Overview

Key Takeaway Messages

- Medicaid provides health coverage for millions of low-income Americans. It is a particularly important source of coverage for children. Today, an estimated 95 percent of children have health coverage. Combined with the Children’s Health Insurance Program (CHIP), Medicaid provides coverage for more than half of all young children (0-5). In Federal Fiscal Year (FFY) 2016, 46 million children were covered under Medicaid/CHIP, out of a total population of 78 million children under age 18. That represents 59 percent of all U.S. children.

- Medicaid is a federal-state partnership in terms of its funding and structure. The federal government provides the majority of funding for Medicaid. Federal law establishes certain minimum eligibility, benefit, and other requirements, while states play the central role in implementing Medicaid, including setting eligibility above federal minimum, provider reimbursement rates, and use of managed care arrangements. While the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires children receive recommended preventive well-child visits and treatment services when medically necessary, the benefit is not uniformly implemented across states. (See part one for details about the EPSDT benefit.)

- Even though Medicaid and CHIP cover a majority of all U.S. children under age 18, program performance for children varies widely by state. Differences in the reach, scale, and performance of Medicaid result from state flexibility in implementing the program. This includes variations in the percentage of children covered, the percentage of Medicaid enrollment and spending accounted for by children, per-child spending, and how many children receive preventive or other services. All states have opportunities and flexibility to use Medicaid to better finance health and related services for young children.

Medicaid as a Source of Health Coverage for Children

The share of children with health insurance has risen substantially thanks to increases in publicly supported coverage, beginning in 1984 with a series of Medicaid eligibility expansions and enactment of the Children’s Health Insurance Program (CHIP) in 1997.¹ ² ³ Those gains occurred with increases in coverage provided by Medicaid and CHIP, despite increases in the costs of family and dependent coverage under employer-based health plans and individually purchased plans (and decline in the proportion of children covered under those private plans). The uninsured rate for children has been nearly cut in half since 2009.⁴ By 2016, 95 percent of children had health coverage, and Medicaid/CHIP participation reached 94 percent among eligible children.⁵ Many children who are not covered today are eligible for Medicaid or CHIP but have not enrolled; others are not eligible due to their residency status (states can select, but are not required, to cover legal residents who are not yet citizens. Undocumented children are not federally eligible for either Medicaid or CHIP).

Figure 2 shows national data on the decline in the percentage of uninsured children. Similar charts can be constructed for any state, and virtually all states have shown improvements in child health coverage rates over this period. (The most recent data indicate progress may have slowed between 2015 and 2017.⁶)
Progress has not been even across the country. The percentage of uninsured children ranges from a low of 0.9 percent in Massachusetts to a high of 9.2 percent in Texas (Figure 3). Currently, while the vast majority of children now have health insurance coverage of some type, some states have substantially more work to do to get children covered. Some states with high proportions of children covered by Medicaid also have relatively high rates of uninsured children, because they have much larger proportions of children who are poor and without private coverage.

As a result of the federal-state policy decisions and coverage trends, Medicaid and CHIP have become a critical source of financing — often the single largest payer — for young children’s health services. There are different Medicaid estimates for the percentage of children covered under Medicaid, but all show a substantial share of the young child population covered. U.S. Census data (based on reports of the adults/parents completing the survey, which tend to underrepresent coverage) show that just over 40 percent of young children (0-5) were covered by Medicaid in 2016. State data reported to the Centers for Medicare and Medicaid Services (CMS) show that 60 percent of children 0 to 3 and 56 percent of children 3 to 5 — 13.8 million young children total — were enrolled in Medicaid some time during FFY2016. The authors of this report believe that more than half of all young children are covered under Medicaid and CHIP for a portion of any given year, and that this figure is higher for children with special health care needs.

This means that Medicaid plays a dominant role in financing the preventive, developmental, socio-emotional, and other services needed to support optimal health in the early years. Young children are the age group most likely to live in poverty (20 to 25 percent are poor) and poverty has strong associations with virtually all measured child outcomes (physical, educational, and social), extending to adolescent...
parenting, justice system involvement, employment, and family formation as young adults. Ensuring that low-income young children receive the services they need to get a strong start and avoid a lifetime of adverse health and other consequences is a key role for Medicaid.

Medicaid is a federal-state partnership in funding and structure. Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit sets the parameters for comprehensive health coverage for children. Federal law requires child health coverage that is preventive, developmental, and more comprehensive than coverage for adults (see parts one and two).

While federal law frames the requirements for children’s benefits and the federal government provides the majority of funding for Medicaid, states play the central role in implementing Medicaid. Specifically, states do the following and more:

1. Establish eligibility levels for Medicaid, at or above federal minimum requirements;
2. Determine what optional services will be provided (federal law has a set of mandatory and optional services), and rules around their use (eligibility for, scope and duration of services);

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3. Set provider reimbursement rates;

4. Define provider qualifications; and

5. Enroll providers directly to provide Medicaid financed services and/or contract with managed care and other entities to do so to organize provider networks.

As with Medicaid, CHIP is funded jointly by states and the federal government and is administered by states, according to broad federal requirements. CHIP provides coverage either through purchase of private insurance coverage or coverage under Medicaid. Children enrolled in CHIP Medicaid expansion qualify for Medicaid benefits.⁹

Medicaid/CHIP coverage matters in large part because it improves children’s access to health services and can improve their health outcomes. Decades of studies have led to two important findings: 1) when Medicaid provides adequate coverage, children generally have access to care similar to their privately insured counterparts; and 2) Medicaid can leverage the quality, effectiveness, and outcomes of health and related services for enrolled children. Using data from the National Health Interview Survey (NHIS) to assess changes in Medicaid and CHIP coverage for children between 2008 and 2015, the Urban Institute found that among children covered by Medicaid and CHIP: 1) a smaller proportion of children did not receive needed care because their families could not afford it; 2) more children had a usual source of care; and 3) fewer children had difficulty finding a physician to serve them.¹⁰
Variation across States in Medicaid Enrollment, Spending, and Utilization among Children

While Medicaid and CHIP cover a majority of all U.S. children under age 18, program performance for children varies widely by state. There is no single source of information on Medicaid and CHIP, and various data sources highlight differences by state in eligibility, enrollment, spending, and service utilization. This section of the sourcebook illustrates and discusses such variations in state policy and performance. (See Appendix A for data tables.)

State-by-state Medicaid data on children have some limitations. First, some children — an estimated 1.6 million — are covered under the Medicaid disability category rather than the child eligibility category, typically but not exclusively those enrolled via the Supplemental Security Income (SSI) program for persons with disabilities. Second, some states use Medicaid/CHIP approaches, while other states use a separate CHIP program or a combination. Third, states may report on different age ranges of children (e.g., up to 18th or the 21st birthday). Fourth, some data sources report on the children ever covered by Medicaid during the course of an entire year, while others look at coverage at a specific point in time. Estimates of the percentage of births that are financed by Medicaid are based on different state methods, such as using claims data or linking to vital statistics (Medicaid birth data are not shown here). Finally, understanding children’s coverage requires knowing how states cover other eligible populations of individuals over age 18.
Eligibility Levels for Children in Medicaid

On average nationally, as of January 2018, child eligibility levels were 195 percent of poverty for infants, 164 percent of poverty for young children ages 1-5 years, and 142 percent of poverty for children ages 6-18 years. Comparisons across states point to variations, with some covering infants and young children with family income at or above 300 percent of the federal poverty level. Notably, federal law requires states to have mechanisms in place to automatically enroll a newborn if the birth was financed by Medicaid and to provide continuous eligibility throughout the first year of life. States have the option to provide continuous annual enrollment periods for children ages 1-21 years.

Proportion of All Children Covered Under Medicaid and CHIP

For the United States as a whole, in Federal Fiscal Year (FFY) 2016, 46 million children under age 18, out of a total population of 78 million children, were covered under Medicaid and CHIP combined at least sometime during the year (see Appendix A for data table and sources.) Of the total, 37 million children were covered under Medicaid and 9 million enrolled in CHIP. Together, Medicaid and CHIP cover 59 percent of all children under age 18. As shown in Figure 4, the proportion of children covered by Medicaid/CHIP varies across states, from a low of 32 percent to a high of 80 percent. As discussed further below, this reflects both child poverty rates and Medicaid/CHIP eligibility levels. Nationally, young children are more likely to be covered as a result of Medicaid eligibility levels and a higher proportion of young children living in poverty.

As portions of the ACA were implemented starting in 2010, more children enrolled in Medicaid and CHIP. Generally, this is not due to expansion of children’s eligibility levels but to more families seeking advice about publicly subsidized health coverage, more parents becoming eligible for Medicaid coverage in expansion states, and having both parents and children enroll in Medicaid, CHIP, or ACA exchange marketplace plans. The effects were largest among children whose parents gained Medicaid eligibility un-
der the ACA expansion to adults. Researchers estimate that if all states had adopted Medicaid expansion, an additional 200,000 low-income children would have gained coverage.\textsuperscript{14} Figure 5 shows the percent change in Medicaid/CHIP child enrollment by state, comparing FFY 2014 to preliminary enrollment estimates for April 2018. Other studies have found that for young children, the effects of Medicaid expansions for parents were particularly important.\textsuperscript{15}

**Proportion of Medicaid Beneficiaries that are Children**

Medicaid covers several categories of low-income people, including children, persons with disabilities, seniors age 65\textsuperscript{*} and over, and adults ages 19-64. (Note that children may be counted in the disability category and are sometimes counted to age 18 and other times to age 21.) Nationally, in recent years, children have made up approximately 40 percent of enrollees in Medicaid. (See Figure 6.) With 34 states adopting the Medicaid expansion option under the ACA between 2010 and 2018, millions of low-income adults under age 64 have enrolled in Medicaid. As a result, the proportion of beneficiaries who are children has declined somewhat in recent years. Still, children are the largest single enrollment group covered by Medicaid, and the percentage is even higher when Medicaid and CHIP are combined.

**Proportion of Medicaid Beneficiaries that are Children**

Figure 7 shows variations in the percentage of Medicaid /CHIP enrollees who are children. This map is often used to show comparisons across state Medicaid programs on who is covered. Just because a state has a high percentage, however, does not mean that it has a high rate of covering children. These commonly used data must be interpreted with a lot of caveats. State-to-state variations are primarily driven by: 1) the coverage levels for adults 19-64, including whether the state has expanded Medicaid under the ACA; 2) the percentage of low-income children in the state; and 3) the eligibility levels set for children. While the level of child poverty contributes to the percent of enrollees that are children, state decisions on adult coverage have a much stronger effect.

States that have lower income eligibility levels for adults (i.e., cover fewer adults) have a higher percentage of Medicaid/CHIP enrollees who are children. States such as Vermont or New York expanded Medicaid eligibility for adults both before and after the ACA, resulting in children being a smaller share of the total, even though they have high rates of child coverage. States such as Texas and Idaho do not cover many poor adults under age 65 outside of pregnancy and disability. This information is presented here because it is important in understanding the relative importance of children to states’ Medicaid enrollment and spending, but it does not provide information on the extent of coverage of children or the effort the state makes in financing health services for them.

**Medicaid Expenditures for Children as Proportion of Total Medicaid Expenditures**

It has long been true that children account for a disproportionately smaller share of spending than other Medicaid enrollees, because they have lower health care costs in Medicaid and overall health expenditures. Persons with disabilities and seniors age 65 and older have much higher costs because of their

\textsuperscript{*} Almost all seniors age 65 and older are covered by Medicare for basic health services; however, if they are living below poverty income they generally also qualify for Medicaid to finance supplemental services. Other seniors qualify for Medicaid coverage of long-term care not covered by Medicare.)
medical needs, representing over 60 percent of Medicaid benefit expenses in FFY 2014. As states look at their Medicaid budgets and particularly their costs, they often focus their attention on groups with higher costs, and not children. As emphasized throughout this sourcebook, however, children, and young children in particular, need to be a distinct focus of Medicaid policy and not treated as “little adults.”

As with children as a percentage of Medicaid enrollees, there is variation in the Medicaid expenditures for those enrolled in the “child” category (noting that some children are covered under the disability category and not as children). With more adults becoming eligible, the proportion of both enrollment and expenditures accounted for by children has declined. Nationally, children accounted for 43 percent of all Medicaid/CHIP enrollees, but only 19 percent of all Medicaid expenditures in FFY 2014 (see Figure 6). In all states the child population accounts for a minority of total Medicaid expenditures — and for many states that percentage is far below the national average of 19 percent.

Figure 8 shows the percentage of state Medicaid expenditures that were made for children in FFY 2014. (See data in Appendix A.) In five states, expenditures on children were at or below 15 percent of total Medicaid expenditures (Massachusetts, New York, Wisconsin, Pennsylvania, and New Jersey). Five states had expenditures greater than 30 percent (New Mexico, Georgia, Texas, Montana, and Oklahoma).16

Similar to the variations in enrollment data, the eligibility levels for adults and the number of low-income children both affect the percent of spending by eligibility group. For example, Texas — which has
the highest rate of uninsured children in the country — spent 31 percent of its funds on children in part because it has many low-income children and covers fewer adults. Adults accounted for only 6 percent of Medicaid spending in Texas, compared with 18 percent for seniors and 45 percent for persons with disabilities. In contrast, New York Medicaid spends 25 percent for adults, 12 percent for children, and close to average amounts for seniors (29 percent) and persons with disabilities (35 percent). Another factor that drives variations in Medicaid spending is that, while benefits for children are defined in federal law, states set payment levels and determine the amount, scope, and duration of services for an individual child that qualify for reimbursement under Medicaid.

**Medicaid Expenditures per Enrolled Child**

States may finance more or fewer services for children in Medicaid and provide higher or lower reimbursement rates. A gross measure of the variation in efforts states make to finance comprehensive child health services is evident by looking at their average expenditure per enrolled child, which averaged $2,527 nationally for FFY 2014. (See Appendix A for data table and sources.) Six states (Nevada, Wisconsin, Florida, Louisiana, South Carolina, and Washington) had annual per-child expenditures below $2,000 in FFY2014. Four states (New Mexico, Alaska, Vermont, and North Dakota) and the District of Columbia had expenditures more than twice that amount, above $4,000. These variations in expenditures could be the result of the amount paid for specific services, the level and scope of services provided, or a combination of the two.
States have the authority under Medicaid to set payment levels and to require approval for payment of services, particularly higher-cost services. Such wide variations in expenditures per child suggest substantial differences across states in both payments and approved services under Medicaid, the result of different state policies and processes in implementing the program. These dollar amounts do not include expenditures for the nearly 1.6 million children who qualified for Medicaid as a result of more severe or long-lasting conditions in the eligibility category for persons with disabilities, another factor that varies by state. These variations cannot be explained by (i.e., do not correspond to) variations across states in child health status, although such variations exist.

Utilization of Preventive Well-Child EPSDT Visits

CMS 416 forms submitted by states provide both state and national Medicaid data on use of EPSDT preventive medical and dental services, broken out across seven age groups. This valuable data source points to variation in the level of service use among children, particularly for well-child visits. (Part six discusses these data in greater detail.)

State variations reflect differences in periodic visit schedules and other factors. In 2018, Medicaid programs in 41 states and D.C. used Bright Futures as the preventive care standard (35) or used a preventive care standard closely aligned with Bright Futures (7) guidelines. For example, Figure 9 shows the EPSDT participation rate for toddlers age 1 and 2 years (12-35 months). In FFY 2016, the national total U.S. participation ratio (reflecting the percentage of toddlers enrolled in Medicaid for at least 90 days who
received at least one EPSDT well-child visit) was 77 percent among the nearly 4.4 million toddlers age 1 and 2 enrolled in Medicaid. The map shows that, for this age group, only 20 states met or exceeded the 80 percent EPSDT performance standard on this measure. This means that, despite the fact that the Bright Futures periodicity schedule recommends five well-child visits for toddlers (i.e., visits at 12, 15, 18, 24, and 30 months of age), 23 percent did not have even one visit.

The Bright Futures schedule recommendation is for nine well-child (EPSDT) visits before age 15 months, but the national performance measure for Medicaid and CHIP is the percentage of children receiving six or more visits by 15 months. Figure 10 shows the variation in states’ performance on this Medicaid–CHIP child core measure for preventive visits among infants and toddlers. To understand more about the different ways of measuring Medicaid program performance for young children see part six. Among the 46 states reporting data for FFY 2016, the national median for this measure was 60 percent. This represents low performance on a measure that is already reduced from the standard of care. Individual states’ performances range from 29 to 83 percent. For children ages 3, 4, 5, and 6, the

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A performance measure is for annual visits as recommended in *Bright Futures*. The national median was 68 percent in FFY 2016, with the variation among 47 states reporting ranging from 45 percent to 86 percent. As this report discusses improvements to child health and the characteristics of high performing medical homes, one key is that young children and their families have frequent well-child visits during the first three years.

**Conclusion**

State-level information on Medicaid’s coverage of young children points to areas of need and opportunity. There is wide variation, and all states are in a position to improve their Medicaid systems by providing more preventive, developmental, and family-centered responses for young children. This overview highlights how states vary in terms of eligibility, expenditures, and service utilization. Part one briefly describes the Medicaid benefit for children, highlighting federal law provisions and state flexibility. Part two then describes policy and program decisions in the context of high performing medical homes for young children. Part three discusses the opportunity to maximize Medicaid funding for and the impact of care coordination and case management for young children and their families. Part four discusses screening for risks related to child development and social determinants of health. Over time, states have expanded the array of services and programs they finance, in keeping with growing knowledge on the contributors to children’s health. However, this has not been equal across states, particularly with respect to more preventive, ecological, and whole child services that are discussed in part five. In part six, financing topics are discussed, including how states vary significantly in terms of the reimbursement they provide for different services, such as preventive well-child visits, child health screening, and treatment services. Although all states cover EPSDT well-child visits, states vary in the degree to which they provide billing codes and coverage for a range of other intervention and treatment services, including developmental and early childhood mental health services, important to meeting young children’s needs. Part seven focuses on key measurement strategies for Medicaid and child health.

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**All states are in a position to improve their Medicaid systems by providing more preventive, developmental, and family-centered responses for young children.**

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**References**


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