Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Medicaid's Role for Children

Medicaid is an essential source of health coverage for the nation's children. The program provides health coverage to children and parents in low-income families who lack access to affordable private health insurance, as well as to children with special health care needs.

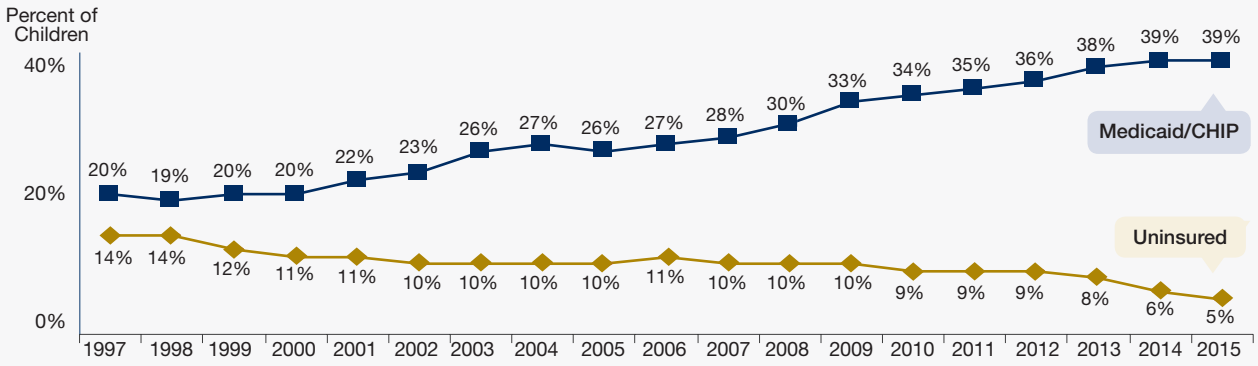
Medicaid and the Children's Health Insurance Program (CHIP) have driven down the rate of children without health coverage from 14 percent in 1997 to 5.3 percent in 2015.[1] (See Figure 1.) Health coverage of children has increased steadily over the past two decades, reaching historic highs in 2015 when the Affordable Care Act (ACA) was fully implemented.[2] By 2015, just under 4 million children remained uninsured in the United States.[3] The rate of uninsurance among children varies by factors such as income, race/ethnicity, age, and geographic location.

In 2015, Medicaid covered 36.8 million children.[4] Children make up the largest group of Medicaid enrollees (41 percent), but take up a much smaller proportion of the program's expenditures (19 percent).[5] (See Figure 2.)

Along with CHIP, Medicaid serves more than one-third (39 percent) of all children under age 19 in the United States.[6] Medicaid, together with CHIP,[7] is an especially important source of coverage for low-income children (covering 69 percent of those with incomes under two times the federal poverty line), young children (45 percent), and those with a disability (62 percent). (See Figure 3.) The program is also an important source of coverage for children who are from racial and ethnic minorities: More than half of black and Hispanic children (58 percent and 56 percent, respectively) receive Medicaid or CHIP coverage.[8]

Federal law outlines broad requirements for state Medicaid programs but affords states substantial flexibility in the design of their state program. States are required to cover children up to the age of 19 with family incomes through 138 percent of the Federal Poverty Level (FPL, $27,821 annual income for a family of three in 2016) and former foster youth up to the age of 26. Most states have expanded coverage to children with higher income levels, with the median upper income eligibility limit for children in Medicaid and CHIP now at 255 percent of the FPL ($51,408 for a family of three).[9]

Figure 1. Coverage Type for Children Under 19 Years of Age, 1997-2015

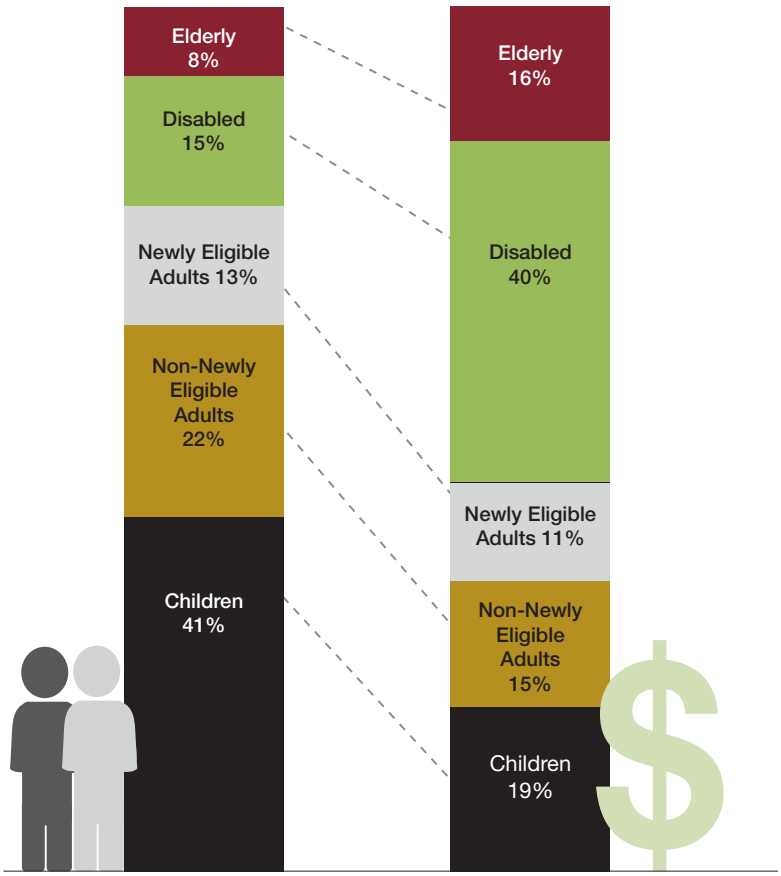


Source: SHADAC analysis of the Current Population Survey (CPS).[10]

Medicaid eligibility expansions and efforts to enroll eligible children have increased coverage rates among children. The majority of uninsured children (62 percent, or 2.8 million) are eligible for Medicaid or CHIP coverage but are not enrolled.[11] Research has shown that when Medicaid eligibility is extended to additional groups—to children at higher income levels and/or to parents or other family members—more children who were already eligible for the program sign up.[12] For example, states that extended ACA Medicaid coverage to more uninsured adults saw greater rates of decline in the number of uninsured children as parents newly eligible for coverage enrolled their children.[13] Thanks to this robust "welcome mat" effect, the number of children who are eligible but not enrolled in Medicaid and CHIP has declined by approximately 40 percent (2.1 million children) since 2008.[14]

Alongside eligibility expansions, dedicated funds for and attention to outreach and enrollment in the ACA, Medicaid, and CHIP helped enroll more children in public health programs and keep them enrolled. The participation rate, which measures the percentage of children eligible for Medicaid or CHIP who are actually enrolled, is another indicator of progress. The participation rate reached a high of 91 percent in 2014, increasing by two full percentage points in just one year (2013-14) and by nine percentage points since 2008.[15] These improvements in Medicaid and CHIP participation rates played a key role in the decline in children's uninsurance.

Figure 2. Children Make Up the Largest Group of Medicaid Beneficiaries, FY 2015



Note: Medicaid enrollment is average monthly enrollment. Medicaid expenditures exclude territorial enrollees and costs, adjustments, administrative costs, and Disproportionate Share Hospital (DSH) payments.

Source: 2016 Actuarial Report on the Financial Outlook for Medicaid.[20]

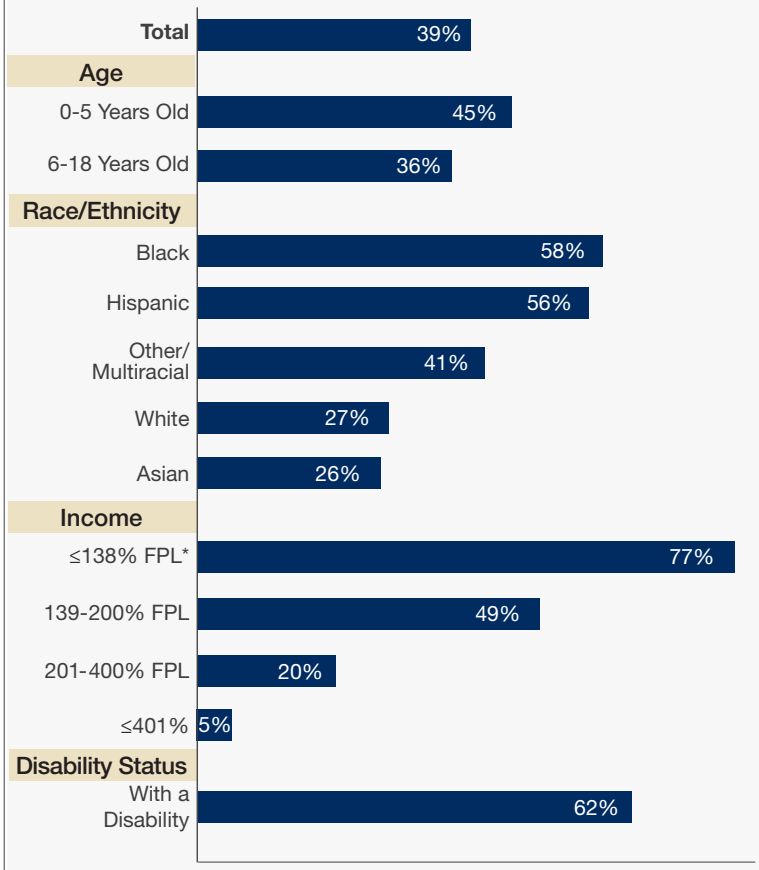
The Medicaid benefit package for children, Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), is robust. States are required to provide comprehensive services and furnish all appropriate and medically necessary services needed to correct and ameliorate health conditions.[17] Medicaid benefits include, but are not limited to, primary care, dental, vision, and hearing coverage, as well as comprehensive screening, prevention, diagnosis, and treatment services.[18]

Preventive care such as screening, diagnosing, and treating children is cost-effective and can preempt complicated treatments and conditions later in life.[19] Most children enrolled in Medicaid do not require extensive services. Notwithstanding the robust package of benefits required, children are by far the least expensive Medicaid population, with the lowest per enrollee cost of any eligibility group.[20]

Medicaid rules limit the ability to charge families premiums and cost-sharing for the vast majority of children.[21] Added out-of-pocket costs can be a burden for families with limited incomes. Research confirms that parents who have trouble paying their child's health care are more likely to skip needed medical care or to become uninsured.[22]

Children with Medicaid coverage have access to services at levels similar to those of children who are privately insured—and far better than those who are uninsured. While some access challenges remain in Medicaid, nearly all children with Medicaid coverage have a usual source of care (97 percent) and receive an annual well-child check-up (84 percent).[23] Children enrolled in Medicaid are less likely than uninsured children to have unmet or delayed needs for medical care, dental care, and prescriptions due to cost.[24]

Figure 3. Medicaid/CHIP Coverage of Children Under 19 Years of Age, 2015



* Federal Poverty Level

Source: SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) file.[27]

Medicaid is an effective investment that improves health, educational, and economic outcomes for children. An emerging body of research underscores the long-term benefits of childhood Medicaid coverage that last through adulthood, including better health outcomes, lower rates of mortality, stronger educational and economic achievements, and a significant return on public investment.[25, 26]

ENDNOTES

[1] J. Gates et al., "Uninsurance among Children, 1997-2015: Long-Term Trends and Recent Patterns," Urban Institute (April 2016), available at http://www. urban.org/sites/default/files/alfresco/publication-pdfs/2000732-Uninsuranceamong-Children-Long-Term-Trends-and-Recent-Patterns.pdf.

[2] J. Alker and A. Chester, "Children's Health Coverage Rate Now at Historic High of 95 Percent," Georgetown University Center for Children and Families (October 2016), available at http://ccf.georgetown.edu/wp-content/uploads/2016/11/Kids-ACS-update-11-02-1.pdf.

[3] State Health Access Data Assistance Center (SHADAC) analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) file, available at http://datacenter.shadac.org/profile/6,295,70,50#1/united-states/percent,count,moe/a/hide.

[4] Indicates FY 2015 unduplicated number of children ever enrolled in Medicaid as reported by the Statistical Enrollment Data System (SEDS). Centers for Medicare & Medicaid Services (CMS), "FFY 2015 Number of Children Ever-Enrolled in Medicaid and CHIP," (June 2016), available at https://www.medicaid.gov/chip/downloads/fy-2015-childrens-enrollmentreport.pdf.

[5] C. Truffer, C. Wolfe, and K. Rennie, "2016 Actuarial Report on the Financial Outlook for Medicaid," Office of the Actuary, Centers for Medicare & Medicaid Services, and the Department of Health & Human Services (January 2017), available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf.

[6] SHADAC analysis of ACS, op. cit.

[7] Because of state program design options and federal minimum eligibility levels for children in Medicaid, the majority of children supported by federal CHIP funds are enrolled in the Medicaid program. Of the 8.4 million children in CHIP-financed coverage, more than half are estimated to be in Medicaid rather than a separate CHIP program. As noted, most of the data in this fact sheet describe Medicaid/CHIP together given their financial and programmatic connections. CMS, op. cit.; L. Dubay, M. Buettgens, and G. Kenney, "Estimates of Coverage Changes for Children Enrolled in Separate Children's Health Insurance Programs in the Absence of Additional Federal CHIP Funding-Key Findings and Methodology," Urban Institute Report to the Medicaid and CHIP Payment and Access Committee (March 2015), available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000145-Estimates-of-Coverage-Changes-for-Children.pdf.

[8] SHADAC analysis of ACS, op. cit.

[9] T. Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey," Georgetown University Center for Children and Families and Kaiser Commission on Medicaid and the Uninsured (January 2016), available at http:// kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-andcost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey/.

[10] Data reported from 1997 through 2012 are from SHADAC analysis of the Current Population Survey's Annual Social and Economic Supplements (CPS SHADAC-Enhanced), available at http://datacenter.shadac.org/ trend/128/coverage-type-by-age#1/1/1,9,12/17,18,19,20,21,22,23,24,25, 26,27,28,29,30,31,32,33,34,35,36,37,1,3,5,6,7/251. Data reported from 2013 through 2014 are from SHADAC analysis of the Current Population Survey's Annual Social and Economic Supplements (CPS ASEC), available at http://datacenter.shadac.org/trend/293/coverage-type-byage#1/1/12,1,9/77,80/541.

[11] G. Kenney et al., "Children's Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation under the ACA," Urban Institute and Robert Wood Johnson Foundation (May 2016), available at http://www.urban. org/research/publication/childrens-coverage-climb-continues-uninsuranceand-medicaid-chip-eligibility-and-participation-under-aca.

[12] L. Dubay and G. Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid," *HSR: Health Services Research* 38, no. 5 (October 2003): 1283-1302.

[13] J. Alker and A. Chester, op. cit.

[14] G. Kenney et al., op. cit.

[15] Ibid.

[16] C. Truffer, C. Wolfe, and K. Rennie, op. cit.

[17] Section 1905(r)(1)(B) of the Social Security Act. For a full description of EPSDT coverage, see Department of Health and Human Services, "EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents," June 2014, available at http://www.medicaid.gov/Medicaid-CHIP-ProgramInformation/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf.

[18] Georgetown University Center for Children and Families, "EPSDT: A Primer," Georgetown University Center for Children and Families (March 2016), available at http://ccf.georgetown.edu/wp-content/uploads/2016/03/epsdt_fact_sheet.pdf.

[19] Department of Health and Human Services, "Birth to 5, Watch Me Thrive! A Compendium of Screening Measures for Young Children," (March 2014), available at https://www.acf.hhs.gov/sites/default/files/ecd/screening_compendium_march2014.pdf.

[20] C. Truffer, C. Wolfe, and K. Rennie, op. cit.

[21] States may not charge premiums for children enrolled in Medicaid with incomes below 150 percent of the FPL ($30,240 for a family of three), and allowable copayments are restricted to nominal charges. For those families with income above 150 percent of the FPL, states cannot adopt premium policies that impose costs that exceed 5 percent of family income for all enrolled members of the family and states may not require copayments for services deemed medically necessary

[22] S. McMorrow et al., "Trade-Offs between Public and Private Coverage for Low-Income Children Have Implications for Future Policy Debates," *Health Affairs* 33, no. 8 (August 2014): 1367-1374, available at http://content.healthaffairs.org/content/33/8/1367.full.pdf+html.

[23] KCMU analysis of 2014 NHIS data. J. Paradise, B. Lyons, and D. Rowland, "Medicaid at 50," Kaiser Commission on Medicaid and the Uninsured (May 2015), available at http://files.kff.org/attachment/report-medicaid-at-50.

[24] J. Paradise and R. Garfield, "What Is Medicaid's Impact on Access to Care Outcomes, and Quality of Care? Setting the Record Straight on the Evidence," Kaiser Commission on Medicaid and the Uninsured (August 2013).

[25] A. Chester and J. Alker, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid," Georgetown Center for Children and Families (July 2015), available at http://ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaidat-50_final.pdf.

[26] D. Brown, A. Kowalski, and I. Lurie, "Medicaid as an Investment in Children: What Is the Long-Term Impact on Tax Receipts?" National Bureau of Economic Research (January 2015), available at http://www.nber.org/papers/w20835.

[27] SHADAC analysis of ACS, op. cit.