.84
Oregon	60.55
Pennsylvania	53.77
Puerto Rico	50.00
Rhode Island	54.05
South Carolina	69.85

South Dakota	68.16
Tennessee	63.09
Texas	62.45
Utah	71.78
Vermont	61.97
Virgin Islands	50.00
Virginia	51.60
Washington	52.50
West Virginia	74.47
Wisconsin	58.85
Wyoming	64.08
Source: Department of Health and Human Services.	

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Children's Health Insurance Coverage and Family Structure, 1977-1996

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Using data from a series of nationally representative medical expenditure surveys, the authors document changes in children's health insurance coverage in a period of two decades. Overall, it is found that the proportion of children with private coverage declined, while the proportions publicly insured and uninsured increased. However, when the authors account for differences in family structure, they find striking disparities in children's insurance experiences. Contrary to overall trends, children in single-parent households made significant gains in private health insurance coverage after 1977 and experienced reductions in public insurance. Coincident with Medicaid expansions in the late 1980s, children in two-parent households experienced significant increases in public health insurance. It is found that the rise in the proportion of children who were uninsured in this period was largely a single-parent family phenomenon, and that parents' marital status, employment status, and family income are crucial factors associated with children's insurance status.

Two major trends have affected children's well-being in the late 20th century. First, rising rates of divorce and nonmarital childbearing have made single-parent families an increasingly common phenomenon with profound consequences for children's economic status, their health status, and their

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health insurance coverage (see Angel and Angel 1993; Cunningham and Monheit 1990; Haveman and Wolfe 1995; McLanahan and Sandefur 1994). Second, in an era of rising health care costs and stagnant real family incomes, the unwillingness of many private medical care providers to accept self-pay patients has made health insurance increasingly essential for ensuring that children's health services are both accessible and affordable.

While each of these trends has had an independent effect on children's lives, their relationship has a particularly important impact on children's health and welfare: differences in family structure may place children at increased risk for adverse outcomes related to their health status and health insurance coverage. For example, compared with children in two-parent families, those in single-parent families may lack key family and social inputs to their health, including the investment of parental time, supervision, and communication between parents. In addition, single parents have lower earnings on average than do parents in two-parent households (U.S. Bureau of the Census 1995). Their lower wage jobs are also less likely to provide these single parents with access to health insurance. Single parents with low earnings may also lack the resources to pay for their share of employer-sponsored family health insurance premiums or for the cost of directly purchased private insurance.

Our focus on the relationship between family structure and children's health insurance status comes at a time when there is intense public policy interest in providing health insurance coverage to children. For example, the recently enacted State Children's Health Insurance Program provides states with \$24 billion during a 5-year period to extend coverage to children. Prior to this provision, a variety of proposals to cover uninsured children were introduced in the 105th Congress in 1997 (Burns 1997; Koppleman 1997), and a number of states had implemented health insurance reforms targeted at children (Gauthier and Schrodell 1997). Most recently, the Clinton administration has stressed the importance of using outreach and educational efforts to help enroll the 4.7 million uninsured children who are eligible for Medicaid (Dao 1998; Selden, Banthin, and Cohen 1998).

NEW CONTRIBUTION

Interest in children's health care coverage has been stimulated by a general consensus regarding the importance of health care to child health and development, and by a failure to reduce the proportion of children who are uninsured during the last two decades. This article makes a new contribution to the literature by examining trends of the past 20 years and focusing specifically on

the relationship between children's family structure and their health insurance coverage. While the role family structure plays in other children's outcomes has been studied extensively, the area of health insurance coverage has been examined only rarely. Understanding how the health insurance status of children in different kinds of families varies and how it has changed in this period can help develop more targeted interventions for those children who are at particular risk of lacking coverage. In addition, since recently enacted federal welfare reform legislation will require that many single parents make the transition from welfare to work, our focus on the interaction of family composition and parents' employment status can help inform evaluations of the impact of this legislation. To the extent that employed single-parent families have difficulty obtaining health care coverage, welfare reform may require additional safeguards to ensure that children in these households have adequate access to health insurance (Moffitt and Slade 1997).

BACKGROUND

TRENDS IN CHILDREN'S LIVING ARRANGEMENTS AND FAMILY ECONOMIC STATUS

During the last several decades, the probability that a child would reside in a two-parent family declined markedly. In 1970, 85 percent of children less than 18 years of age lived in households with both parents; by 1980 this figure had declined to 77 percent of children and by 1994 to 69 percent of children (U.S. Bureau of the Census 1995). This change in children's living arrangements reflects the influence of rising rates of divorce and nonmarital childbearing (Hernandez 1996; Office of the Assistant Secretary for Planning and Evaluation 1996). In combination, these changes have resulted in a substantial increase in the proportion of children living in mother-only families in the last two decades. Just under 12 percent of children were living in mother-only families in 1970; by 1990 this figure had increased to 20 percent (Hernandez 1996).

The past two decades have also witnessed striking changes in the economic security of American families. The period between 1977 and 1996 was characterized by a deterioration in family living standards and worker earnings. For example, median real family income remained almost unchanged between 1979 and 1991; between 1980 and 1993, median family income actually declined for female-headed households with no husband present and for married couples in which the husband was the only worker (Danziger and Gottschalk 1995; U.S. Bureau of the Census 1995).

Since children tend to reside in families headed by younger workers and increasingly in single-parent households, the decline in real earnings for many male workers and the low earnings of female workers meant that children fared less well than the typical American during the 1970s and 1980s (Danziger and Gottschalk 1995). Overall, the proportion of children younger than 18 living in poverty increased from 16 percent in 1979 to 22 percent in 1993. Rates of child poverty were exceptionally high and continued to rise for children in single-parent (female-headed) households, from 48.6 percent in 1979 to 53.7 percent in 1993 (U.S. Bureau of the Census 1995).

TRENDS IN THE COST AND AVAILABILITY OF HEALTH INSURANCE

At the same time that the economic circumstances of particular families were worsening, workers were required to pay more out of pocket for family health insurance. Between 1980 and 1993, the percentage of employers in medium and large establishments who fully financed employment-related family coverage declined from 54 percent to 21 percent (Pemberton and Holmes 1995). As employees became increasingly responsible for financing such family coverage, monthly employee contributions for family insurance coverage (in constant 1982-1984 dollars) increased from \$32.51 in 1983 to \$74.34 in 1993, a 129 percent rise in one decade.¹ Although the availability of employment-based coverage to working Americans increased in the last decade, more working families declined offers of coverage, perhaps as a response to the increase in out-of-pocket premium costs, which far exceeded wages increases (Cooper and Schone 1997).

While private employment-based health care coverage was becoming more costly for families, their access to public health insurance was characterized by both contractions and expansions in eligibility criteria. The *Omnibus Budget Reconciliation Act* (OBRA) of 1981 severely affected Medicaid enrollment by limiting the allowable income that could be earned by a family applying for Aid to Families with Dependent Children (AFDC) and thereby decreasing the Medicaid rolls by an estimated 2 million persons, mostly children (Axelroad 1987). However, by the late 1980s and early 1990s, a series of Medicaid expansions had severed the tie between Medicaid enrollment and AFDC eligibility by targeting specific groups of children and pregnant women with family income in excess of the poverty line.² As a result, enrollment in Medicaid increased by an estimated 4.8 million children between 1989 and 1993 (General Accounting Office 1995). As Medicaid enrollment was increasing, employment-related coverage of children was declining, leading some to

conclude that Medicaid had displaced or "crowded out" enrollment by low-income children in employment-based coverage.³

CONCEPTUAL FRAMEWORK

The effects of family structure on children's health insurance status operate through two interrelated dimensions: family resource availability and eligibility for public health insurance programs. Children in two-parent households (especially those with two working parents) generally have higher family incomes as compared with their counterparts in single-parent households. These income differences may be associated with differential access to health insurance, since individuals with better paying jobs tend to have greater access to employer-sponsored coverage (Cooper and Schone 1997). In addition, families with higher incomes can more easily afford to pay the required employee contribution toward family coverage or, alternatively, can more easily purchase private coverage directly. Two-parent families also have a potentially greater number of jobs through which they may obtain family health insurance than do single-parent families. Finally, if child care responsibilities can be shared by two parents (or purchased directly via two-parent families' increased income), at least one parent will more likely be able to work the requisite number of hours to ensure eligibility for benefits. To the extent that both parents are employed, these advantages relative to single-parent households are magnified.

Until fairly recently, single-parent households had an advantage in meeting enrollment criteria for publicly provided health insurance such as Medicaid. In general, this advantage was based primarily on the eligibility requirements for participation in AFDC, which was typically restricted to poor and low-income families headed by single women and was, until recently, the primary linkage to Medicaid coverage. While recent program expansions have severed the tie with AFDC, single-parent households are still more likely to qualify for Medicaid due to their poorer economic status.

DATA AND METHOD

The data used in our analysis come from a series of three household-based medical expenditure surveys sponsored by the Agency for Health Care Policy and Research: the 1977 National Medical Care Expenditure Survey (NMCES), the 1987 National Medical Expenditure Survey (NMES), and the 1996 Medical Expenditure Panel Survey (MEPS). The main goal of each of these surveys was to provide detailed information on the health care use and expenditures,

sources of payment, health status, health insurance status, demographic characteristics, income, and employment status of a representative sample of the civilian, noninstitutionalized U.S. population. Our analysis is limited to those children younger than 18 in each of the three surveys who were living with at least one of their parents.

Each of the three surveys collected data from a sample of randomly selected households via multiple contacts during 1 or more years with one respondent per household. The data we use for this analysis come from the first round of data collection for each of the surveys, representing on average approximately the first quarter of 1977 and 1987, and the first half of 1996.⁴ Our unweighted samples sizes (of children younger than 18 living with at least one of their parents) are 7,345 for 1977, 9,212 for 1987, and 6,646 in 1996. Additional details on the surveys are available in Bonham and Corder (1981), Edwards and Berlin (1989), and Cohen et al. (1996).

The key analytic variables are derived in similar ways for all three survey years. Health insurance coverage is a trichotomous, hierarchical outcome: any private health insurance, public insurance only, and being uninsured. A child is coded as having private insurance if he or she had private health insurance coverage at any time during the first round of the survey. Those with private insurance whose parents obtained such coverage from their employers were further classified as having employment-related health insurance.⁵ Children without private insurance, but with public insurance (e.g., Medicaid or CHAMPUS coverage) at some time during Round 1 were classified as having public insurance. Finally, those children without private or public insurance at any time during the survey round were classified as uninsured.

Family structure is based on the number of parents with whom each child lives and includes both biological parents and stepparents, since either may be a source of private health insurance. Other variables that are used in conjunction with family structure to draw further distinctions among family types and children's living arrangements include parents' marital status, parents' employment status, and whether parents were offered employer-sponsored health insurance through their jobs. All of these variables come from the Round 1 data collection effort for each of the surveys.

Finally, we include family income as a measure of household resource availability. Family income for 1977 was obtained from the Round 5 NMES interview and for 1987 in the Round 4 NMES interview, and represents family income for the respective survey's calendar year. Family income data for 1996 is not yet available from the MEPS. However, the households in the MEPS were all participants in the National Health Interview Survey (NHIS), which assessed family income for calendar year 1995. We make use of this income information to provide a rough comparison of how children in particular

income classes fared in 1996 relative to the two earlier survey years. All the income variables are shown as family income relative to the federal poverty line.⁶

Our analysis is descriptive and the estimates we present have been weighted to be nationally representative. All differences discussed in the text are statistically significant at the 0.05 level or better, unless otherwise noted. Our statistical tests were done using the SUDAAN software package to correct standard errors for the complex design of each of the surveys.

RESULTS

AGGREGATE CHANGES IN FAMILY STRUCTURE AND CHILDREN'S HEALTH INSURANCE

In Table 1, we use data from each of the three medical expenditure surveys to provide aggregate estimates of trends in children's living arrangements and health insurance status. These data reveal that between 1977 and 1987, the percentage of children in single-parent families grew by more than half (from 16.9 percent to 26.2 percent) and then remained at roughly the same level from 1987 to 1996. While this transition in children's living arrangements was occurring, important shifts in children's health insurance were also taking place. Between 1977 and 1996, the percentage of children covered by private insurance declined from 73.8 percent to 65.2 percent, and employment-related coverage declined from 68.1 percent of children to 61.5 percent.⁷ Although these changes in private coverage were somewhat offset by the increase in the percentage of children with public coverage between 1987 and 1996, the percentage of children without any health care coverage remained above its 1977 level (12.7 percent), rising to 17.1 percent in 1987 and 15.1 percent in 1996.⁸

HOUSEHOLD COMPOSITION AND CHILDREN'S HEALTH INSURANCE

Table 2 displays estimates of children's health insurance status in each survey year by family structure. Consistent with the decline in private coverage observed in our aggregate estimates, the percentage of children in two-parent households with private insurance also declined, from 81.9 percent in 1977 to 73.7 percent in 1996. In contrast, the percentage of children in single-parent families with private coverage increased from 34.3 percent of children in 1977 to 40.0 percent in 1987 ($p = 0.052$) and then remained at roughly the same level in 1996 (38.7 percent).⁹ Thus, despite their economic disadvantage compared with children in two-parent households, children in single-parent households

TABLE 1 Trends in Children's Family Structure and Health Insurance Coverage, 1977-1996

	1977	1987	1996
Number of children, in thousands	63,235	62,466	69,116
Percentage in single-parent families	16.9 (0.93)	26.2 (1.03)	24.3 (1.04)
Percentage of children with			
Private insurance	73.8 (1.32)	68.1 (1.25)	65.2 (1.22)
Employment related	68.1 (1.39)	63.6 (1.25)	61.5 (1.26)
Public insurance only	13.5 (0.99)	14.8 (0.98)	19.7 (1.01)
Uninsured	12.7 (0.82)	17.1 (0.76)	15.1 (0.79)

Source: 1977 National Medical Care Expenditure Survey; 1987 National Medical Expenditure Survey; 1996 Medical Expenditure Panel Survey.

Note: Standard errors of estimates are shown in parentheses.

did not experience a decline in private health insurance coverage between 1977 and 1996.

The expansions in Medicaid eligibility after 1987 appear to have had little impact on children in single-parent households, whose rate of public coverage actually declined in the study period.⁹ Unlike the period between 1977 and 1987, single-parent families were unable to replace their children's lack of public coverage with private insurance after 1987. As a result, about one fifth of children in single-parent families remained uninsured in both 1987 and 1996, nearly a one third increase over their 1977 rate. In contrast, the percentage of children with public coverage in two-parent families doubled between 1987 and 1996 and offset the decline in their rate of private coverage. As a result, the rate at which such children were uninsured in 1996 was no different than in 1987. Our results in Table 2 indicate that children in single-parent and two-parent families have had very different health insurance experiences in the last two decades and suggest that family structure is an important dimension to consider when assessing children's health insurance status.

SOURCES OF PRIVATE HEALTH INSURANCE IN SINGLE-PARENT FAMILIES

The stability in the private health insurance of children in single-parent households since 1987 masks some important differences in the coverage rates among these households. Distinguishing single-parent households by whether the parent was *ever* or *never* married, we observe striking differences in the rate of children's private coverage (Table 3). Although both types of single-parent families exhibited similar trends in their children's health

TABLE 2 Family Structure and Children's Health Insurance Status, 1977-1996

	Percentage Distribution		
	Private Health Insurance	Public Insurance Only	Uninsured
1977			
Two-parent families	81.9 (1.10)	5.9 (0.64)	12.2 (0.89)
Single-parent families	34.3 (2.33)	50.6 (2.86)	15.0 (1.55)
1987			
Two-parent families	78.0 (1.18)	6.1 (0.89)	15.9 (0.90)
Single-parent families	40.0 (1.79)	39.4 (1.64)	20.6 (1.10)
1996			
Two-parent families	73.7 (1.30)	12.7 (0.99)	13.6 (0.86)
Single-parent families	38.7 (1.86)	41.5 (1.88)	19.8 (1.64)

Source: 1977 National Medical Care Expenditure Survey; 1987 National Medical Expenditure Survey; 1996 Medical Expenditure Panel Survey.

Note: Standard errors of estimates are shown in parentheses.

insurance coverage, nearly half the children in ever-married single-parent households were privately insured in 1987 and 1996, compared with only one fifth of children in never-married single-parent families. Children whose single parents never married, however, were far more likely to be publicly insured in each of these years than those whose parent had been married. While children in both types of single-parent families experienced declines in public coverage between 1977 and 1987, the decline was especially severe for those with ever-married parents. As a result, by 1987, children in ever-married single-parent households were more likely to be uninsured than those with never-married single parents.

Between 1987 and 1996, the proportion of privately insured children in ever-married single-parent families who received their private insurance from a policyholder outside their household (most likely a noncustodial parent) increased from 4.5 percent to 21.4 percent. In 1996, such children were nearly twice as likely to obtain coverage from sources outside their household as their counterparts with never-married single parents ($p = 0.054$). This represents a substantial increase in noncustodial parents' involvement in their children's health insurance coverage. Despite such an increase, in 1996 sources outside the household provided insurance coverage for only 10 percent of children in single-parent families whose parent was ever married and did not yield an increase in the proportion of these children who were privately insured.

TABLE 3 Private Health Insurance Coverage of Children in Single-Parent Families by Parent's Marital Status

Single Parent's Marital Status	Number of Children (thousands)	Percentage of Children with			Percentage of Privately Insured Children Who Are Covered under the Plan of Someone Outside Their Household
		Private Insurance	Public Insurance Only	Uninsured	
1977					
Single parent never married	1,738	11.1 (2.76)	76.0 (2.97)	12.8 (2.48)	— ^a
Single parent ever married	8,776	38.8 (2.64)	45.4 (3.19)	15.8 (1.80)	
1987					
Single parent never married	4,424	19.5 (1.96)	65.4 (2.48)	15.1 (1.66)	4.3 (1.93)
Single parent ever married	11,838	47.9 (2.16)	29.4 (1.84)	22.7 (1.34)	4.5 (0.91)
1996					
Single parent never married	5,753	21.6 (2.29)	62.9 (2.61)	15.5 (1.94)	12.2 (3.78)
Single parent ever married	11,023	47.6 (2.40)	30.3 (2.26)	22.1 (2.20)	21.4 (2.92)

Source: 1977 National Medical Care Expenditure Survey; 1987 National Medical Expenditure Survey; 1996 Medical Expenditure Panel Survey.
Note: Standard errors of estimates are shown in parentheses. Children whose single parent's marital status is unknown are omitted from this table.

a. Information is not available for 1977.

FAMILY STRUCTURE, PARENT'S EMPLOYMENT STATUS, AND CHILDREN'S HEALTH INSURANCE STATUS

Table 4 shows the relationship between parental employment status and family structure to provide a more complete description of how children's insurance status is related to family circumstances. The most striking finding to emerge is that having *two employed parents* living in the same household is associated with substantial increases in the likelihood of a child obtaining private coverage and with reductions in the probability of a child being uninsured. This relationship holds in each of the survey years, with more than 80 percent of children in two-parent, two-worker households being privately insured and only 1 in 10 of these children being uninsured. In contrast, children in two-parent, one-worker households were less likely to have private coverage than those in two-worker families; their experience is largely responsible for the observed decline in private coverage in two-parent households in the period we study.

This decline in employment-related coverage since 1987 for children in two-parent, one-worker households came at a time when the availability of such coverage to parents in all households was increasing. As Table 4 reveals, employed parents in each type of household were more likely to obtain an offer of an employment-related plan in 1996 than in 1987. Children in two-parent, two-worker families were more likely to have insurance available to them in both years than those in other families. The relatively low rate of employment-based coverage for children in single-parent households reflects the lower likelihood that such working households were offered coverage by their employers. For example, only in 1996 did the availability of employment-based coverage for children in single-parent households resemble the availability of such coverage to two-parent, one-worker households nearly a decade earlier in 1987.¹⁰

Prior to 1987, the decline in private coverage for children in two-parent, one-worker households was associated with a large increase in the rate at which such children were uninsured (from 13.8 percent in 1977 to 21.6 percent in 1987). Compared with children with two employed parents, these children in two-parent, one-worker households may have gained considerably from the expansions in Medicaid after 1987; nearly one fifth of such children (19.5 percent) had public coverage in 1996 and the rate at which they were uninsured declined below its 1987 level (21.6 percent in 1987 vs. 17.5 percent in 1996, $p = 0.077$). Children in two-parent households with no employed parents also experienced a dramatic increase in public coverage between 1987 and 1996. As a result, their uninsured rate in 1996 was less than half their 1987 rate and was comparable to children in households with employed parents. In

TABLE 4 Children's Health Insurance Status and Parents' Employment Status, 1977-1996

Parents' Employment Status	Private Health Insurance			Total Public Coverage Only	Total Uninsured
	Total Covered	Employment Related ^a			
		Offered to Parents	Covered		
1977					
Two-parent families					
Two parents employed	85.0 (1.23)	— ^b	90.1 (1.51)	4.5 (0.77)	10.5 (1.05)
One parent employed	80.4 (1.92)		72.9 (2.01)	5.8 (1.03)	13.8 (1.79)
No parents employed	14.8 (5.06)		9.3 (4.61)	52.8 (7.66)	32.4 (6.17)
Single-parent families					
Parent employed	46.5 (3.05)		42.0 (2.94)	38.3 (3.58)	15.2 (1.93)
Parent not employed	7.3 (2.12)		2.3 (1.17)	77.4 (2.31)	15.3 (2.25)
1987					
Two-parent families					
Two parents employed	86.6 (0.96)	86.9 (1.00)	81.8 (1.20)	3.0 (0.53)	10.4 (0.81)
One parent employed	70.9 (1.96)	70.8 (1.92)	67.0 (2.01)	7.5 (1.58)	21.6 (1.71)
No parents employed	18.6 (5.00)	— ^c	6.1 (2.04)	39.7 (4.96)	41.7 (5.17)
Single-parent families					
Parent employed	64.4 (2.11)	62.4 (1.95)	60.3 (2.00)	13.4 (1.34)	22.2 (1.84)
Parent not employed	10.5 (1.31)	— ^c	7.2 (1.05)	70.8 (1.91)	18.8 (1.66)
1996					
Two-parent families					
Two parents employed	83.0 (1.28)	91.7 (0.93)	79.1 (1.42)	5.6 (0.74)	11.4 (1.00)
One parent employed	62.9 (2.26)	78.8 (2.11)	58.8 (2.37)	19.5 (1.90)	17.5 (1.56)
No parents employed	12.4 (3.59)	— ^c	10.5 (3.76)	71.5 (4.56)	16.1 (3.58)
Single-parent families					
Parent employed	54.8 (2.41)	70.1 (2.54)	51.1 (2.50)	23.8 (1.89)	21.4 (2.20)
Parent not employed	5.8 (1.49)	— ^c	5.0 (1.46)	78.5 (2.51)	15.7 (2.22)

Source: 1977 National Medical Care Expenditure Survey; 1987 National Medical Expenditure Survey; 1996 Medical Expenditure Panel Survey.

Note: Standard errors of estimates are shown in parentheses. Children whose parents' employment status is unknown are omitted from this table.

a. Employment-related private health insurance is a subset of all private health insurance.

b. Information is not available for 1977.

c. Inapplicable.

contrast to this decline, the uninsurance rate among children in single-parent households whose parent was not employed was unchanged between 1987 and 1996. This may reflect the fact that the Medicaid expansions were not

targeted at children in this population, many of whom were already in low-income households.

FAMILY INCOME, FAMILY STRUCTURE, AND CHILDREN'S HEALTH INSURANCE STATUS

In Table 5, we examine changes in children's health care coverage according to family structure and income. This allows us to determine whether family structure plays a role independent of economic status as a correlate of children's health insurance status. These data suggest that the health insurance status of children at specific family income levels differs by family type. In any given year and at most income levels, children in two-parent families were far more likely to have private coverage and far less likely to have public coverage than those in single-parent households. However, at lower income levels, children in two-parent families were far more likely to be uninsured than their counterparts in single-parent families.

Most of the changes in children's health insurance coverage during this period occurred to those in poor and near-poor households. For example, only among poor households do we observe dramatic shifts in health insurance status for children in two-parent families: private coverage in these households declined precipitously between 1977 and 1996 (from 52.0 percent to 20.0 percent), while their rate of public insurance increased more than threefold between 1987 and 1996 (from 14.6 percent to 51.7 percent). The decline in private coverage could be related to overall declines in take-up rates during this period (Cooper and Schone 1997), because, as noted above, out-of-pocket premium costs were rising dramatically and may have been particularly burdensome for low-income workers. Another explanation for this decline in take-up rates is the crowding out of private coverage by the expansion of Medicaid eligibility after 1987. In addition, the decline after 1987 in the proportion of children from poor two-parent families who were uninsured suggests that the Medicaid expansions were also associated with a decrease in the risk that children in these households would be uninsured. However, these poor children and those in near-poor families remain more than twice as likely as all children in two-parent households to be uninsured.

In contrast to their counterparts in two-parent households, the rate of private coverage among children in single-parent poor and near-poor households increased between 1977 and 1987, their rate of public insurance declined markedly, and the proportion of children in single-parent poor households who were uninsured increased. However, after 1987, the patterns of coverage for poor and near-poor children in single-parent households closely resembled those of their counterparts in two-parent households. In addition to these

TABLE 5 Children's Health Insurance Status and Family Income, 1977-1996

Income Level ^a	Children in Two-Parent Families				Children in Single-Parent Families			
	Number of Children in Thousands	Private Insurance	Public Insurance Only	Uninsured	Number of Children in Thousands	Private Insurance	Public Insurance Only	Uninsured
1977								
Poor	4,074	52.0 (5.05)	16.5 (2.65)	31.5 (4.65)	4,464	6.3 (1.65)	81.9 (2.86)	11.9 (2.00)
Near poor	1,464	42.6 (6.52)	17.5 (5.62)	39.9 (7.09)	917	16.6 (5.27)	70.8 (7.01)	12.7 (5.61)
Low income	9,508	73.8 (2.82)	7.8 (1.66)	18.5 (2.48)	1,940	45.8 (4.91)	33.7 (5.32)	20.6 (3.42)
Middle income	24,580	86.7 (1.22)	4.7 (0.95)	8.6 (0.89)	2,494	70.7 (4.04)	15.8 (3.61)	13.5 (2.95)
High income	12,904	92.5 (1.43)	2.3 (0.74)	5.3 (1.18)	890	66.6 (6.66)	7.8 (3.15)	25.6 (6.27)
1987								
Poor	5,924	38.0 (3.69)	14.6 (2.58)	47.4 (3.53)	6,463	17.2 (1.71)	56.5 (2.28)	26.3 (2.09)
Near poor	1,771	42.7 (5.78)	20.0 (5.47)	37.3 (5.08)	1,454	31.9 (4.60)	44.1 (4.58)	24.0 (3.49)
Low income	6,755	64.8 (2.77)	9.0 (1.88)	26.3 (2.46)	3,163	35.8 (2.99)	46.2 (2.73)	18.0 (2.85)
Middle income	19,384	87.7 (0.93)	3.5 (0.67)	8.8 (0.80)	3,843	68.9 (3.28)	15.2 (2.21)	15.9 (2.27)
High income	12,277	94.4 (0.74)	2.5 (0.46)	3.1 (0.54)	1,432	82.9 (3.20)	6.7 (1.84)	10.4 (2.62)
1996								
Poor	7,621	20.0 (2.52)	51.7 (3.44)	28.3 (2.77)	6,635	11.4 (1.79)	71.5 (2.82)	17.1 (2.48)
Near poor	3,273	41.8 (4.39)	26.9 (3.98)	31.4 (4.26)	1,730	26.6 (4.77)	50.9 (5.99)	22.5 (4.00)
Low income	6,938	68.8 (3.08)	11.4 (2.05)	19.9 (2.20)	2,478	56.8 (4.19)	21.3 (3.95)	21.9 (3.69)
Middle income	14,910	89.5 (1.24)	2.4 (0.54)	8.1 (1.12)	2,977	67.5 (4.05)	13.0 (3.25)	19.6 (3.48)
High income	14,246	93.7 (1.07)	1.2 (0.50)	5.1 (0.99)	1,305	77.8 (4.54)	9.6 (3.47)	12.6 (4.06)

Source: 1977 National Medical Care Expenditure Survey; 1987 National Medical Expenditure Survey; 1996 Medical Expenditure Panel Survey and 1995 National Health Interview Survey.

Note: Standard errors of estimates are shown in parentheses. Children with unknown family incomes are omitted from this table.

a. Where poor refers to incomes less than or equal to the federal poverty line; near poor, between the poverty line and 125 percent of the poverty line; low income, above 125 percent to 200 percent of the poverty line; middle income, above 200 percent to 400 percent of the poverty line; and high income, above 400 percent of the poverty line.

changes for children in poor and near-poor households, we also find that, since 1987, middle-income children in single-parent families were more likely to lack private coverage and were approximately twice as likely to be uninsured compared with middle-income children in two-parent families.

DISCUSSION

In this article, we use data from a series of three nationally representative medical expenditure surveys to examine the relationship between family structure and children's health insurance status in the period from 1977 to 1996. Overall, we find that there have been decreases in private insurance, increases in public coverage, and increases in the proportion of children who were uninsured during this period. However, when children's family circumstances are considered, these patterns differ, and we find that the rise in the proportion of children who were uninsured was largely a single-parent family phenomenon. We conclude that these changes in health insurance coverage during this two-decade period differentially affected children from single- and two-parent families.

Many of the changes we observe between 1987 and 1996 may reflect the effects of expansions in Medicaid eligibility in the late 1980s and early 1990s.¹¹ Consistent with these expansions, which effectively severed the tie between Medicaid and AFDC eligibility, our data reveal a large increase in the proportion of children in two-parent households with public coverage after 1987, primarily among poor families and those with only one working parent. The targeted expansions in public coverage more than offset the reduction in private insurance for children in each of these types of households between 1987 and 1996, so that the percentage uninsured declined.

Similar to their counterparts in two-parent families, those children in poor single-parent families experienced increases in public insurance coverage and decreases in the likelihood of being uninsured after 1987. However, the Medicaid expansions had less impact on the overall experiences of all children in single-parent families, who saw stable rates of public and private insurance coverage between 1987 and 1996, and whose likelihood of being uninsured remained higher than that of children in two-parent families. Children whose single parent had ever married were at particularly high risk of being uninsured.

Our examination of the relationship between children's health insurance status and family structure has revealed continuing disparities in coverage. Despite relative and absolute improvements in private insurance coverage, children in single-parent families are, on average, substantially more likely than those in two-parent families to lack private health insurance. In

particular, we find that children in middle-income single-parent households are substantially more likely to lack private coverage and to be uninsured than their counterparts in two-parent families, and that those children whose single parent never married are at extremely high risk of lacking private health insurance. Among children living in two-parent families, those with only one working parent and those in poor or near-poor households have been at a distinct disadvantage with regard to private insurance coverage and in 1996 remained far more likely than other children in two-parent families to be uninsured.

Such information on family structure can provide an additional gauge for evaluating which children are at increased risk of lacking private insurance or being uninsured and, in turn, can help in developing public policies that reduce these disparities by targeting interventions in appropriate ways. For example, Connecticut, Rhode Island, and Missouri are using approved plans under the State Children's Health Insurance Program to provide coverage to uninsured children with family incomes between 200 and 300 percent of the federal poverty line; our findings suggests that outreach to these middle-income children may be most profitably targeted toward single-parent families. Children in two-parent households with only one working parent or whose family incomes are near or below poverty also warrant special policy consideration, since their experience is largely responsible for the decline in private health insurance among children in two-parent households. Improving their access to private coverage and their families' ability to bear rising out-of-pocket premium costs may play an important role in reducing their likelihood of remaining uninsured and their reliance on publicly provided coverage, and hence, may moderate Medicaid crowd out. Other efforts might include greater enforcement of the financial obligations of noncustodial parents to make them a more common source of health insurance coverage for children in single-parent families. Finally, as welfare reform moves many single parents from welfare to work, our research highlights the importance of ensuring that such families have access to affordable private health insurance once their incomes increase and transitional Medicaid coverage for their children ends. As our results indicate, the low rate of private coverage for many children in low- and even middle-income single-parent households suggests that the transition to work may not be accompanied by coverage under private, employment-based health insurance.

Public policies affecting children's health insurance coverage are likely to continue to evolve during the next several years as states obtain the resources to expand coverage to uninsured children and as welfare reform requires employment for many single parents. As we have shown, looking at family structure provides insights that are often obscured in more aggregated estimates of

children's health insurance coverage. Further research that focuses on how children in different family circumstances are affected by expansions and contractions of different types of health insurance programs can help policy makers understand more fully the implications of various interventions and their success in achieving stated objectives. If one national goal related to health care is to ensure that children have adequate health insurance coverage, such studies will be vital to evaluating progress toward that goal.

NOTES

1. Employee contributions were obtained from Pemberton and Holmes (1995) and deflated by the Consumer Price Index (1982-84 = 100). In nominal dollars, employee contributions were \$32.51 in 1983 and \$107.42 in 1993.
2. These initiatives included a series of optional and mandated coverage expansions directed at state Medicaid programs and were contained in the *Omnibus Budget Reconciliation Acts* (OBRA) of 1986, 1987, 1989, and 1990 and in the *Medicare Catastrophic Amendments* of 1988. Beginning on or after April 1990, OBRA 1989 required states to cover pregnant women and children under age 6 up to 133 percent of the federal poverty line. OBRA 1990 went further by requiring states to phase in coverage of children born after September 30, 1983 until all children under age 19 living below the poverty line are covered. For a summary, see General Accounting Office (1995, 25).
3. For evidence supporting the "crowd out" hypothesis, see Cutler and Gruber (1996). For a contrary view, see Dubay and Kenney (1996).
4. On average, shorter reference periods may yield lower estimates of private and public insurance, and somewhat higher estimates of being uninsured than do longer reference periods. While these measurement issues may affect the estimates presented in this article, the three surveys were designed to facilitate cross-year analyses. More important, rather than reflecting differences in the length of reference periods, any health insurance differentials we observe are far more likely to be associated with the changes in household circumstances and costs of coverage that we have documented.
5. Information on employment-related health insurance was directly available from the household survey components of the 1996 Medical Expenditure Panel Survey (MEPS) and the 1987 National Medical Expenditure Survey (NMES) but not from the 1977 National Medical Care Expenditure Survey (NMCES). To obtain such information for our 1977 sample, we used data from the 1977 NMCES Health Insurance Employer Survey and followed procedures developed by Cunningham and Monheit (1990). Our estimates of employment-related coverage for children in 1977 differ slightly from Cunningham and Monheit's estimates since our data are based on edited and updated household data on family relationships in Round 1 from the 1977 NMCES.

6. Since a family's poverty status may change dramatically from one year to the next, caution must be used in drawing implications for poor, near-poor, and low-income households in the 1996 MEPS, since income is measured using the 1995 National Health Interview Survey (NHIS). However, we do not believe that this potential measurement error distorts the broad changes in children's health insurance that we observe, because these changes are generally consistent with expansions of public coverage and the change in costs of employment-based health insurance during the last decade.
7. The 1987 and 1996 uninsured rates are not statistically different from one another.
8. The difference between 40.0 percent in 1987 and 38.7 percent in 1996 is not statistically significant.
9. The decline in public coverage for children in single-parent households occurred during the 1977-1987 period. The proportion of such children with public coverage in 1996 remained below 1977 levels but was not statistically different from the 1987 level.
10. Our information on the availability of health insurance to children in single-parent families is limited to the parent with whom they live. To the extent that insurance may be available through noncustodial parents, our results may understate the extent to which private health insurance is available to such children. In addition, our information on the availability of health insurance consists of whether working parents are offered insurance, regardless of whether or not they are offered family coverage. To the extent that workers are offered individual rather than family coverage, our results may overstate the extent to which private health insurance is available to all children of working parents. However, our information on actual insurance coverage for these children does not suffer from these problems.
11. The data we use are collected approximately every 10 years. As a result, we do not have continuous measurement throughout the two-decade period we study. While our results describe general long-term trends in health insurance status, we cannot describe any of the shorter term fluctuations that may have been caused by rapid policy or economic changes.

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FAX TRANSMISSION COVER SHEET

Date: *March 8, 1999*
To: *Audrey Paige/White House Domestic Policy Staff*
Fax: *202/456-2878*
Re: *Children's Health Insurance and Family Structure*
Sender: *Karen Carp*

YOU SHOULD RECEIVE 11 PAGES, INCLUDING THIS COVER SHEET.

Audrey,

Here is the article. Please let me know if you need anything else, or if it's not readable.

Thanks.

Karen

CENSUS BRIEF

U.S. Department of Commerce
Economics and Statistics Administration
BUREAU OF THE CENSUS



Children Without Health Insurance

MANY AMERICANS VIEW access to health care as essential for the healthy and secure development of children in their formative years. This Census Brief, based on data collected during the March 1997 Current Population Survey, reports on how well American children are protected by health insurance. The data show that the number of American children without health coverage rose from 8.2 million to 10.6 million from 1987 to 1996, overall a period of relative prosperity.

This increase was not simply due to an increase in the number of children (defined as those below the age of 18) during the 9-year period. The proportion of uncovered children rose as well, from 12.9 percent to 14.8 percent of the under-18 population.

Fact: In 1996, 1 in 7 children in the United States had no health insurance.

ethnic group. In 1996, 13.9 percent of White children had no health coverage. For Hispanics, the percentage was more than twice that, 28.9 percent. African-American children fell between those two groups at 18.8 percent.

Fact: Hispanic children are the least likely to have health-insurance coverage.

While poverty might seem the easy answer to why the lack of coverage varies by race and ethnic group, that is not the case.

The percent of poor White children without health insurance was actually higher than that of poor African Americans in 1996 — 25.2 percent versus 19.7 percent. And the proportion of poor Hispanic children without health insurance was essentially the same as for all Hispanic children.

The gap in children's health coverage, in addition to increasing over the past decade, widened in the most recent period studied, 1995-96. During that period, the percentage

WHO ARE THE UNINSURED CHILDREN?

By number, the largest group of children are not poor, as four-fifths are above the poverty level. Nevertheless, there were about 7.2 million non-poor children who did not have health insurance in 1996. They were joined by 3.4 million poor children.

Proportionately, poor children were far more likely to lack necessary health coverage than non-poor children. Among the poor children, 23.3 percent lacked health coverage in 1996, almost twice the 12.7 percent of children above the poverty line.

Fact: Almost 1 in 4 poor children lacked health insurance in 1996.

The proportion of children without health insurance varies greatly by race and

CHILDREN WHO LACKED HEALTH INSURANCE IN 1996

All children	14.8%
Poor children	23.3%
■ ALL CHILDREN	
White	13.9%
Black	18.8%
Hispanic origin	28.9%
■ POOR CHILDREN	
White	25.2%
Black	19.7%
Hispanic origin	29.9%
■ AGE	
Less than 6	13.8%
6-11	14.6%
12-17	16.1%

of children not covered rose a full point, from 13.8 percent to 14.8 percent. Among racial and ethnic groups, the proportion of African-American children without coverage was the only one to show a significant rise, from 14.6 percent in 1995 to 19.7 percent in 1996 among poor African-American children and from 15.3 percent to 18.8 percent among all African-American children.

Fact: Most of the increase in uninsured children from 1995-1996 was accounted for by African-American children.

By age, the group most likely to be uninsured has been 12- to 17-year-olds. In 1996, 16.1 percent of this group lacked health coverage; recall that the average for all children was 14.8 percent.

Recent increases in the number and percentage of uninsured children appear to be similarly due to losses of government, not private coverage. From 1995 to 1996, the number of children covered under Medicaid fell from 16.5 million to 15.5 million, the largest drop in any coverage category both in percentage and absolute numbers.

Notably, coverage of children under private, employment-based programs did not change, a predictable result of low levels of unemployment in recent years.

Fact: The growth in the number of children lacking health insurance is largely attributable to the fall-off in Medicaid coverage.

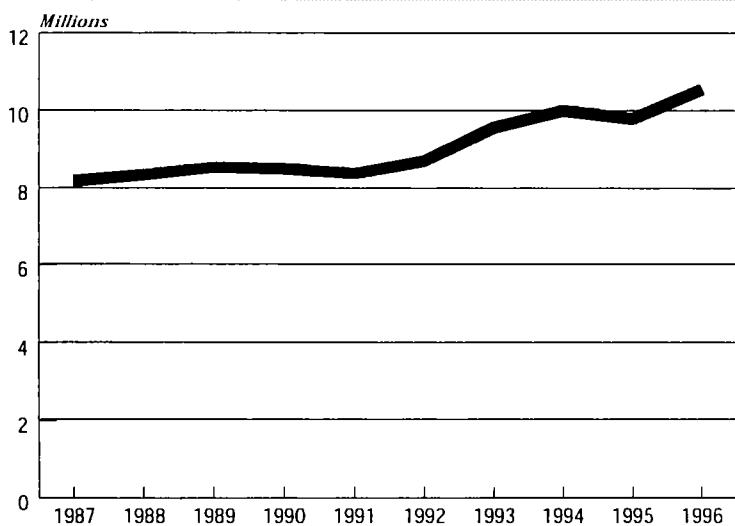
Health insurance coverage for persons under 18 years varies sharply from that of life's other most vulnerable group, the elderly (65 years and older). Mainly because of Medicare, only 1.1 percent of the elderly are without health insurance, compared with 14.8 percent of Americans under 18 years of age.

Fact: A youngster under age 18 is far more likely to be without health insurance coverage than a person 65 years old or older.

Health coverage of the population is a vital issue to the nation's health and is one on which the Census Bureau will continue to report. Future changes in health coverage as programs devolve to the states have emerged as a key issue.

Note: Redesign of health insurance questions in the March 1996 Current Population Survey may partially affect coverage estimates of employment-based and military health care coverage in that year, although overall coverage estimates were not affected.

CHILDREN WITHOUT HEALTH INSURANCE: A NUMBER ON THE RISE



Note: In March 1995 (1994 estimates), the Current Population Survey used redesigned health insurance questions. Increases in estimates of employment-based and military health-care coverage may be partially the result of these questionnaire changes. Overall coverage estimates were not affected.

U.S. Department of Commerce; BUREAU OF THE CENSUS

CENSUS BRIEF

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This Brief is one of a series that presents information of current policy interest. All statistics are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The Census Bureau has taken steps to minimize errors, and analytical statements have been tested and meet statistical standards. However, because of methodological differences, use caution when comparing these data with data from other sources.

Current Population Reports

Consumer Income

Health Insurance Coverage: 1997

By Robert L. Bennefield

C E N S U S B U R E A U

P60-202

Issued September 1998

The Haves and Have-Not's

An estimated 43.4 (± 0.5) million people in the United States or 16.1 (± 0.2) percent of the population were without health insurance coverage during the entire 1997 calendar year. This number was up 1.7 million from the previous year; statistically, the proportion was also higher than the previous year.

Other highlights are:

- The status of children's health care coverage was unchanged in 1997. The number of uninsured children under 18 years of age was 10.7 (± 0.2) million in 1997, 15.0 (± 0.3) percent of all children; both the number and percent were not significantly different from the previous year.
- Despite the Medicaid program, 11.2 (± 0.3) million poor people had no health insurance in 1997, nearly one-third of all poor people, or 31.6 (± 0.7) percent.
- The highest uninsured rate was among people of Hispanic origin: Over one-third or 34.2 (± 0.6) percent of Hispanics were uninsured in 1997, compared with 12.0 (± 0.2) percent for non-Hispanic Whites.
- Among the general population 18 to 64 years old, workers (full- and part-time) were more likely to be insured than nonworkers, but among the poor, workers were less likely to be insured than nonworkers. About one-half, or 49.2 (± 2.0) percent, of poor full-time

workers were uninsured in 1997.

- A higher proportion of the foreign-born population in the U.S. was without health insurance in 1997, compared with natives, 34.3 (± 0.8) percent versus 14.2 (± 0.2) percent. Poor immigrants were even worse off; 51.7 (± 2.0) percent were without health insurance.
- Young adults between the ages of 18 to 24 were more likely than other age groups to not have coverage; 30.1 (± 0.7) percent were without coverage in 1997. Because of Medicare, the elderly were at the other

extreme; only 1.0 (± 0.1) percent lacked coverage.

Note: The figures above in parentheses denote the 90-percent confidence intervals.

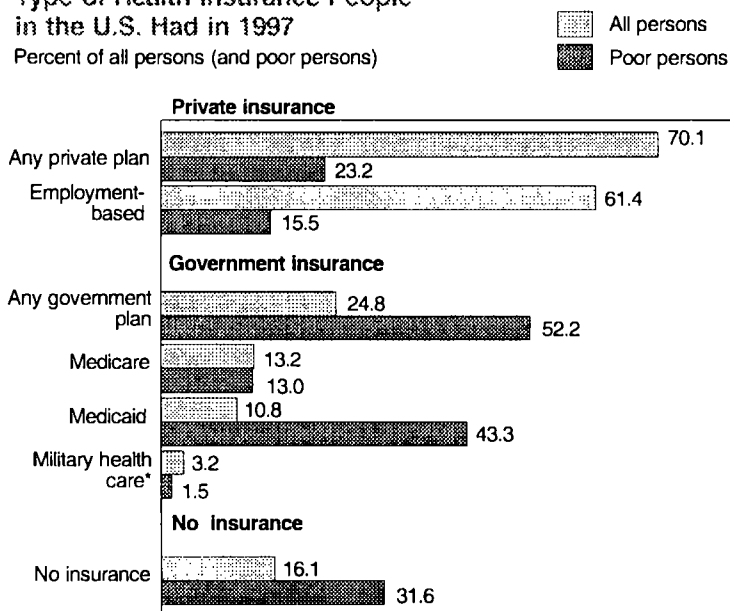
Employment is the leading source of health insurance coverage.

Most people (70.1 percent) were covered by a private insurance plan for some or all of 1997. A private plan is one that is offered through employment (either one's own or a relative's) or privately purchased. Most private insurance was obtained through a current or former employer or union (employment-based), (Figure 1).

The government also provides health care coverage (24.8

Figure 1.
Type of Health Insurance People
in the U.S. Had in 1997

Percent of all persons (and poor persons)



*Military health care includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare, CHAMPVA (Civilian Health and Medical Program of the Department of Veteran's Affairs), Veteran's and military health care.

Note: The percentages by type of coverage are not mutually exclusive; in other words, persons can be covered by more than one type of health insurance during the year.

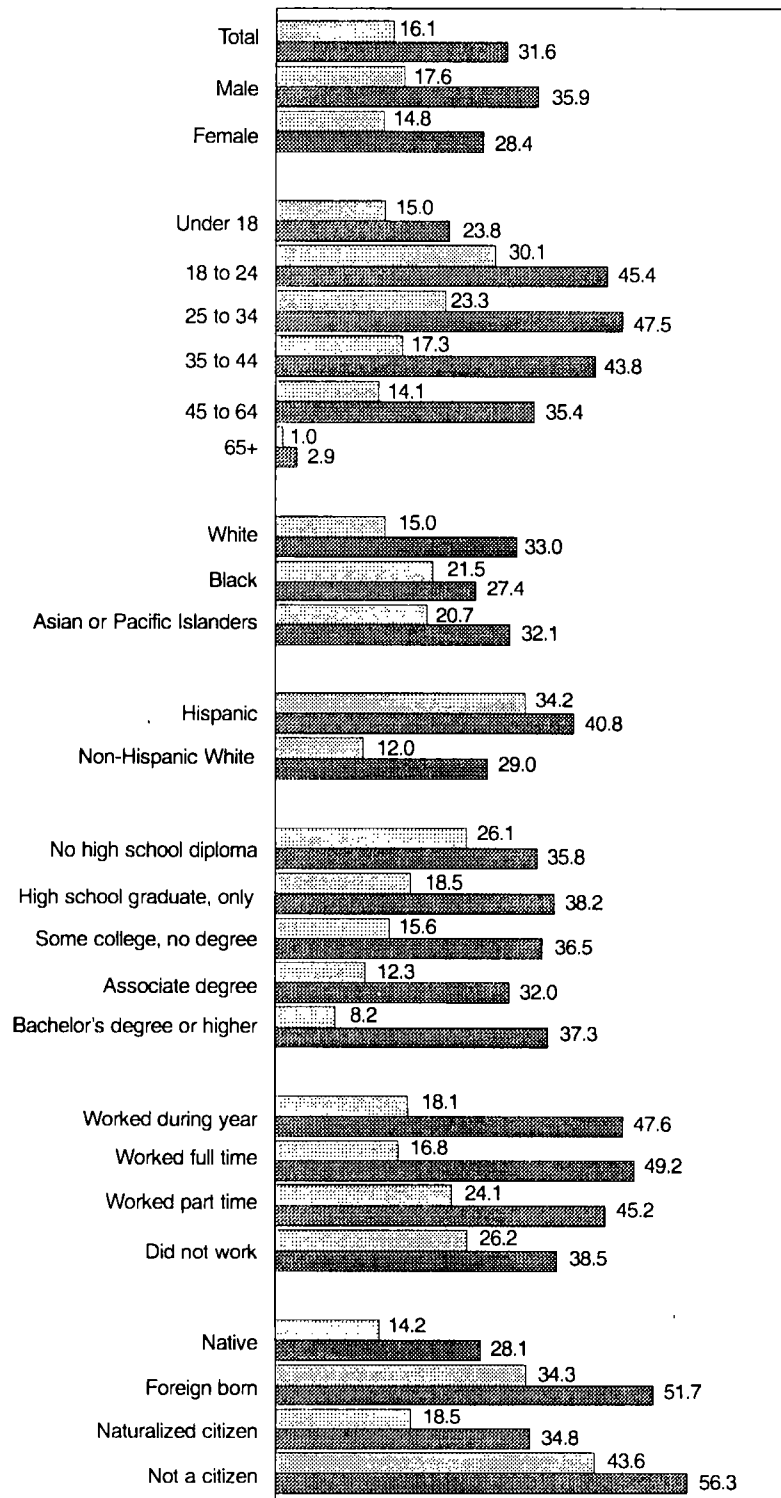
Source: U.S. Census Bureau, March 1998 Current Population Survey.

Figure 2.

Who Lacked Coverage in 1997?

Percent of all persons (and poor persons) never covered by health insurance during the year, by selected characteristics

□ All persons
■ Poor persons



Note: Persons of Hispanic origin may be of any race. The percent is derived by dividing the number of uninsured people in a particular category by the total number of people in that category.

Source: U.S. Census Bureau, March 1998 Current Population Survey.

percent of people have government insurance)—Medicare (13.2 percent), Medicaid (10.8 percent), and military health care (3.2 percent). Many people carry coverage from more than one plan during the year; for example, 7.9 percent were covered by both private insurance and Medicare.

The poor and near poor are more likely not to have coverage.

Despite the Medicaid program, 31.6 percent of the poor (11.2 million) had no health insurance of any kind during 1997. This percentage—which was double the rate for all people—was statistically unchanged from the previous year. Poor people comprised 25.9 percent of all uninsured people.

Medicaid was the most widespread type of coverage among the poor. About 43.3 percent of all poor people were covered by Medicaid at some time during the year.

Among the near poor, 30.8 percent were without health insurance (3.8 million). (The near poor are those with a family income greater than the poverty level but less than 125 percent of the poverty level.)

Key factors influencing the chances of not having health insurance coverage are: (See Figure 2.)

Age — Young adults between the ages of 18 to 24 were more likely than other age groups to lack coverage during all of 1997 (30.1 percent). Because of Medicare, the elderly were at the other extreme (only 1.0 percent lacked coverage). Among the poor, adults aged 18 to 64 had much higher noncoverage rates than either children or the elderly.

Race and Hispanic origin — People of Hispanic origin had the highest chance of not having health insurance coverage in 1997. The uninsured rate for

Hispanics was 34.2 percent, compared with 12.0 percent for non-Hispanic Whites. Among the poor, African Americans and non-Hispanic Whites had the lowest uninsured rates (27.4 percent and 29.0 percent, respectively);¹ many poor African Americans were covered by Medicaid.

Educational attainment —

Among all adults, the likelihood of being uninsured declined as the level of education rose. Among those who were poor in 1997, there were few differences across the education groups.

Work experience — Of those 18 to 64 years old who worked, part-time workers had a higher noncoverage rate (24.1 percent) than full-time workers (16.8 percent).² Among the general population 18 to 64, workers (full- and part-time) were more likely to be insured than nonworkers, but among the poor, workers were less likely to be insured than nonworkers. About one-half of poor full-time workers were uninsured in 1997 (49.2 percent).

Foreign born — In 1997, a higher proportion of the foreign-born population in the U.S. was without health insurance (34.3 percent), compared with natives³ (14.2 percent). Of the foreign born, noncitizens had a noncoverage rate more than twice as high as naturalized citizens, 43.6 percent versus 18.5 percent. Poor immigrants were even

¹ The uninsured rate for poor African Americans was not significantly different from that of poor non-Hispanic Whites.

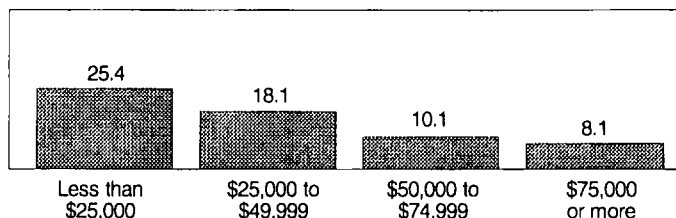
² Workers were classified as part-time if they worked less than 35 hours per week in the majority of the weeks they worked in 1997.

³ "Natives" are people born in the United States, Puerto Rico, or an outlying area of the U.S., such as Guam or the U.S. Virgin Islands, and people who were born in a foreign country but who had at least one parent who was a U.S. citizen. All other people born outside the U.S. are "foreign born."

Figure 3.

As Income Rises, Chances of Having No Insurance Generally Decline

Percent of persons never covered by health insurance during the year, by household income: 1997

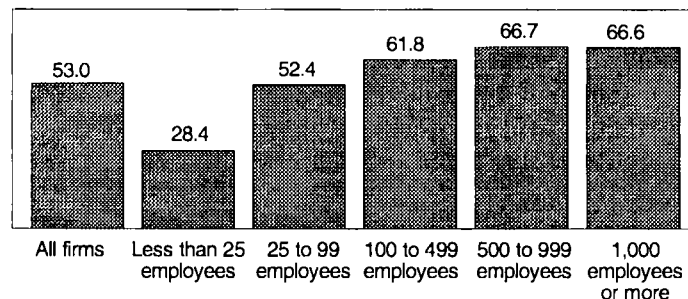


Source: U.S. Census Bureau, March 1998 Current Population Survey.

Figure 4.

Workers in Large Firms Are the Most Likely to Have Employment-Based Insurance

Percent of workers (aged 15 and over) with employment-based health insurance policies in their own name, by size of firm they worked for: 1997

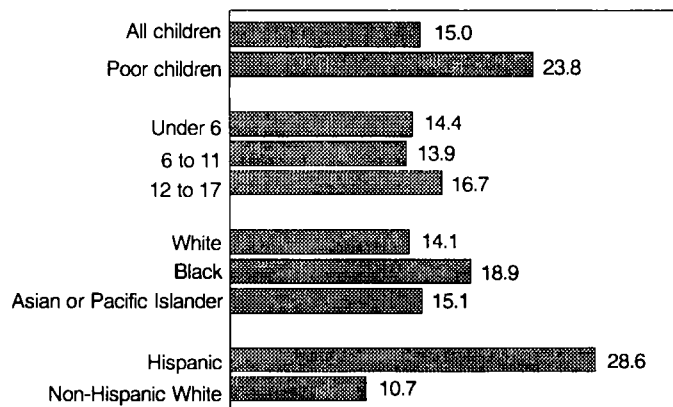


Source: U.S. Census Bureau, March 1998 Current Population Survey.

Figure 5.

Who Are the Uninsured Children?

Percent of children without health insurance in 1997



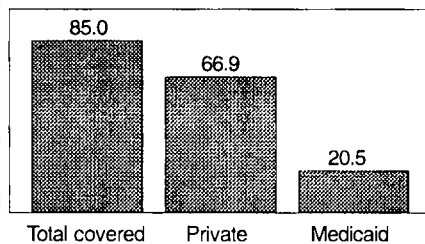
Note: Persons of Hispanic origin may be of any race.

Source: U.S. Census Bureau, March 1998 Current Population Survey.

Figure 6.

About One-Fifth of Children Were Covered by Medicaid in 1997

Percent of children covered in 1997

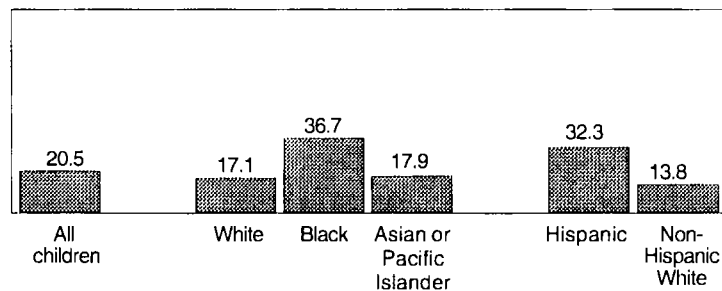


Source: U.S. Census Bureau, March 1998 Current Population Survey.

Figure 7.

Black and Hispanic Children Were Much More Likely to Have Medicaid Coverage Than White or Asian/Pacific Islander Children

Percent of children never covered by Medicaid in 1997



Note: Persons of Hispanic origin may be of any race.

Source: U.S. Census Bureau, March 1998 Current Population Survey.

worse off; 51.7 percent were without health insurance.

Income and firm size play important roles.

Noncoverage rates fall as household income rises. In 1997, the percent of people without health insurance ranged from 8.1 percent (among those in households with incomes of \$75,000 or more) to 25.4 percent (among those in households with incomes less than \$25,000), (Figure 3).

Of the 144.6 million workers, 53.0 percent had employment-based health insurance policies in their own name. The proportion varied widely by size of employing firm; workers employed by small firms (less than 25 employees) were the least likely to have employment-based health insurance policies in their own name (Figure 4). These estimates do not reflect the fact that some workers are covered by employment-based coverage through another family member.

Children's health care coverage status was unchanged in 1997.

The number of uninsured children less than 18 years of age was 10.7 million (15.0 percent of all children) in 1997;

both the number and percent were not significantly different from the previous year.

Among poor children, 3.4 million (23.8 percent) were uninsured in 1997, statistically unchanged from the previous year. Poor children comprised 31.3 percent of all uninsured children in 1997.

Other findings concerning children are—

- Older children (12 to 17 years of age) were less likely to have health care coverage than younger children (those less than 12 years of age). Uninsured rates for children by age group were—14.4 percent of children less than 6, 13.9 percent of children 6 to 11, and 16.7 percent of children 12 to 17 (Figure 5).⁴
- Children of Hispanic origin were far more likely to be uninsured (28.6 percent) than non-Hispanic White children (10.7 percent); and African-American children were more likely to go uninsured (18.9 percent) than White children (14.1 percent) or Asian and Pacific Islander children (15.1 percent).⁵

⁴ Statistically, there was no significant difference between the uninsured rates for children under 6 and those 6 to 11.

- While most children were covered by a private health insurance plan (privately purchased or employment-based) in 1997, about one-fifth were covered by Medicaid: 66.9 percent were covered by a private plan and 20.5 percent (14.7 million) were covered by Medicaid in 1997 (Figure 6).

- Significantly higher proportions of African-American and Hispanic children, than of White or Asian and Pacific Islander children, were covered by Medicaid in 1997—36.7 percent of African-American children, 17.1 percent of White children and 17.9 percent of Asian and Pacific Islander children; 32.3 percent of Hispanic children and 13.8 percent of non-Hispanic White children (Figure 7).

Some states have higher noncoverage rates than others. (See Table 1.)

Using 3-year averages between 1995 and 1997, state uninsured rates ranged from 7.9 percent in Wisconsin to 24.4

⁵ Statistically, there was no difference between the uninsured rates for White children and for Asian and Pacific Islander children.

Table 1.
Percent of Persons Without Health Insurance Coverage Throughout the Year,
by State and Two Largest Metropolitan Areas (CMSA): 1995 to 1997

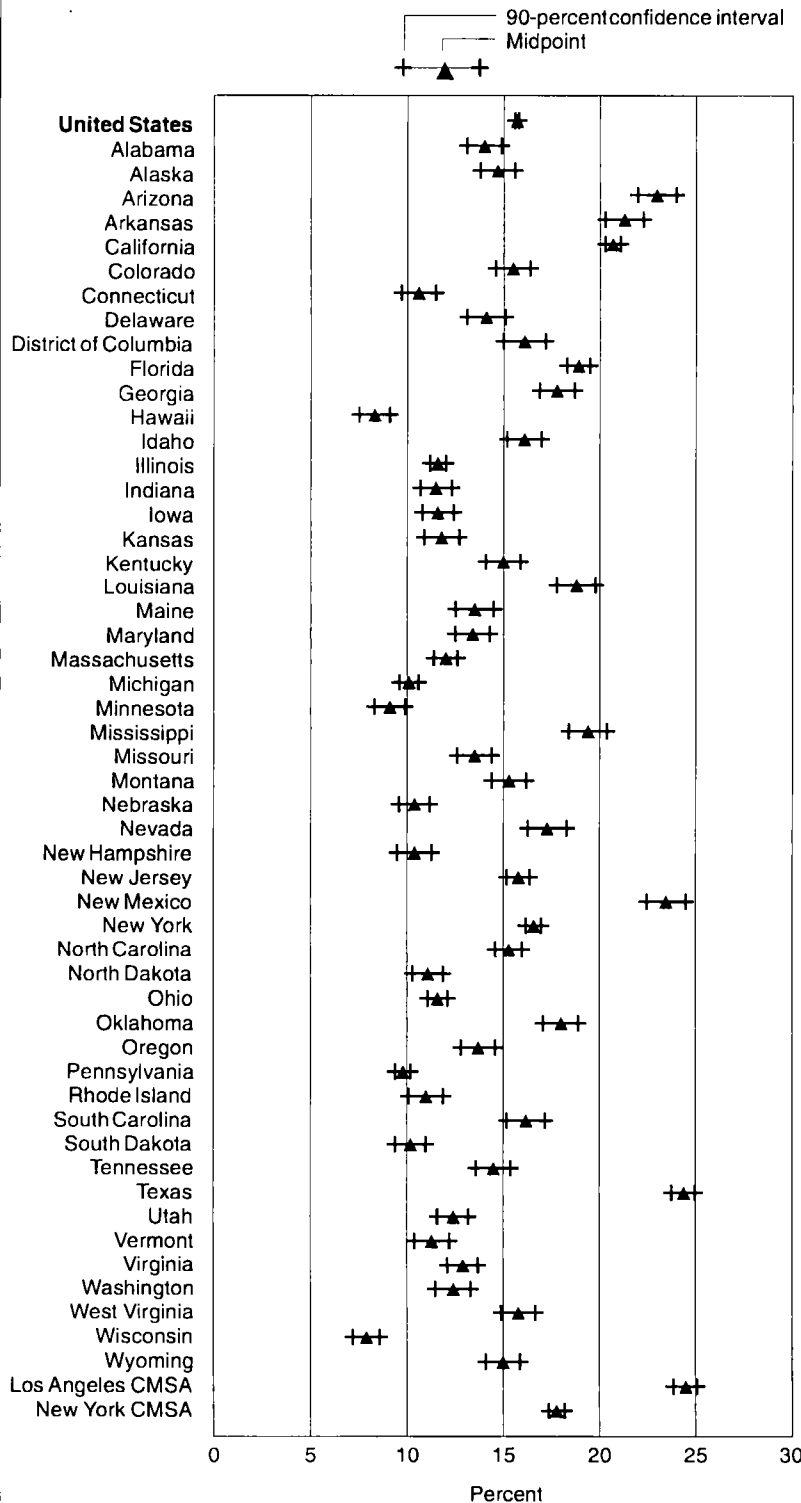
State/CMSA	1997		1996		1995		3-year average 1995-1997		Average 1996-1997		Average 1995-1996		Difference in 2-year moving averages 1996-97 less 1995-96	
	Percent	Stand- ard error	Percent	Stand- ard error	Percent	Stand- ard error	Percent	Stand- ard error	Percent	Stand- ard error	Percent	Stand- ard error	Percent	Stand- ard error
United States	16.1	0.1	15.6	0.1	15.4	0.1	15.7	0.1	15.9	0.1	15.5	0.1	* 0.4	0.1
Alabama	15.5	0.8	12.9	0.8	13.5	0.8	14.0	0.5	14.2	0.6	13.2	0.6	* 1.0	0.6
Alaska	18.1	0.9	13.5	0.8	12.5	0.8	14.7	0.6	15.8	0.7	13.0	0.6	* 2.8	0.6
Arizona	24.5	0.9	24.1	0.9	20.4	0.9	23.0	0.6	24.3	0.7	22.3	0.7	* 2.0	0.6
Arkansas	24.4	1.0	21.7	0.9	17.9	0.9	21.3	0.6	23.1	0.8	19.8	0.7	* 3.3	0.7
California	21.5	0.4	20.1	0.4	20.6	0.4	20.7	0.3	20.8	0.3	20.4	0.3	0.4	0.3
Colorado	15.1	0.8	16.6	0.9	14.8	0.8	15.5	0.6	15.9	0.7	15.7	0.7	0.1	0.6
Connecticut	12.0	0.8	11.0	0.8	8.8	0.7	10.6	0.5	11.5	0.6	9.9	0.6	* 1.6	0.5
Delaware	13.1	0.9	13.4	0.9	15.7	0.9	14.1	0.6	13.3	0.7	14.6	0.7	-1.3	0.6
District of Columbia	16.2	1.0	14.8	0.9	17.3	1.0	16.1	0.7	15.5	0.8	16.1	0.8	-0.5	0.7
Florida	19.6	0.5	18.9	0.5	18.3	0.5	18.9	0.3	19.3	0.4	18.6	0.4	* 0.7	0.4
Georgia	17.6	0.8	17.8	0.8	17.9	0.8	17.8	0.5	17.7	0.6	17.9	0.6	-0.1	0.6
Hawaii	7.5	0.7	8.6	0.7	8.9	0.7	8.3	0.5	8.1	0.6	8.8	0.6	-0.7	0.5
Idaho	17.7	0.8	16.5	0.8	14.0	0.8	16.1	0.5	17.1	0.6	15.3	0.6	* 1.9	0.6
Illinois	12.4	0.4	11.3	0.4	11.0	0.4	11.6	0.3	11.9	0.3	11.2	0.3	0.7	0.3
Indiana	11.4	0.7	10.6	0.7	12.6	0.8	11.5	0.5	11.0	0.6	11.6	0.6	-0.6	0.5
Iowa	12.0	0.8	11.6	0.7	11.3	0.7	11.6	0.5	11.8	0.6	11.5	0.6	0.3	0.5
Kansas	11.7	0.8	11.4	0.7	12.4	0.8	11.8	0.5	11.6	0.6	11.9	0.6	-0.4	0.6
Kentucky	15.0	0.8	15.4	0.8	14.6	0.8	15.0	0.5	15.2	0.6	15.0	0.6	0.2	0.6
Louisiana	14.9	0.8	20.9	0.9	20.5	0.9	18.8	0.6	17.9	0.7	20.7	0.7	* 2.8	0.6
Maine	14.9	0.9	12.1	0.8	13.5	0.9	13.5	0.6	13.5	0.7	12.8	0.7	0.7	0.6
Maryland	13.4	0.8	11.4	0.8	15.3	0.9	13.4	0.6	12.4	0.6	13.4	0.7	-1.0	0.6
Massachusetts	12.6	0.6	12.4	0.6	11.1	0.5	12.0	0.4	12.5	0.5	11.8	0.4	0.8	0.4
Michigan	11.6	0.5	8.9	0.4	9.7	0.4	10.1	0.3	10.3	0.4	9.3	0.3	* 1.0	0.3
Minnesota	9.2	0.7	10.2	0.7	8.0	0.6	9.1	0.5	9.7	0.6	9.1	0.5	0.6	0.5
Mississippi	20.1	0.9	18.5	0.9	19.7	0.9	19.4	0.6	19.3	0.7	19.1	0.7	0.2	0.6
Missouri	12.6	0.8	13.2	0.8	14.6	0.9	13.5	0.6	12.9	0.6	13.9	0.7	* -1.0	0.6
Montana	19.5	0.9	13.6	0.8	12.7	0.7	15.3	0.5	16.6	0.7	13.2	0.6	3.4	0.6
Nebraska	10.8	0.7	11.4	0.7	9.0	0.7	10.4	0.5	11.1	0.6	10.2	0.6	* 0.9	0.5
Nevada	17.5	0.9	15.6	0.9	18.7	1.0	17.3	0.6	16.6	0.7	17.2	0.8	-0.6	0.7
New Hampshire	11.8	0.8	9.5	0.8	10.0	0.8	10.4	0.5	10.7	0.6	9.8	0.6	0.9	0.6
New Jersey	16.5	0.6	16.7	0.6	14.2	0.5	15.8	0.4	16.6	0.5	15.5	0.4	* 1.1	0.4
New Mexico	22.6	0.9	22.3	0.9	25.6	1.0	23.5	0.6	22.5	0.7	24.0	0.8	* -1.5	0.7
New York	17.5	0.4	17.0	0.4	15.2	0.4	16.6	0.3	17.3	0.3	16.1	0.3	* 1.1	0.3
North Carolina	15.5	0.6	16.0	0.6	14.3	0.6	15.3	0.4	15.8	0.5	15.2	0.5	0.6	0.4
North Dakota	15.2	0.8	9.8	0.7	8.3	0.6	11.1	0.5	12.5	0.6	9.1	0.5	* 3.5	0.5
Ohio	11.5	0.5	11.5	0.4	11.9	0.5	11.6	0.3	11.5	0.4	11.7	0.4	-0.2	0.4
Oklahoma	17.8	0.8	17.0	0.8	19.2	0.9	18.0	0.6	17.4	0.6	18.1	0.7	-0.7	0.6
Oregon	13.3	0.8	15.3	0.9	12.5	0.8	13.7	0.6	14.3	0.7	13.9	0.7	0.4	0.6
Pennsylvania	10.1	0.4	9.5	0.4	9.9	0.4	9.8	0.3	9.8	0.3	9.7	0.3	0.1	0.3
Rhode Island	10.2	0.8	9.9	0.8	12.9	0.9	11.0	0.6	10.1	0.6	11.4	0.7	* -1.4	0.6
South Carolina	16.8	0.9	17.1	0.9	14.6	0.9	16.2	0.6	17.0	0.7	15.9	0.7	* 1.1	0.6
South Dakota	11.8	0.7	9.5	0.7	9.4	0.7	10.2	0.5	10.7	0.6	9.5	0.6	* 1.2	0.5
Tennessee	13.6	0.8	15.2	0.8	14.8	0.8	14.5	0.5	14.4	0.6	15.0	0.6	-0.6	0.6
Texas	24.5	0.5	24.3	0.5	24.5	0.5	24.4	0.3	24.4	0.4	24.4	0.4	-	-
Utah	13.4	0.7	12.0	0.7	11.7	0.7	12.4	0.5	12.7	0.6	11.9	0.6	* 0.8	0.5
Vermont	9.5	0.8	11.1	0.8	13.2	0.9	11.3	0.6	10.3	0.6	12.2	0.7	* -1.8	0.6
Virginia	12.6	0.7	12.5	0.7	13.5	0.8	12.9	0.5	12.6	0.6	13.0	0.6	-0.4	0.5
Washington	11.4	0.8	13.5	0.8	12.4	0.8	12.4	0.5	12.5	0.6	13.0	0.6	-0.5	0.6
West Virginia	17.2	0.8	14.9	0.8	15.3	0.8	15.8	0.5	16.1	0.6	15.1	0.6	* 0.9	0.6
Wisconsin	8.0	0.6	8.4	0.6	7.3	0.6	7.9	0.4	8.2	0.5	7.9	0.5	0.3	0.4
Wyoming	15.5	0.8	13.5	0.8	15.9	0.9	15.0	0.6	14.5	0.6	14.7	0.7	-0.2	0.6
Los Angeles CMSA	24.9	0.5	23.9	0.5	24.8	0.5	24.5	0.3	24.4	0.4	24.4	0.4	0.1	0.4
New York CMSA	18.8	0.4	18.6	0.4	16.1	0.3	17.8	0.3	18.7	0.3	17.4	0.3	* 1.4	0.3

*Statistically significant at the 90-percent confidence level.

-Represents or rounds to zero.

SOURCE: U.S. Census Bureau, March 1996, 1997, and 1998 Current Population Surveys.

Figure 8.
Percent of Persons Without Health Insurance, by State and Two Largest Metropolitan Areas: 1995 to 1997, Three-Year Average



Source: U.S. Census Bureau, March 1996, 1997, and 1998, Current Population Surveys.

percent in Texas. However, we advise against using these estimates to rank the states. Results from different samples could easily show different estimates and rankings because of small sample sizes. For example, the high noncoverage rate for Texas was not statistically different from that in New Mexico (23.5 percent), while the rate for Wisconsin was not statistically different from Hawaii (8.3 percent), (Figure 8).

Based on comparisons of 2-year averages (1996-97 versus 1995-96), noncoverage rates fell in five states: Louisiana, Missouri, New Mexico, Rhode Island, and Vermont. Meanwhile, noncoverage rates rose in sixteen states: Alabama, Alaska, Arizona, Arkansas, Connecticut, Florida, Idaho, Michigan, Nebraska, New Jersey, New York, North Dakota, South Carolina, South Dakota, Utah, and West Virginia.

Technical Note

This report presents data on the health insurance coverage of people in the United States during the 1997 calendar year. The data, which are shown by selected demographic and socioeconomic characteristics, as well as by state, were collected by the March 1998 Supplement to the Current Population Survey (CPS).

In the Current Population Survey (CPS), Medicare and Medicaid coverage estimates are underreported, compared with enrollment and participation data from the Health Care Financing Administration (HCFA).⁶ A major reason for the lower CPS estimates is the fact that CPS is not designed to specifically collect health insurance data. Instead, it is largely a labor force survey, with minimum interviewer training on health insurance concepts.

⁶ HCFA is the federal agency primarily responsible for administering the Medicare and Medicaid program at the national level.

Data from HCFA represent the actual number of people who were enrolled or participated in these programs and is therefore a more accurate source of data on levels of coverage. Also, it is believed that many people are not aware that they or their children are covered by a health insurance program, and therefore do not report coverage.

Since the publication of last year's CPS health insurance report, as a result of consultation with health insurance experts, the Census Bureau has made a modification in its definition of the population without health insurance. Previously, people with no coverage other than access to Indian Health Service were considered to be part of the insured population. Beginning with this report, that is no longer true; instead, these people are considered to be uninsured. The

effect of this change on the overall estimates of health insurance coverage is negligible.

Accuracy of the Estimates

All statistics are subject to sampling error, as well as non-sampling error such as survey design flaws, respondent classification and reporting errors, data processing mistakes and under-coverage. The Census Bureau has taken steps to minimize errors in the form of quality control and edit procedures to reduce errors made by respondents, coders, and interviewers. Ratio estimation to independent age-race-sex-Hispanic population controls partially corrects for bias attributable to survey undercoverage. However, biases exist in the estimates when missed people have characteristics different from those of interviewed people in the same age-race-sex-Hispanic group.

Analytical statements in this report have been tested and meet statistical standards. However, because of methodological differences, use caution when comparing these data with data from other sources. Contact Andrew Zbikowski, Demographic Statistical Methods Division, at 301-457-4214 or via E-mail at azbikows@census.gov for information on (1) the source of the data, (2) the accuracy of the estimates, (3) the use of standard errors, and (4) the computation of standard errors.

Contact:

Robert Bennefield
301-457-3242

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Economics and Statistics Administration
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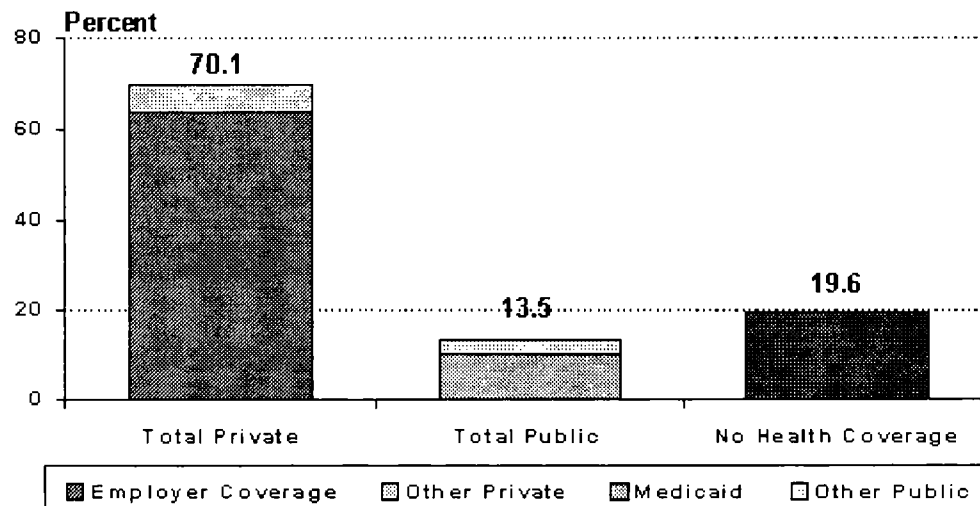
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Of the 60.5 million women between the ages of 15 and 44 (reproductive age), 11.8 million (19.6 percent) had no health insurance coverage in 1997.

In 1997, 13.5 percent (8.2 million women, 15-44 years) received publicly-funded health coverage, with 10.6 percent (6.4 million women) receiving this insurance through Medicaid.

Private health insurance for women ages 15-44 was reported for 70.1 percent (42.5 million women), with 63.8 percent (38.6 million women) covered through an employer-based plan.

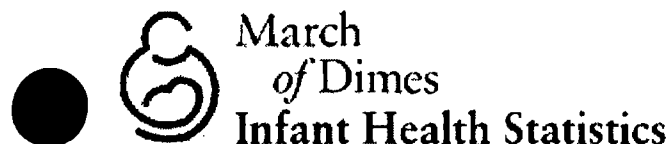
Health Insurance Coverage for Women 15-44 United States, 1997



Note: Total exceeds 100 percent due to multiple coverage by some women

Source: US Bureau of Census, March Current Population Survey, 1998

Prepared by March of Dimes Perinatal Data Center, 1998

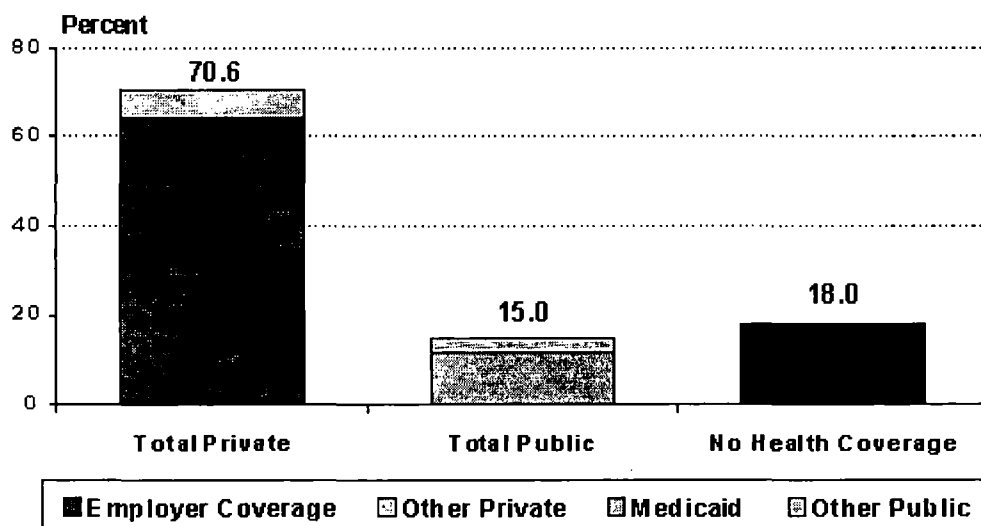


Of the 60.5 million women between the ages of 15 and 44 (reproductive age), 10.9 million (18.0 percent) had no health insurance coverage in 1996.

In 1996, 15.0 percent (9.1 million women, 15-44 years) received publicly-funded health coverage, with 11.8 percent (7.1 million women) receiving this insurance through Medicaid.

Private health insurance for women ages 15-44 was reported for 70.6 percent (42.7 million women), with 64.2 percent (38.8 million women covered through an employer-based plan.

Health Insurance Coverage Women 15-44, United States, 1996



Total exceeds 100 percent due to multiple coverage by some women
Source: US Bureau of Census from the March 1997 Current Population Survey
Prepared by March of Dimes Perinatal Data Center, 1998

Total exceeds 100 percent due to multiple coverage by some women
Source: US Bureau of the Census from the March 1997 Current Population Survey
Prepared by March of Dimes Perinatal Data Center, 1998

For more details see the 1997 March of Dimes Statbook.



Children Without Health Insurance Coverage: 1995 and 1996

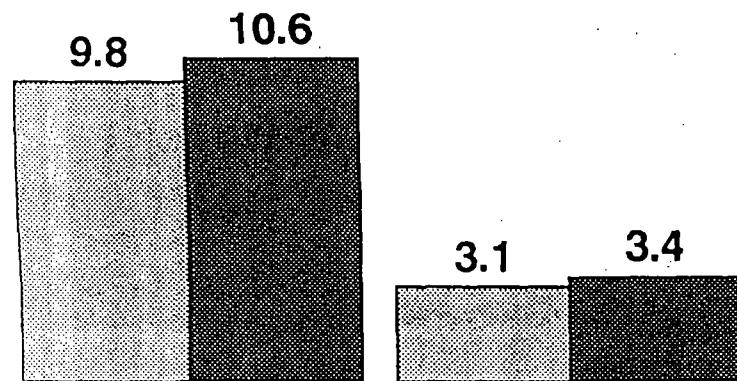
	1995	1996	Change
Number (millions)			
All Children	9.8	10.6	(0.8million increase)
Poor Children	3.1	3.4	(no change)
Percent			
All Children	13.8	14.8	(1.0 percent increase)
Poor Children	21.4	23.3	(no change)

Source: Census Bureau, March Current Population Survey.

Children Without Health Insurance Coverage: 1995 and 1996

1995
1996

Number (millions)



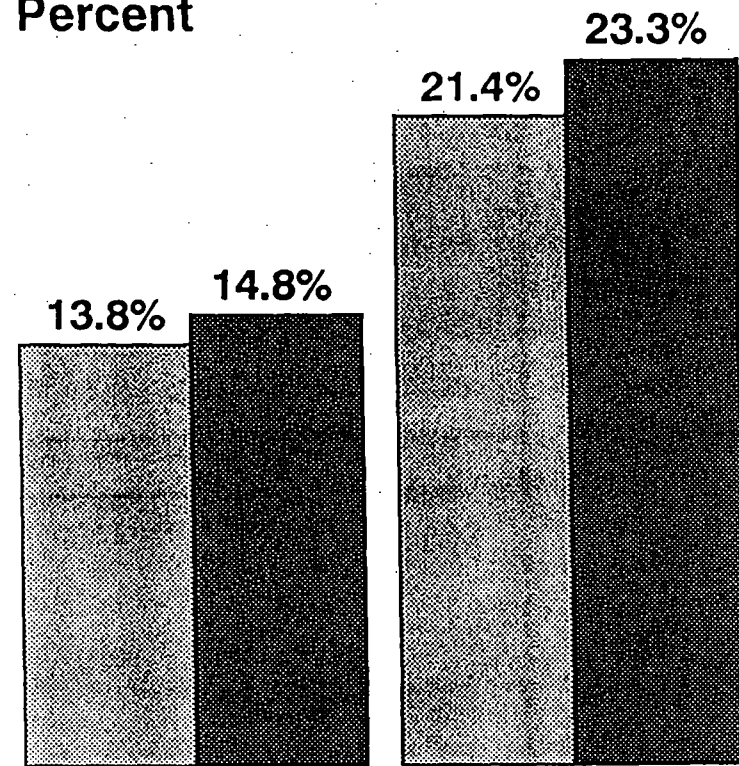
All children

Poor children

(0.8 million increase)

(no change)

Percent



All children

Poor children

(1.0% increase)

(no change)

2ND STORY of Level 1 printed in FULL format.

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September 29, 1998, Tuesday, Home Edition

SECTION: Part A; Page 3; Metro Desk

LENGTH: 914 words

HEADLINE: CALIFORNIA AND THE WEST;
PERCENTAGE OF UNINSURED IS RISING, U.S. SAYS;
HEALTH: ABOUT 16% IN NATION LACK COVERAGE, WITH THE CALIFORNIA FIGURE CLIMBING
TO 21%. AMONG LATINOS, LACK OF INSURANCE IS EVEN MORE COMMON.

BYLINE: ALISSA J. RUBIN, TIMES STAFF WRITER

DATELINE: WASHINGTON

BODY:

Despite the prosperous economy, the proportion of Americans without health insurance climbed to 16.1% last year, with Latinos having the highest uninsured rates, the Census Bureau reported Monday.

Nationwide, 43.4 million Americans lacked health insurance in 1997, up from 40 million, or 15.6% of the population, in 1996. The incidence of children under 18 without insurance remained unchanged near 15%, or nearly 11 million.

Some states have higher non-coverage rates than others. Rates range from 7.9% in Wisconsin to 24.4% in Texas, according to the census report. In California, the rate is 21.5%--meaning that more than 7 million Californians lack health insurance.

However, the percentage of Latino children without health insurance remained disproportionately high. Nearly 29% of Latino children were uninsured in 1997, in contrast to 19% of African American children and 11% of non-Hispanic white children.

"A lot of the Hispanic community is concentrated in sectors and industries that do not provide health insurance--the blue-collar jobs and the service-sector jobs," said Luis Arteaga, the interim executive director of the Latino Issues Forum, a San Francisco-based public policy and advocacy organization that follows health care trends.

"A second factor is that historically the Hispanic community has not participated in the government-sponsored health programs--it's partly because of distrust of government and, here in California, it's also due to the anti-immigrant feeling. Parents are afraid of being considered a public charge," Arteaga said.

And if parents do not have insurance, it is unlikely that their children will be covered, said Jane Delgado, the president of the National Coalition of

Los Angeles Times September 29, 1998, Tuesday,

Hispanic Health and Human Services Organizations. "Even in companies where they cover the workers, often they don't cover the families," Delgado said.

President Clinton in 1993 proposed a national health care system that would have guaranteed health insurance for every American. But his plan was rejected by Congress and much of the public. Since then, lawmakers have not backed any ambitious expansions of the health insurance system.

The major obstacle to the purchase of health insurance is cost. The problem is particularly severe among the working poor whose incomes are too high to qualify them or their children for government-subsidized health insurance but so low that they cannot afford to buy it.

"While we had a big reform debate several years ago with President Clinton's health plan, we haven't done much since to expand coverage," said Diane Rowland, the executive director of the Kaiser Commission on the Future of Medicaid, a nonprofit group that studies health care issues for low-income Americans.

The Health Insurance Portability Act, passed in 1996, has made it somewhat easier for people with preexisting medical conditions to move from one health insurance plan to another.

And it is too early to tell if the new Children's Health Insurance Program, which aims to help children whose families are just above the poverty line to afford insurance, will make much difference.

Among the most striking changes in the Census Bureau data, according to many health policy experts, was the 1.3-million-person increase in the number of uninsured adults of all races in the 18-65 age group. In part, this may be explained by the drop in the number of people who are insured through the federal government's Medicaid program, which provides health insurance for the poor and disabled.

The Medicaid rolls lost nearly 2.6 million people--about 8% of enrollees--in 1997, according to the census report, in part because many women forced off the welfare rolls--who previously were eligible for Medicaid--have taken jobs that do not offer insurance or that offer coverage that they cannot afford.

"Our numbers of uninsured patients are going up and our numbers of Medi-Cal insured patients are going down," said Sylvia Drew Ivie, executive director of T.H.E. Clinic for Women in Los Angeles. A year ago, about 60% of the clinic's patients were uninsured and 40% had Medi-Cal. Now, about 25% have Medi-Cal and 75% are uninsured, she said.

While some people leaving welfare for work are getting insurance coverage through new jobs, many appear to be falling through the cracks.

Indeed, the number of people covered through their employment is up but not enough to make any change in the percentage of people who get health insurance through jobs.

Perhaps the most surprising statistics in the report show that middle-income and high-income Americans are dropping insurance coverage. The number of people with annual incomes from \$ 25,000 to \$ 50,000 who were without insurance in 1997 rose by 900,000 over 1996.

Los Angeles Times September 29, 1998, Tuesday,

And there was a similar increase in the number of uninsured with annual incomes above \$ 75,000. Experts are at a loss to explain it.

"I'm not sure why there would be a drop," said Mark Hoyt, who heads the government health care group for William Mercer, a national health care consulting firm. "The only guess I'd have is that it would pertain to dependent coverage."

Some companies that offer health insurance to their workers do not extend the coverage to their spouses and children. Or, the family coverage is available but too expensive for employees to afford the cost of paying for their share of family plans. Generally family coverage costs three to four times that of an individual plan.

LANGUAGE: English

LOAD-DATE: September 29, 1998

NEWS AND NOTES

VITAL STATISTICS



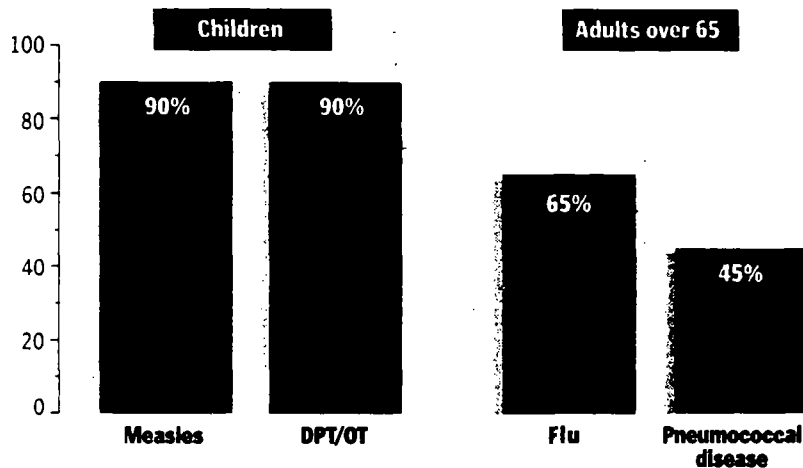
FILE PHOTO OF JOSE REYES BY LUCIAN PERKINS—THE WASHINGTON POST

AN OUNCE OF PREVENTION

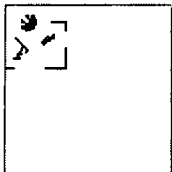
The nation's health care system is doing a good job of protecting children against vaccine-preventable diseases, but a poorer job with seniors, according to a recent report.

The Bethesda-based National Coalition for Adult Immunization reports that while nine of every 10 toddlers receive protection against polio, measles and diphtheria, tetanus and pertussis, much larger percentages of seniors are not getting shots to protect against the flu and pneumonia. These diseases rank as the fifth leading cause of death among Americans 65 and older.

National Immunization Report



SOURCES: Centers for Disease Control and Prevention, National Coalition for Adult Immunization.



April 02, 1999 / 48(12);243-248

Achievements in Public Health, 1900-1999 Impact of Vaccines Universally Recommended for Children -- United States, 1990-1999

At the beginning of the 20th century, infectious diseases were widely prevalent in the United States and exacted an enormous toll on the population. For example, in 1900, 21,064 smallpox cases were reported, and 894 patients died (1). In 1920, 469,924 measles cases were reported, and 7575 patients died; 147,991 diphtheria cases were reported, and 13,170 patients died. In 1922, 107,473 pertussis cases were reported, and 5099 patients died (2,3).

In 1900, few effective treatment and preventive measures existed to prevent infectious diseases. Although the first vaccine against smallpox was developed in 1796, greater than 100 years later its use had not been widespread enough to fully control the disease (4). Four other vaccines -- against rabies, typhoid, cholera, and plague -- had been developed late in the 19th century but were not used widely by 1900.

Since 1900, vaccines have been developed or licensed against 21 other diseases (5) (Table_1). Ten of these vaccines have been recommended for use only in selected populations at high risk because of area of residence, age, medical condition, or risk behaviors. The other 11 have been recommended for use in all U.S. children (6).

During the 20th century, substantial achievements have been made in the control of many vaccine-preventable diseases. This report documents the decline in morbidity from nine vaccine-preventable diseases and their complications -- smallpox, along with the eight diseases for which vaccines had been recommended for universal use in children as of 1990 (Table_2). Four of these diseases are detailed: smallpox has been eradicated, poliomyelitis caused by wild-type viruses has been eliminated, and measles and *Haemophilus influenzae* type b (Hib) invasive disease among children aged less than 5 years have been reduced to record low numbers of cases.

Information about disease and death during the 20th century was obtained from the MMWR annual summaries of notifiable diseases and reports by the U.S. Department of Health, Education, and Welfare. For smallpox, Hib, and congenital rubella syndrome (CRS), published studies were used (2,3,7-14).

Current Delivery and Use of Vaccines

National efforts to promote vaccine use among all children began with the appropriation of federal funds for polio vaccination after introduction of the vaccine in 1955 (5). Since then, federal, state, and local governments and public and private health-care providers have collaborated to develop and maintain the vaccine-delivery system in the United States.

Overall, U.S. vaccination coverage is at record high levels. In 1997, coverage among children aged 19-35 months (median age: 27 months) exceeded 90% for three or more doses of diphtheria and tetanus toxoids and pertussis vaccine (DTP), three or more doses of poliovirus vaccine, three or more doses of Hib vaccine, and one or more doses of measles-containing vaccine. Coverage with four doses of DTP was 81% and for three doses of hepatitis B vaccine was 84%. Coverage was substantially lower for the recently introduced varicella vaccine (26%) and for the combined series of four DTP/three polio/one

measles-containing vaccine/three Hib (76%) (15). Coverage for rotavirus vaccine, licensed in December 1998, has not yet been measured among children aged 19-35 months. Coverage among children aged 5-6 years has exceeded 95% each school year since 1980 for DTP; polio; and measles, mumps, and rubella vaccines (CDC, unpublished data, 1998).

Vaccine Impact

Dramatic declines in morbidity have been reported for the nine vaccine-preventable diseases for which vaccination was universally recommended for use in children before 1990 (excluding hepatitis B, rotavirus, and varicella) (Table 2). Morbidity associated with smallpox and polio caused by wild-type viruses has declined 100% and nearly 100% for each of the other seven diseases.

Smallpox. Smallpox is the only disease that has been eradicated. During 1900-1904, an average of 48,164 cases and 1528 deaths caused by both the severe (variola major) and milder (variola minor) forms of smallpox were reported each year in the United States (1). The pattern in the decline of smallpox was sporadic. Outbreaks of variola major occurred periodically in the first quarter of the 1900s and then ceased abruptly in 1929. Outbreaks of variola minor declined in the 1940s, and the last case in the United States was reported in 1949. The eradication of smallpox in 1977 enabled the discontinuation of prevention and treatment efforts, including routine vaccination. As a result, in 1985 the United States recouped its investment in worldwide eradication every 26 days (1).

Polio. Polio vaccine was licensed in the United States in 1955. During 1951-1954, an average of 16,316 paralytic polio cases and 1879 deaths from polio were reported each year (9,10). Polio incidence declined sharply following the introduction of vaccine to less than 1000 cases in 1962 and remained below 100 cases after that year. In 1994, every dollar spent to administer oral poliovirus vaccine saved \$3.40 in direct medical costs and \$2.74 in indirect societal costs (14). The last documented indigenous transmission of wild poliovirus in the United States occurred in 1979. Since then, reported cases have been either vaccine-associated or imported. As of 1991, polio caused by wild-type viruses has been eliminated from the Western Hemisphere (16). Enhanced use of the inactivated polio vaccine is expected to reduce the number of vaccine-associated cases, which averaged eight cases per year during 1980-1994 (17).

Measles. Measles vaccine was licensed in the United States in 1963. During 1958-1962, an average of 503,282 measles cases and 432 measles-associated deaths were reported each year (9-11). Measles incidence and deaths began to decline in 1965 and continued a 33-year downward trend. This trend was interrupted by epidemics in 1970-1972, 1976-1978, and 1989-1991. In 1998, measles reached a provisional record low number of 89 cases with no measles-associated deaths (13). All cases in 1998 were either documented to be associated with international importations (69 cases) or believed to be associated with international importations (CDC, unpublished data, 1998). In 1994, every dollar spent to purchase measles-containing vaccine saved \$10.30 in direct medical costs and \$3.20 in indirect societal costs (7).

Hib. The first Hib vaccines were polysaccharide products licensed in 1985 for use in children aged 18-24 months. Polysaccharide-protein conjugate vaccines were licensed subsequently for use in children aged 18 months (in 1987) and later for use in children aged 2 months (in 1990). Before the first vaccine was licensed, an estimated 20,000 cases of Hib invasive disease occurred each year, and Hib was the leading cause of childhood bacterial meningitis and postnatal mental retardation (8,18). The incidence of disease declined slowly after licensure of the polysaccharide vaccine; the decline accelerated after the 1987 introduction of polysaccharide-protein conjugate vaccines for toddlers and the 1990 recommendation to vaccinate infants. In 1998, 125 cases of Hib disease and *Haemophilus influenzae* invasive disease of unknown serotype among children aged less than 5 years were provisionally reported: 54 were Hib and 71 were of unknown serotype (CDC, unpublished data, 1998). In less than a decade, the use of the Hib conjugate vaccines nearly eliminated Hib invasive disease among children.

Future Direction

Vaccines are one of the greatest achievements of biomedical science and public health. Despite

remarkable progress, several challenges face the U.S. vaccine-delivery system. The infrastructure of the system must be capable of successfully implementing an increasingly complex vaccination schedule. An estimated 11,000 children are born each day in the United States, each requiring 15-19 doses of vaccine by age 18 months to be protected against 11 childhood diseases (6). In addition, licensure of new vaccines is anticipated against pneumococcal and meningococcal infections, influenza, parainfluenza, respiratory syncytial virus (RSV), and against chronic diseases (e.g., gastric ulcers, cancer caused by *Helicobacter pylori*, cervical cancer caused by human papilloma virus, and rheumatic heart disease that occurs as a sequela of group A streptococcal infection). Clinical trials are under way for vaccines to prevent human immunodeficiency virus infection, the cause of acquired immunodeficiency syndrome.

To achieve the full potential of vaccines, parents must recognize vaccines as a means of mobilizing the body's natural defenses and be better prepared to seek vaccinations for their children; health-care providers must be aware of the latest developments and recommendations; vaccine supplies and financing must be made more secure, especially for new vaccines; researchers must address increasingly complex questions about safety, efficacy, and vaccine delivery and pursue new approaches to vaccine administration more aggressively; and information technology to support timely vaccinations must be harnessed more effectively. In addition, the vaccine-delivery system must be extended to new populations of adolescents and adults. Each year, thousands of cases of potentially preventable influenza, pneumococcal disease, and hepatitis B occur in these populations. Many of the new vaccines will be targeted at these age groups. The U.S. vaccine-delivery system must routinely include these populations to optimally prevent disease, disability, and death.

Despite the dramatic declines in vaccine-preventable diseases, such diseases persist, particularly in developing countries. The United States has joined many international partners, including the World Health Organization and Rotary International, in seeking to eradicate polio by the end of 2000. Efforts to accelerate control of measles, which causes approximately one million deaths each year (5), and to expand rubella vaccination programs also are under way around the world. Efforts are needed to expand the use of existing vaccines in routine childhood vaccination programs worldwide and to successfully introduce new vaccines as they are developed. Such efforts can benefit the United States and other developed countries by decreasing disease importations from developing countries.

Reported by: National Immunization Program, CDC.

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Table_1

Note: To print large tables and graphs users may have to change their printer settings to landscape and use a small font size.

TABLE 1. Vaccine-preventable diseases, by year of vaccine development or licensure
-- United States, 1798-1998

Disease	Year
Smallpox*	1798+
Rabies	1885+
Typhoid	1896+
Cholera	1896+
Plague	1897+
Diphtheria*	1923+
Pertussis*	1926+
Tetanus*	1927+
Tuberculosis	1927+
Influenza	1945&
Yellow fever	1953&
Poliomyelitis*	1955&
Measles*	1963&
Mumps*	1967&
Rubella*	1969&
Anthrax	1970&
Meningitis	1975&
Pneumonia	1977&
Adenovirus	1980&
Hepatitis B*	1981&
Haemophilus influenzae type b*	1985&
Japanese encephalitis	1992&
Hepatitis A	1995&
Varicella*	1995&
Lyme disease	1998&
Rotavirus*	1998&

* Vaccine recommended for universal use in U.S. children. For smallpox, routine vaccination was ended in 1971.

+ Vaccine developed (i.e., first published results of vaccine usage).

& Vaccine licensed for use in United States.

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Table_2

Note: To print large tables and graphs users may have to change their printer settings to landscape and use a small font size.

TABLE 2. Baseline 20th century annual morbidity and 1998 provisional morbidity from nine diseases with vaccines recommended before 1990 for universal use in children

-- United States

Disease	Baseline 20th century annual morbidity	1998 Provisional morbidity	% Decrease
Smallpox	48,164*	0	100%
Diphtheria	175,885+	1	100%&
Pertussis	147,271@	6,279	95.7%
Tetanus	1,314**	34	97.4%
Polio myelitis (paralytic)	16,316++	0&&	100%
Measles	503,282@@	89	100%&
Mumps	152,209***	606	99.6%
Rubella	47,745+++	345	99.3%
Congenital rubella syndrome	823&&&	5	99.4%
Haemophilus influenzae type b	20,000@@@	54****	99.7%

* Average annual number of cases during 1900-1904 (1).

+ Average annual number of reported cases during 1920-1922, 3 years before vaccine development.

& Rounded to nearest tenth.

@ Average annual number of reported cases during 1922-1925, 4 years before vaccine development.

** Estimated number of cases based on reported number of deaths during 1922-1926 assuming a case-fatality rate of 90%.

++ Average annual number of reported cases during 1951-1954, 4 years before vaccine licensure.

&& Excludes one case of vaccine-associated polio reported in 1998.

@@ Average annual number of reported cases during 1958-1962, 5 years before vaccine licensure.

*** Number of reported cases in 1968, the first year reporting began and the first year after vaccine licensure.

+++ Average annual number of reported cases during 1966-1968, 3 years before vaccine licensure.

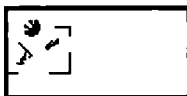
&&& Estimated number of cases based on seroprevalence data in the population and on the risk that women infected during a childbearing year would have a fetus with congenital rubella syndrome (7).

@@@ Estimated number of cases from population-based surveillance studies before vaccine licensure in 1985 (8).

**** Excludes 71 cases of Haemophilus influenzae disease of unknown serotype.

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Asthma Is Found in 38% Of Children in City Shelters

Rate Is Six Times the Average for Children

By NINA BERNSTEIN

A study has found that at least 38 percent of homeless children in the city's shelters have asthma, more than six times the national rate for all children and more than double the rate found by an earlier study of some of the city's poorest neighborhoods.

Moreover, only 9 percent of the asthmatic homeless children were on proper medication, according to Dr. Diane McLean, the author of the study and director of the childhood asthma initiative of the Children's Health Fund. The results have been presented at professional meetings over the last few days.

In another sign of inadequate treatment, almost half the children already found to have asthma had made at least one trip to a hospital emergency room in the previous year because of the disorder, an irritation of the lungs that, if improperly treated, can cause chronic breathing impairment and even death.

Dr. Suzanne S. Hurd, director of the division of lung diseases at the National Heart, Lung and Blood Institute, said that even though poor children in big cities are disproportionately affected by asthma, she found the "terribly high rates" the study documented among homeless children surprising.

"It's of great concern," Dr. Hurd said, calling the study's indications of undertreatment particularly important. "If these children had good medical care and someone showing them how to use their medication, they should do very well."

The study was based on checks from July through September last year of all 383 children who entered two New York City family shelters, one in Queens and one in the Bronx. Because families all over the city are randomly assigned to the shelters as space becomes available, the researchers consider these children representative of the 8,685 children in 4,800 families who are in the city's shelter system in any given month.

For reasons that remain unclear to researchers, the prevalence of asthma is rising worldwide. But the problem is most acute in cities, where studies have found it to be aggravated by poverty — exposure to factors like cockroach feces, dust mites, mold, dampness, rat and mouse urine and crowded living conditions.

The last national survey, in 1996, reported that 6.3 percent of all children in the United States have asthma. A survey conducted that year in association with a seven-city study by researchers at the Albert Einstein College of Medicine put the highest childhood asthma rate in poor sec-

tions of the Bronx at just under 15 percent.

The highest asthma rate reported by any previous study in New York City was the 21 to 23 percent found last year in three elementary schools in the Hunts Point section of the Bronx in a survey by the New York City Health Department, which is conducting its own childhood asthma initiative, a program of citywide asthma education and prevention. But asthma had already been diagnosed in 30 percent of the homeless children involved in Dr. McLean's study, and 8 percent of the rest showed persistent, moderate to severe symptoms of the disorder.

"It's astounding," Dr. McLean said. "Asthma really is an indicator of what's happening to the health of homeless children and their living conditions in the broadest sense."

Clayvon Brown, now 3, seems typical of the children seen in the study. His mother, April Brown, 33, said the boy's asthma kept flaring up last year as his family spent almost five months shuttling between the Emergency Assistance Unit in the Bronx, the central office where homeless families apply for emergency shelter, and a 10-day temporary shelter

**'Terribly high,' even
for the poor, a doctor
says.**

in Jamaica, Queens, where the family's eligibility was still under review. Ms. Brown said she repeatedly took Clayvon to emergency rooms, in part because it was too far to travel to the medical clinic where she had taken him and his two brothers, 8 and 10, when she lived in her mother's apartment in Queens.

While many families are found eligible for shelter the first time they apply, city data show that half those eventually approved have had to apply an average of five times, under rules intended to insure that only families truly in need of emergency shelter are allowed into the system.

Dr. Irwin Redlener, president of the Children's Hospital at Montefiore Medical Center, said, "We knew that the prevalence of asthma had increased dramatically," he said, referring to national studies that show a two-thirds increase in cases since 1980. "But even we who work with homeless children were taken aback by the extent to which this vulnerable population was affected by this debilitating, chronic disease."



Karen Coutrier giving asthma medication to Clayvon Brown, 3, in the Children's Health Fund's van, with his mother, April, looking on.

The New York Times

WEDNESDAY, MAY 5, 1999

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

April 21, 1997

EXECUTIVE ORDER

13045

PROTECTION OF CHILDREN FROM ENVIRONMENTAL
HEALTH RISKS AND SAFETY RISKS

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Policy.

1-101. A growing body of scientific knowledge demonstrates that children may suffer disproportionately from environmental health risks and safety risks. These risks arise because: children's neurological, immunological, digestive, and other bodily systems are still developing; children eat more food, drink more fluids, and breathe more air in proportion to their body weight than adults; children's size and weight may diminish their protection from standard safety features; and children's behavior patterns may make them more susceptible to accidents because they are less able to protect themselves. Therefore, to the extent permitted by law and appropriate, and consistent with the agency's mission, each Federal agency:

- (a) shall make it a high priority to identify and assess environmental health risks and safety risks that may disproportionately affect children; and
- (b) shall ensure that its policies, programs, activities, and standards address disproportionate risks to children that result from environmental health risks or safety risks.

1-102. Each independent regulatory agency is encouraged to participate in the implementation of this order and comply with its provisions.

Sec. 2. Definitions. The following definitions shall apply to this order.

2-201. "Federal agency" means any authority of the United States that is an agency under 44 U.S.C. 3502(1) other than those considered to be independent regulatory agencies under 44 U.S.C. 3502(5). For purposes of this order, "military departments," as defined in 5 U.S.C. 102, are covered under the auspices of the Department of Defense.

2-202. "Covered regulatory action" means any substantive action in a rulemaking, initiated after the date of this order or for which a Notice of Proposed Rulemaking is published 1 year after the date of this order, that is likely to result in a rule that may:

- (a) be "economically significant" under Executive Order 12866 (a rulemaking that has an annual effect on the economy of \$100 million or more or would adversely affect in a material way the economy, a

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sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities); and

- (b) concern an environmental health risk or safety risk that an agency has reason to believe may disproportionately affect children.

2-203. "Environmental health risks and safety risks" mean risks to health or to safety that are attributable to products or substances that the child is likely to come in contact with or ingest (such as the air we breath, the food we eat, the water we drink or use for recreation, the soil we live on, and the products we use or are exposed to).

Sec. 3. Task Force on Environmental Health Risks and Safety Risks to Children.

3-301. There is hereby established the Task Force on Environmental Health Risks and Safety Risks to Children ("Task Force").

3-302. The Task Force will report to the President in consultation with the Domestic Policy Council, the National Science and Technology Council, the Council on Environmental Quality, and the Office of Management and Budget (OMB).

3-303. Membership. The Task Force shall be composed of the:

- (a) Secretary of Health and Human Services, who shall serve as a Co-Chair of the Council;
- (b) Administrator of the Environmental Protection Agency, who shall serve as a Co-Chair of the Council;
- (c) Secretary of Education;
- (d) Secretary of Labor;
- (e) Attorney General;
- (f) Secretary of Energy;
- (g) Secretary of Housing and Urban Development;
- (h) Secretary of Agriculture;
- (i) Secretary of Transportation;
- (j) Director of the Office of Management and Budget;
- (k) Chair of the Council on Environmental Quality;
- (l) Chair of the Consumer Product Safety Commission;
- (m) Assistant to the President for Economic Policy;
- (n) Assistant to the President for Domestic Policy;
- (o) Assistant to the President and Director of the Office of Science and Technology Policy;
- (p) Chair of the Council of Economic Advisers; and
- (q) Such other officials of executive departments and agencies as the President may, from time to time, designate.

Members of the Task Force may delegate their responsibilities under this order to subordinates.

3-304. Functions. The Task Force shall recommend to the President Federal strategies for children's environmental health and safety, within the limits of the Administration's budget, to include the following elements:

- (a) statements of principles, general policy, and targeted annual priorities to guide the Federal approach to achieving the goals of this order;
- (b) a coordinated research agenda for the Federal Government, including steps to implement the review of research databases described in section 4 of this order;
- (c) recommendations for appropriate partnerships among Federal, State, local, and tribal governments and the private, academic, and nonprofit sectors;
- (d) proposals to enhance public outreach and communication to assist families in evaluating risks to children and in making informed consumer choices;
- (e) an identification of high-priority initiatives that the Federal Government has undertaken or will undertake in advancing protection of children's environmental health and safety; and
- (f) a statement regarding the desirability of new legislation to fulfill or promote the purposes of this order.

3-305. The Task Force shall prepare a biennial report on research, data, or other information that would enhance our ability to understand, analyze, and respond to environmental health risks and safety risks to children. For purposes of this report, cabinet agencies and other agencies identified by the Task Force shall identify and specifically describe for the Task Force key data needs related to environmental health risks and safety risks to children that have arisen in the course of the agency's programs and activities. The Task Force shall incorporate agency submissions into its report and ensure that this report is publicly available and widely disseminated. The Office of Science and Technology Policy and the National Science and Technology Council shall ensure that this report is fully considered in establishing research priorities.

3-306. The Task Force shall exist for a period of 4 years from the first meeting. At least 6 months prior to the expiration of that period, the member agencies shall assess the need for continuation of the Task Force or its functions, and make appropriate recommendations to the President.

Sec. 4. Research Coordination and Integration.

4-401. Within 6 months of the date of this order, the Task Force shall develop or direct to be developed a review of existing and planned data resources and a proposed plan for ensuring that researchers and Federal research agencies have access to information on all research conducted or funded by the Federal Government that is related to adverse health risks in children resulting from exposure to environmental health risks or safety risks. The National Science and Technology Council shall review the plan.

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4-402. The plan shall promote the sharing of information on academic and private research. It shall include recommendations to encourage that such data, to the extent permitted by law, is available to the public, the scientific and academic communities, and all Federal agencies.

Sec. 5. Agency Environmental Health Risk or Safety Risk Regulations.

5-501. For each covered regulatory action submitted to OMB's Office of Information and Regulatory Affairs (OIRA) for review pursuant to Executive Order 12866, the issuing agency shall provide to OIRA the following information developed as part of the agency's decisionmaking process, unless prohibited by law:

- (a) an evaluation of the environmental health or safety effects of the planned regulation on children; and
- (b) an explanation of why the planned regulation is preferable to other potentially effective and reasonably feasible alternatives considered by the agency.

5-502. In emergency situations, or when an agency is obligated by law to act more quickly than normal review procedures allow, the agency shall comply with the provisions of this section to the extent practicable. For those covered regulatory actions that are governed by a court-imposed or statutory deadline, the agency shall, to the extent practicable, schedule any rulemaking proceedings so as to permit sufficient time for completing the analysis required by this section.

5-503. The analysis required by this section may be included as part of any other required analysis, and shall be made part of the administrative record for the covered regulatory action or otherwise made available to the public, to the extent permitted by law.

Sec. 6. Interagency Forum on Child and Family Statistics.

6-601. The Director of the OMB ("Director") shall convene an Interagency Forum on Child and Family Statistics ("Forum"), which will include representatives from the appropriate Federal statistics and research agencies. The Forum shall produce an annual compendium ("Report") of the most important indicators of the well-being of the Nation's children.

6-602. The Forum shall determine the indicators to be included in each Report and identify the sources of data to be used for each indicator. The Forum shall provide an ongoing review of Federal collection and dissemination of data on children and families, and shall make recommendations to improve the coverage and coordination of data collection and to reduce duplication and overlap.

6-603. The Report shall be published by the Forum in collaboration with the National Institute of Child Health and Human Development. The Forum shall present the first annual Report to the President, through the Director, by July 31, 1997. The Report shall be submitted annually thereafter, using the most recently available data.

Sec. 7. General Provisions.

7-701. This order is intended only for internal management of the executive branch. This order is not intended, and should not be construed to create, any right, benefit, or trust responsibility, substantive or procedural, enforceable at law or

equity by a party against the United States, its agencies, its officers, or its employees. This order shall not be construed to create any right to judicial review involving the compliance or noncompliance with this order by the United States, its agencies, its officers, or any other person.

7-702. Executive Order 12606 of September 2, 1987 is revoked.

WILLIAM J. CLINTON

THE WHITE HOUSE,
April 21, 1997.

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