THE TRENTON TIMES | TRENTON | NJ | 10/24/95 | MARO
Publication | City | State | Date | Submitted By

Agricultural chief attacks GOP cuts during visit to N.J.

NEWARK (AP) — Speaking to toddlers scooping up macaroni and cheese at a day-care center, U.S. Agriculture Secretary Dan Glickman yesterday attacked GOP-backed cuts on the federal program that paid for their lunch.

"Nutrition has to remain a national priority," Glickman said. "Children will suffer if these programs are ended."

While the children were more interested in their dessert raisin boxes than Glickman's moral support, women working with the group feeding them said the cuts were cruel and unnecessary.

"They hit us right in the gut," said Sister Guadalupe Nieto, who works with the New Community Corporation. "How can people be expected to go out and look for work if their children aren't taken care of? These children won't excel at school because they won't have food for their brains."

Glickman said Republican-backed bills to convert up to $38 billion in nutrition programs into block grants for states would jeopardize the health of inner city children, because states would have no incentive to use the money for meals.

Michelle Davis, a spokeswoman in House Speaker Newt Gingrich's office, responded that getting rid of federal red tape would make the money go further.

"The governors and the state legislators know better how to best provide for low-income families with children," she said in a phone interview from Washington.

GLICKMAN WAS speaking at Babyland, one of seven Newark day-care centers where 700 children ages 5 months to 4 years get breakfast, lunch and snacks. The program run by the New Community Corporation, a grass-roots Newark group, gets $158,000 from the federal child care food program.

About 208,000 New Jersey children get food stamps each month, and about 35,000 infants — 30 percent of the infants born in the state — get food through the Women, Infants and Children program, according to the USDA.

Glickman also visited a Kosher food processing plant in Newark to reassure Orthodox Jews that Kosher ritual will be taken into account in new federal regulations to crackdown on meat contamination.

The government, partly in response to the four deaths that resulted from an E. Coli contamination in 1993, hopes this year to enact more testing and stricter regulations of meat.

The regulations, pushed by Rep. Robert Torricelli, D-Englewood, would require a anti-microbial rinse and the cooling of freshly killed meat.

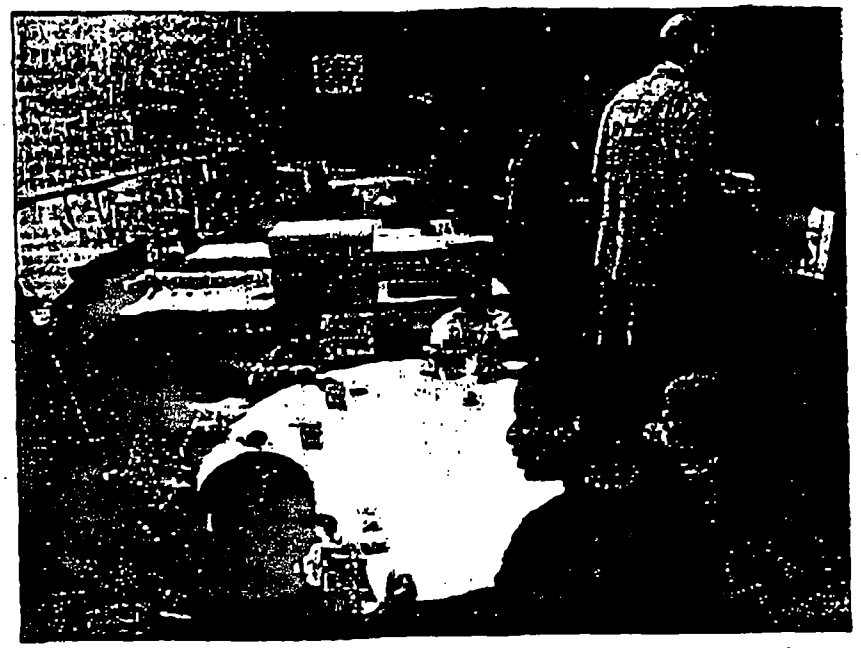
Kosher butchers are alarmed that the rules would interfere with ritual meat preparation, which requires that meat be deveined and salted at a lukewarm temperature immediately after slaughter.

Rabbi Menachem Genack of the Union of Orthodox Jewish Congregations, which certifies production by 2,500 Kosher food manufacturers, described to Glickman the Biblical injunction against eating bloody meat.

"There's a passage in Leviticus that says, 'Don't eat blood,'" Genack said as he and Glickman examined a leg of salted beef.

Genack, rabbinic process administrator at the Orthodox Union, estimated that 2 percent of U.S. meat is prepared kosher.

"We're not going to do anything to create a hardship for the kosher meat industry," Glickman said later. He wouldn't comment on specifics.



AP photo

Children at Babyland Day-Care Center in Newark eat lunch yesterday as Agriculture Secretary Dan Glickman, right, tours the facility.

FT WAYNE IN
FRIDAY OCT 8

Assistant labor secretary visits JobWorks program

▶ Timothy Bamicle came to drum up support for Youth Life Skills.

By ASHRAF ISMAIL
of The News-Sentinel

Ebony Banks eyed the crowd on the lawn with vague suspicion and tried to keep her mind on her painting.

"They're making me nervous," said Banks, one of about a dozen young people working on the house at 1928 St. Joseph Blvd. When told that the various reporters and television cameras were waiting for the arrival of the assistant U.S. secretary of labor, Banks grinned. "That sounds about right, because this is labor."

The workers were all high school dropouts earning their General Equivalency Degrees through the JobWorks Youth Life Skills program. Their visitor, Assistant Secretary for Employment and Training Timothy Bamicle, was there to drum up support for Youth Life Skills and similar programs in the face of a looming federal budget battle.

Bamicle praised Youth Life Skills as exactly the sort of pro-active social program the Clinton administration is trying to protect from Republican budget cuts.

"These are great programs, and their funding is in jeopardy," he said before the cameras, as the youth on the porch continued their scraping and painting. "If you need to know why this is a valid investment, all you have to do is ask these people where they'd be otherwise. This is not some theoretical abstract debate. This is very pragmatic."

Since its creation in 1987, Youth Life Skills has rehabilitated 91 houses for low-income residents while helping nearly 300 dropouts earn their GEDs. The students spend half the day in class and the other half working for pay on the houses.

JobWorks, with the help of federal funds, pays for the program coordinator, construction supervisor, tutoring and wages for the youth. Fort Wayne Community Schools pays for the classroom instructor, and the city covers the cost of paint and building materials.

See [illegible], Page 5A

FROM THE FRONT PAGE

U.S. Assistant Secretary of Labor Timothy Barnicle, right, talks with Rita Shaul, a Youth Life Skills supervisor, as program workers paint a house at 1026 St. Joseph Blvd. Barnicle was in Fort Wayne to generate publicity for programs like Youth Like Skills.

By LEISA THOMPSON of *The News-Sentinel*

JOBWORKS:

Assistant labor secretary visits

▶ *From Page 1A*

All of this adds up to another chance for students like Jairus Wheaton, who would have needed an extra year to get his degree from Harding High School. Now, after only six months with Youth Life Skills, he's on the verge of getting his GED and looking to attend Tennessee State University to become a surgical technician.

"It's better than school," said Wheaton, 19. "The classes are smaller . . . You learn a lot more."

Wheaton also has learned enough about painting in the last six months that he's able to earn extra money on the side.

Still, little of this training prepared them for the arrival of Barnicle and the accompanying media.

"They told us someone from the state was coming. I thought it'd be just one person who'd walk around and leave," Wheaton said. "I saw all these cameras and my heart started beating fast."

2B DEMOCRAT AND CHRONICLE, ROCHESTER, N.Y., SATURDAY, OCTOBER 14, 1995

Education official speaks out on federal cuts

By REGINA MEDINA
STAFF WRITER

Proposed slashes in federal education programs will mean "a lot of kids won't be getting the basics" like reading and math, Deputy U.S. Education Secretary Madeleine M. Kunin said yesterday while on a visit to Rochester.

The Clinton administration "feels very strongly that this is the wrong place to balance the budget," Kunin said after appearing on a WGRC-TV (Channel 9) call-in show with Rep. Louise Slaughter, D-Fairport.

"There are ways to balance the budget without hurting the children," said Kunin, who criticized military budget increases in the face of educational cuts.

According to figures supplied by Kunin's office, the House Republicans' proposed 18 percent cut in education funding would coincide with a 15 percent increase in the elementary and secondary student population — the biggest ever.

New York state and Rochester will be deeply affected by the cuts, said the former Vermont governor.

For example, Monroe County would lose nearly $2 million of its $16.3 million in Title I federal grants — focused on improving skills of low-performing students — if the Senate Appropriations Committee has its way, Kunin said.

New York gets a total of $600 million from the Title I program.

"On top of cuts from the state and the city, this is going to put a lot of stress on the (school) system in Rochester," which has a high level of disadvantaged students, she said.

Kunin, who was recently a finalist in New York's search for a state education commissioner, said she saw the impact of cuts "firsthand" during a visit to School 19.

"They used to have an early childhood program there," she said. Cuts have also resulted in bigger classes and less help.

"It's hitting the hardest at the children who need it the most." ❑

Classroom field trip

KAREN SCHIELY staff photographer

Deputy Secretary of Education Madeleine Kunin talks to School 19 first-grader Alfonza Turner, 6, yesterday. • STORY, PAGE 2B

Newsday / K. Wilson Stubbs

HUD General Counsel Nelson Diaz, gesturing, speaks with children at the center. Nunez sits to his right.

Queens Center for Homeless Faces Deep Cut in Its Funds

By Dan Morrison
STAFF WRITER

For all the recent talk of welfare reform ringing through the halls of the nation's capital, Ralph Nunez says you need only drop by the homeless facility he runs in Jamaica to see it in practice.

In the eight years since Nunez' nonprofit Homes for the Homeless converted an abandoned Holiday Inn on Rockaway Boulevard into a transitional housing center for homeless mothers and children, hundreds of families have found permanent housing and solid living skills.

But with the budget-cutting that has swept Congress in the wake of the 1994 Republican victory, Nunez said yesterday, the Saratoga Family Inn may soon become little more than a warehouse for its 600 residents.

The group stands to lose $4 million of its $18 million operating budget if Congress follows through with a 30 percent to 40 percent cut in the U.S. Department of Housing and Urban Development's funding for the homeless.

Nunez and Diaz discussed the cuts while touring the white brick facility near Kennedy Airport. "It's gonna hit us right at the heart," Nunez said. "We're gonna go backwards. We'll be warehousing families."

To attack the myriad problems of homelessness, the inn offers a comprehensive range of social services, education and recreation programs, counseling to find permanent housing and follow-up services once clients make the big move. The average stay for each family is 12 months, Nunez said, and there is 12 months of follow-up.

Ida Vasquez came to the fenced-in compound after leaving her ex-husband three months ago. With children Michael, 11, and Terry, 1, in tow, she spent six nights on the floor of the city's Emergency Assistance Unit in the Bronx. After another six days in a shelter near the Brooklyn House of Detention, a city van brought her and her kin to Saratoga.

"It looked like a mansion," the former Ridgewood resident said.

Standing in Saratoga's Patrolman Edward Byrne Rec Center, Vasquez said she was anxious to rejoin the real world. "I like to work," she said. "I don't want to stay in the system."

NEWSDAY WEDNESDAY, OCTOBER 25, 1995

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NEIL SCHNEIDER

NOT HOME FREE: Ralph Nunez (l.) and HUD official Nelson Diaz with youngsters in homeless facility.

Shelter fears program cuts

By CLAIRE SERANT
Daily News Staff Writer

Without the Saratoga Interfaith Family Inn, Stephanie Harper and her 18-month-old daughter, Aaron, would not have access to the educational programs that have kept them off the streets.

"I want to get a job, get my life together," said Harper, 23, who studies computers during the day while her daughter attends preschool at the Rockaway Blvd. transitional housing facility where they live.

However, congressional proposals to cut 35% to 40% from programs for the homeless threaten to reduce the quality and quantity of a wide range of educational and social service programs Saratoga provides, said Ralph Nunez, president of Homes for the Homeless, which sponsors the project.

Yesterday, Nunez, along with Nelson Diaz, general counsel of the federal Department of Housing and Urban Development, discussed the impact the $32 million cut homeless programs face citywide during a tour of the Springfield Gardens facility.

Those cuts, Diaz explained, could reduce funding for HUD's homeless programs in 1996 from $1.1 billion to $676 million.

That means Saratoga's day-care program, which watches 100 youngsters while their mothers attend on-site job training programs or GED classes, is in jeopardy — as are the classes the children's parents take, Nunez said.

Saratoga, a 222-unit transitional housing facility, has an annual budget of $18 million, of which $4 million comes from HUD. The inn is one of five shelters Homes for the Homeless operates in the five boroughs.

"All the programs we have are about welfare reform," Nunez said. "Now people are making calls for change without looking at what's right."

Residents can receive on-the-job training as receptionists, housekeeping workers and day-care providers, said Jacqueline Crichlow, 27. Saratoga gives her the daily inspiration she needs to leave the shelter, she said.

Cynthia Jiles, 32 — who has lived at Saratoga with her 3-year-old daughter, Shanique, for more than a year, said: "I would love to support myself. This will help me get a better job."

Saratoga provides services to 600 residents, including 400 children.

Martha Rial/Post-Gazette

Mayor Murphy puts a shot up over Stephanie Truman, resident services coordinator of the Pittsburgh Housing Authority, during a pickup game of basketball yesterday at Addison Terrace. Murphy and 10-year-old teammate Chris Wood, left, beat Truman and 12-year-old John Griffin, 3-1.

HUD aide warns that cuts will harm public housing

By Tom Barnes
Post-Gazette Staff Writer

Tenant Council President Erma Johnson proudly lifted up a 2-foot-high baseball trophy that her Addison Terrace Little League team won this summer.

Problem is, there may not be a second season next summer if cuts proposed by congressional Republicans go through for the budget of the federal Department of Housing and Urban Development.

The Addison Terrace team was one of nine public housing community teams funded by a $15,000 HUD grant. The money went for uniforms and other equipment and transportation for the 180 youngsters and 40 coaches in the league.

But Kevin Marchman, a deputy assistant HUD secretary, came to Addison Terrace from Washington yesterday to warn tenants of impending federal budget cuts engineered by congressional Republicans.

He said programs like the Little League, summer employment, Head Start meals for school children, prenatal care for pregnant women, after-school tutoring for youths and other HUD programs faced the budget ax within about three weeks.

He said the Clinton administration had sought $26 billion for HUD nationally in the 1996 fiscal year. House and Senate Republicans want to cut that amount to between $19 billion and $20 billion in an effort to balance the federal budget, he said. A final budget proposal could go to Clinton in three weeks to Clinton, who may veto it, Marchman said.

"These cuts will hurt our [public housing] communities," he said. "They are balancing the budget on the backs of poor people."

As a child growing up in Denver 25 years ago, he said, he benefited from Head Start preschool breakfast programs of juice, milk and oatmeal.

He urged the public housing residents to call and write members of Congress before final action occurs on the proposed budget reductions.

"Public housing residents have to raise their voice. Tell Congress that these cuts can't occur. If Congress feels it has nothing to lose by cutting the HUD budget, it will do it. If Congress doesn't think you count, you will be left on the side."

Marchman said he had gone to Chicago, Richmond, Va., and other cities in a Clinton administration effort to fight the GOP budget reductions. HUD Secretary Henry Cisneros and other top HUD officials are also on the road.

Marchman was joined yesterday by Mayor Murphy and Stanley Lowe, director of the Pittsburgh Housing Authority. Murphy said the city stood to lose $1.3 million in summer-job funding, and Lowe said the city would lose $5 million in modernization funds for public housing units.

"You need to start making noise at the federal level, and raise the awareness of what public housing means in the country," Murphy said.

He said Clinton had hoped to "revolutionize" public housing in the U.S. through improved delivery of services, but that because of GOP funding reductions, "We are watching the whole program be undercut."

Reached in Washington yesterday, Mary Crawford, a spokeswoman for the Republican National Committee, said Democrats could only criticize GOP cuts because Democrats have no plan for balancing the federal budget.

"The Democrats have grown increasingly shrill in their attacks," she said. She said election results and polls had shown that the public wants the budget balanced, which it would be by 2002 under the GOP plan.

"The American people recognize that balancing the budget is the best thing we can do for future generations," Crawford said.

"sovereignty" the instead of independence at an unspecified date. But it also requires the Quebec government to try to negotiate a new political and economic partnership with what would remain of Canada. The partnership offer is intended to cushion against the potential economic hardships of separation by maintaining trade relationships, a currency union and other financial links with Canada.

(End optional trim)

A separatist victory would contradict the conventional wisdom in Canada, which is that Quebeckers like to flirt with independence but shy away from a full commitment. A similar referendum in 1980 was defeated 60 percent to 40 percent.

Mindful of that, most Canadians outside Quebec have been mostly blase about the campaign. In the last week, however, with polls showing the race tightening, Canada has begun to snap to attention.

More than 70 city councils across British Columbia have passed resolutions urging Quebeckers to reject separation. School children in the prairie province of Saskatchewan have been telephoning Quebec families with a message of unity. A farmer in Alberta plowed his field with the phrase "It's better together" in French in letters large enough to be read from a passing airliner.

The separatist comeback is largely attributed to one man, Lucien Bouchard, the charismatic leader of the separatist opposition party in the Canadian parliament. On Oct. 7, with the separatists falling in the polls and drawing small and desultory crowds, Bouchard displaced Quebec Premier Jacques Parizeau, an aloof, professorial economist, as principal campaigner.

Bouchard is a fiery orator who has long been Quebec's most popular politician. His recovery last December from an attack by a muscle-destroying disease that forced the amputation of one leg further elevated him to near-hero status.

He transformed and energized the separatist campaign. Quebeckers flocked to hear Bouchard speak, chanted his name and struggled to shake his hand.

The polls immediately went into reverse. The most recent surveys show a slight lead for the separatist cause among decided voters, with about 11 percent saying they are undecided.

One factor in the federalists' favor, however, is that polls in Quebec traditionally overestimate the separatist vote.

Panetta Alleges GOP Budget Proposals Would Harm Children By Janet Hook and Jonathan Peterson= (c) 1995, Los Angeles Times=

A1

WASHINGTON White House Chief of Staff Leon Panetta charged Monday that millions of children would be harmed by Republican budget proposals, and released a state-by-state analysis seeking to show how young people would be affected by restrictions in health care, nutrition and other areas.

Republicans are saying "you have to harm children in order to save them," Panetta contended, whereas the White House maintains that "we should continue to invest in children for our future."

House Speaker Newt Gingrich, R-Ga., meanwhile traveled to Boys Town in Nebraska to underscore his contention that private charity can do more for children than government. Boys Town, he said, shows that even with "remarkably few resources," people can "achieve great things if they love other enough."

But the escalating war of words between the White House and Republican leaders Monday obscured an entirely different set of conflicts that stand in the way of a spending deal: Republicans are confronting fierce, intra-party divisions that must be bridged before the goal of a sweeping budget deal with the White House even can be considered.

These realities are taking on extra meaning this week as the House and Senate consider major spending and tax-cut bills that were designed to put a GOP imprint on a transformation of federal policy.

On Monday, the Senate Budget Committee passed a voluminous bill aimed at balancing the budget over seven by slashing $664 billion from projected spending. In the coming days, however, the legislation known as the reconciliation bill will be the object of internecine struggles over health care, agriculture and other issues.

Squabbling GOP factions may force Republican leaders to proposed cuts in education, agriculture and other programs to assure passage of the measure. That will set the stage for another intraparty brawl as negotiators try to resolve the thorny differences between the versions of the budget bill passed by the Senate and by the more c rative House.

A y, Republicans who disagree over abortion, environ l regulation other

stalled as of the 13 appropriations bills needed to finance of the government.

President Clinton himself faces painful divisions within his own party. Many Democrats remain furious with his recent statements suggesting the tax increase that some of them risked their seats to give him in the 1993 budget deal was a mistake. Although some are unhappy with the White House, their irritation is not likely to affect the outcome of the budget debate because they do not have enough votes to prevent passage of the budget.

Yet the administration also has scored points in the drawn-out budget fight by arguing that proposed restrictions on Medicare were too harsh. On Monday, White House officials sought to expand the strategy by mounting a campaign that that GOP budget cuts take an unfair toll on children.

Hillary Clinton visited babies at a New York hospital and Panetta distributed the analysis of how children would be affected by GOP proposals for health care, immunization, taxes, summer jobs, nutrition and other programs.

The report said, for example, that the Republican proposals would eliminate Medicaid coverage for 4.4 million low-income children nationally in 2002.

Such programs "are investments that pay off in the future, that save money in the future," Panetta said.

The new White House push prompted a swift GOP response, as Republicans argued that their policy prescriptions would prove far more helpful to needy kids: "What's hurting children today is the welfare system that is trapping them in poverty and forcing them into schools that don't teach them anything and permitting an environment of drugs and crime to destroy their young lives," said Gingrich spokesman Tony Blankley.

Many analysts say that the current atmosphere of brinkmanship is largely for the benefit of the purists in each party, who will jump all over their leaders if they are seen as compromising too easily. Most budget experts expect the initial round of budget and appropriations bills to be vetoed, after which both sides will reposition themselves for possible negotiations.

(Optional add end)

Amid the partisan fireworks in recent days there have been some small signals of where the two sides may be willing to give. Clinton reversed field last week and said he might be willing to accept the Republicans' seven-year line for balancing the budget. And some House Republicans have indicated they would be willing to compromise on the amount of savings wrung from Medicare.

Both sides agree there should be a tax cut, but differ on how much and who should benefit.

Still, even as the public is deafened by the high-volume argument between the White House and Republicans in Congress, GOP leaders are working sotto voce to bring their troops in line behind key budget measures.

The far-reaching budget reconciliation bill, which includes GOP proposals to curb spending on Medicare, Medicaid, farm programs, student loans, welfare and a host of other federal programs, moved another step closer to enactment Monday when it was approved on a party line vote of 12-10 by the Senate Budget Committee.

The Senate is expected to take up the budget reconciliation bill
so called because it is designed to reconcile spending and taxes to the targets set in Republicans' seven-year budget balancing plan
on Wednesday and pass it by Friday.

As a result, Senate GOP leaders face the challenge of ensuring 51 Republican votes to pass it; with 54 Republicans in the Senate, they can afford to lose only three Republicans. A group of about half a dozen Republican moderates have begun meeting to seek changes that would ease cuts in Medicaid, education and tax credits for the working poor. But any changes the leadership makes to appease party moderates risks alienating more conservative Republicans.

The House is expected to take up its version of the bill Thursday. The biggest threat to House passage of the bill is a dispute among Republicans over proposals to revamp and scale back federal subsidies to farmers. Fighting the proposals are Republicans from areas that grow cotton and rice and that have small dairy farms areas of agriculture that critics say would be disadvantaged by the overhaul.

Scientists Get New View of Bottom of the Sea (Washn) By Earl Lane= (c) 1995, Newsday=

WASHINGTON Using formerly secret Navy satellite data other information, scientists have created the first detailed of the global seafloor.

The on the subtle variations in the strength

Clinton and Yeltsin agree Russians will help enforce Bosnian peace By Robert A. Rankin Knight-Ridder Newspapers

NEW YORK President Clinton and Russian President Boris Yeltsin agreed Monday that Russian troops would play some role in enforcing any peace settlement in Bosnia, but they delegated all the sticky details to military aides.

The Russian-American dispute over how to police an emerging peace in Bosnia has threatened to disrupt relations between the two former Cold War antagonists. The topic dominated some three hours of face-to-face talks between the two leaders Monday at Hyde Park, N.Y., the Hudson River Valley estate that was former President Franklin D. Roosevelt's family home.

Both men emerged from the talks to hail the warmth of their partnership at a sometimes rollicking news conference, and both said they made progress toward resolving their dispute over Bosnia.

But if progress was made, it was not clear what it was.

The Clinton administration insists that NATO will run any Bosnia peacekeeping operation and has pledged to send up to 25,000 U.S. troops to help. Yeltsin asserts just as sternly that Russian troops should be present and insists they will not serve under NATO command.

Neither side yielded from those polar opposite positions Monday, senior Clinton administration officials said. They said the important point was that Yeltsin and Clinton agreed on the goal that Russian troops must play some role; having set the goal, their subordinates now must work out how to do it.

Defense Secretary William Perry and his Russian counterpart, Defense Minister Pavel Grachev, are to resume talks on how to square this circle later this week, Clinton said.

"It was addressed at a fairly high but useful level of generality today," said a senior administration official, briefing reporters on condition that he not be identified. "This is a highly technical issue. It involves everything from organization charts to the size of forces to functions to be assigned."

Clinton said he and Yeltsin also agreed to push the START II nuclear disarmament treaty, to continue cooperating on nuclear security issues, and to push for a nuclear test-ban treaty in 1996 that wouldn't allow any active nuclear tests.

Yeltsin challenged widespread skepticism in the global media about his prospects for meeting fruitfully with Clinton. Delivering one of his theatrical news-conference performances, Yeltsin said many news reports had predicted his meeting with Clinton would be "a disaster."

"Well, now for the first time, I can tell you that you're a disaster," Yeltsin told reporters gathered outside the Roosevelt mansion.

Clinton dissolved in laughter and curled an arm around Yeltsin's shoulders, doubtless pleased by the Russian president's blunt insult to a press corps that often has hounded Clinton mercilessly.

"Be sure you get the right attribution there," Clinton warned reporters, who shared his laughter.

Yeltsin talked on, scowling and growling, saluting his partnership with Clinton, saying it will forge a U.S.-Russian concord for a century.

Yeltsin's harsh-sounding Russian rhetoric flowed menacingly, only to be revealed in translation to be flowery praise of Hyde Park's beauty, of the wonderful staff there that made his visit so pleasant, and of "the personality of President Roosevelt, who was a personality not only for the United States, but for all the people of the world for all time."

And if the news media do not understand how what he and Clinton said constitute progress, Yeltsin said in closing, perhaps it is because "you are underestimating the presence of such two great powers. Maybe something didn't quite reach you. Maybe you can't quite figure out how we can solve it, but it came to us, it reached us."

(EDITORS: STORY CAN TRIM HERE)

The two presidents, smiling and shaking hands, then descended the mansion steps

This was Clinton's ninth meeting with Yeltsin. The Russian conceded that he expected this one to be "very, very tough," but it turned out to be "the friendliest meeting, the best meeting" of all so far.

As a token of their friendship, Clinton gave Yeltsin a leather-bound volume of FDR's 31 "fireside chat" speeches in Russian, published earlier this year in Moscow.

Yeltsin, under fire back home from Russian nationalists for subordinating Russia to Washington and NATO, acknowledged such political realities in his gift to Clinton. He gave him two Moscow Penguin hockey jerseys one in English with "Clinton" on the front and "96" on the back, the second in Russian with "Yeltsin" on the front and "'96" behind.

Both men face re-election challenges next year.

Clinton threatens to veto GOP budget By Rachel L. Jones and William Hershey Knight-Ridder Newspapers

NEW YORK A buoyant President Clinton urged more than 1,000 cheering delegates to the AFL-CIO convention in New York on Monday to stand with him in defeating Republican plans to balance the budget at the expense of the poor, the elderly and children.

"If it takes a veto, you'll have it. I need you in the streets standing up for America's future," Clinton told the union audience.

Clinton's speech came as his administration turned to a new front in its budget battle with the Republican Congress, focusing on the effect of Republican legislation on America's children.

"The bottom line is that kids are getting screwed in these budgets, and we won't let that happen," White House chief of staff Leon Panetta said at a news briefing in Washington on Monday afternoon.

Senate Majority Leader Bob Dole, R-Kan., responded sharply, telling the Associated Press that the newest charges were "just the latest in the Clinton administration's transpArent campaign to scare Americans one day it's seniors, the next day it's farmers, today it's children."

Republicans and Democrats are already feuding over proposed changes to Medicaid and Medicare programs, whose growth would be trimmed by nearly half a trillion dollars over seven years. Republicans say both programs will go bankrupt if cuts are not made, while Democrats say the move would devastate the poor and the elderly.

In New York, the president lashed out at Republican plans to end the Earned Income Tax Credit for the poor and to make changes in federal college loans that he said would prevent many poor and middle-class children from attending college.

"I'm going to do everything I can to stop it. I want you to help me, too," Clinton said.

Clinton said his budget proposals are based on achieving family values giving people an opportunity to achieve the American dream. "It's about whether the American dream is going to be alive," he said.

Meanwhile, Panetta punctuated this latest salvo in a fight that promises to get nastier by releasing a state-by-state analysis of the Republican budget's effect

on children.

According to the Democratic study, the Republican legislative plan would eliminate Medicaid coverage for as many as 4.4 million children, deny as many as 755,000 disabled children Supplemental Security Income cash benefits by 2002 and lock 180,000 children out of the Head Start program for preschool children.

Some independent economists agree with the Democrats' negative assessment of the budget plan's effect on children.

The Clinton administration analysis is based on state projections of how services might be affected if the Republican budget passes. Data from the federal Office of Management and Budget and the Congressional Budget Office was also included.

Among the report's assertions by the year 2002, the proposed budget would:

Sharply limit Medicaid child-care resources. Currently, one of 5 kids relies on Medicaid for basic health needs like immunizations, checkups and intensive care. Republicans say eliminating the program's status as a federal entitlement and turning health care over to states would save money; Democrats say overburdened states might be hard-pressed to do the right thing.

Slash the number of disabled children who would receive Supplemental Security Income cash benefits. Republicans say the program, which tripled its rolls between 1989 and 1994, is rife with fraud. Democrats say that while eligibility standards must be stricter, no more than 50,000 children should be removed. The Democrats estimate three-quarters of a million might go.

Deny Head Start to 180,000 children, and cut the Title I program by $1.1 billion, paring basic and advanced skills programs for 1.1 million disadvantaged students. Republicans have challenged the alleged benefits of these education programs, claiming they are minimal at best.

Cut food stamp benefits for families with children by $8.1 billion, which would affect 14 million children. Republicans say too many able-bodied people receive food stamps, and must be weaned from the program and urged to work. Democrats say the big losers would be the children of those kicked off the program.

Cut nutritional support or reduce food assistance to 32 million children by converting the money for school food and the Women, Infants and Children nutrition programs into block grants to the states. Republicans say a yearly increase in block grants would actually provide more funds for nutrition programs; Democrats say the grants don't allow for inflation, recession or increased participation.

Panetta conceded that the Republican goal of balancing the budget is important for children, to relieve them of the burden of huge debt.

"But investing in our children is equally important," he said. "You don't have to sacrifice one goal to achieve the other.

Panetta holds out little hope for compromise during the budget process, and predicts an unavoidable presidential veto.

(EDITORS: STORY CAN TRIM HERE)

But as one children's advocate noted, Clinton has already "caved in" on one aspect of welfare reform.

By accepting the proposal to end welfare's federal entitlement status, "the administration is making a lot of activists nervous," said David S. Liederman, executive director of the Child Welfare League of America.

Liederman, who served as a state representative and a governor's aide in Massachusetts, said it's "ludicrous" to believe that states will be able to handle the burden.

"When push comes to shove, and you're in a downturn, you make hard choices," Liederman said. "I would bet most of the money I have that in 10 years, governors will be screaming for federal aid."

But Panetta vowed that will not happen.

"I don't know how to say it more clearly; the president will veto any legislation that harms children," he said.

Farm-state Democrats to offer bill replacing farm programs with loan plan By Juan Miguel Pedraza Knight-Ridder Newspapers

In a sharp change of strategy for farm state Democrats, a handful of lawmakers announced Monday that they're launching a radical new farm bill plan.

Reps. Earl Pomeroy, D-N.D., David Minge and Collin Peterson, both Minnesotans, and South Dakota's Tim Johnson, said that together with the National Farmers Union, they'll unveil a Family Farm Empowerment Act Tuesday
at a noon press conference in Washington.

The bill, which will cut farm spending over the next seven years by $4.4 billion instead of the $13.4 billion called for in the Republican farm plan, would overhaul the current structure of farm programs with
a comprehensive marketing loan plan.

Marketing loans of up to $175,000 would be provided for barley, corn, cotton, grain sorghum, oats, rice, soybeans and wheat. Loans would be for 15 months and would be ba on 115 percent of the average market price of the previous five years, according to a statement from Pomeroy's office.

The Freedom to Farm Act, engineered by House Agriculture Committee Chairman Pat Roberts, R-Kan., failed in the farm panel and was kicked over to the Budget Committee, where it will become part of an overall budget package.

Republicans argue that in order for Congress to balance the federal budget by the year 2002, farm spending only one of several sectors taking heavy hits must be cut by at least $13.4 billion.

Congress is scheduled to vote on the Budget Reconciliation Act later this week.

Pomeroy has predicted for several weeks that President Clinton will veto the budget package because it cuts some programs more deeply than he wants, including agriculture and Medicare.

The House Democrats, with their family farm act, are "laying a marker down for where the post-veto" farm bill debate will take off,
a Pomeroy aide said Monday.

=White House Budget Tactics Shift Focus To Children
By Alex Keto
Dow Jones Staff Reporter

WASHINGTON -DJ- In a signal that the budget battle remains very much alive, the Clinton administration is shifting its tactics by focusing its efforts on spotlighting how the Republican budget proposals will affect children.

Pointing to cuts in spending on health care, education, food programs and the environment, White House Chief of Staff Leon Panetta said: ''The bottom line is that kids are getting screwed with these (Republican) budget cuts.''

The move by the White House to again paint the Republicans as ruthless budget cutters who are unconcerned about the suffering their plans would cause comes just days after President Clinton appeared to give up significant ground to the GOP when he said he could accept one of their key proposals, a move to balance the budget in seven years.

The move to spotlight children also fits in closely with earlier efforts by the Clinton administration to highlight the impact of spending cuts on the elderly, rural families and the disabled. These earlier efforts paid off handsomely for the White House when polls showed decreasing support for the GOP's balanced-budget plans.

On the broader topic of the budget, the current proposals in both the House and the Senate are unacceptable to Clinton and will be vetoed if they arrive unchanged on his desk, Panetta again warned.

(MORE) DOW JONES NEWS 10-23-95
04:33 PM

**** filed by:TAPE(--) on 10/23/95 at 16:34EDT ****
**** printed by:WHPR(BAND) on 10/23/95 at 22:24EDT ****

White House blasts GOP over kids

WASHINGTON, Oct. 23 (UPI) In another blast at Republican spending plans, the White House issued a comprehensive report Monday showing how ``kids are getting screwed in these budgets,'' said chief of staff Leon Panetta.

Panetta said proposed Republican budgets would cut Medicaid coverage for 4.4 million children, cut nutrition aid for 14 million children, and deny assistance to more than 16,000 homeless children.

``The bottom line is that kids are getting screwed in these budgets,'' Panetta told a White House briefing.

President Clinton also joined Monday in general denunciations of Republican budget priorities.

He told cheering delegates at the annual AFL-CIO labor union convention in New York that his budget alternative ``protects instead of hurts'' the elderly, disabled and children, and vowed to veto GOP plans that are not ``consistent with our values and our objectives.''

The White House report came on the same day the Senate Budget Committee approved a measure that cuts about $500 billion from Medicare, Medicaid and welfare as part of the seven-year Republican plan to balance the federal budget and cut taxes by $245 billion.

The House already has given initial approval to Medicare and welfare reform, as well as the Republican tax cuts. Those three items, plus Medicaid reform and dozens of other provisions, will be wrapped into a budget reconciliation package that hits the House floor Thursday.

The Republican-led Congress is working on its spending plans for fiscal 1996 more than three weeks after the fiscal year began. Congress has enacted a six-week temporary funding measure that has kept the government running, but GOP leaders have threatened to let the government shut down if Clinton carries out his threat to veto their budget plans once lawmakers complete their work.

In its report, the White House compiled both state-by-state and nationwide calculations of the effects of Republican budget cuts that would affect children, from education and day care to medical care, housing and environmental protection.

It said the proposed GOP cuts would, by 2002:

Eliminate Medicaid coverage for as many as 4.4 million children;

Cut nutrition assistance for 14 million children;

Eliminate home energy assistance for about 6 million children;

Deny 180,000 children access to the Head Start educational program;

Deny as many as 755,000 disabled children federal Supplemental Security Income cash benefits;

Deny housing assistance to the families of more than 16,000 homeless children; and

Deny 404,000 children child care assistance.

Panetta declined to predict how or when the budget stalemate would be resolved. ``It's difficult to see that right now because the Republicans have basically taken their blood oath,'' he said.

But he reiterated his belief that Republicans could accept Democratic priorities if they could be convinced to declare political victory on areas of mutual agreement, such as the general need to balance the budget, strengthen the financial health of the Medicare program, and grant some tax relief.

The Clinton administration has suggested balancing the budget within nine or 10 years, rather than the GOP-proposed seven-year timetable, has advocated smaller cuts in Medicare and other social programs, along with smaller cuts in taxes, especially those affecting wealthier taxpayers.

**** ' filed by:UPI-(us) on 10/23/95 at 18:50EDT ****
**** printed by:WHPR(BAND) on 10/23/95 at 22:24EDT ****

LOCAL NEWS

Detroit Free Press

SECTION

Michigan Dateline, Page
Obituaries, Page
Call City Desk, 1-313-222-66

Budget hits kids, White House says

Thousands in Michigan could lose some benefits

BY VICTORIA BENNING
Free Press Staff Writer

A bruising political battle over the federal budget looms this week in Washington, and the White House claimed Monday that thousands of children are smack in the middle of it, in Michigan and around the country.

The Office of Management and Budget released a series of statistics about what's in store for kids under a spending plan favored by the Republican-controlled Congress and facing a veto from President Bill Clinton, a Democrat.

State officials challenged the gloomy White House forecast, and a spokesman for Sen. Spencer Abraham, R-Mich., described the data as "completely invalid."

According to the White House, the GOP plan would eliminate health care coverage through Medicaid for as many as 69,096 children in Michigan in 2002.

Medicaid, the government system of health care for the poor, covers immunizations, regular checkups and intensive care in case of emergencies for about 571,000 children in Michigan — 23 percent of the state's child population.

The Republican budget would cut Medicaid funding to Michigan by $4.3 billion over seven years and by 25 percent in 2002 alone.

Even if Michigan could absorb half of the cuts by reducing services and provider payments, it would still have to eliminate coverage for 147,292 people, including 69,096 children in 2002, based on an analysis by the Urban Institute that was included in the White House assessment.

State officials said many of the figures used in the analysis are accurate, but the presentation was distorted.

"I don't believe the numbers translate into the horror stories being presented in this

See CUTS, Page 8B

DIRE WARNING

Here are some of the cuts the White House warned Monday would be forced on children in Michigan under the Republican plan for the federal budget:

- 69,096 children cut off from Medicaid health care by 2002.
- 32,280 disabled children lose Supplemental Security Income cash benefits by 2002.
- An average tax increase of $442 by 2002 on families with two or more children.
- 7,456 children lose access to Head Start preschool programs.
- 20,164 summer jobs for young people eliminated in 1996, a total of 141,148 jobs over seven years.

Canto boys

GOP budget cuts would affect Michigan kids, White House says

CUTS, from Page 1B

report," said Margarete Gravina, a spokeswoman for the state Department of Social Services.

She said the conclusions drawn are based on current versions of service programs and not reflective of changes in the works.

Last year's total federal Medicare funding, for example, was about $2.6 billion. Over seven years, that's about $18 billion. A $4.3 billion cut is less than one-fourth of the total figure for seven years, she said.

Gravina said the impact of the cut would also be less because the state is looking at new, more efficient approaches to running its welfare system, which encompasses Medicaid. Second, she said, there has been a steady decline in the number of people on various forms of public assistance, including Medicare, which would free more money.

"It's a little bit confusing to me," she said, "because the idea of a block grant is that states would be given a lump sum of money and they would determine what programs they would provide and who would be eligible.

"We feel we'll be just as good if not better off."

Abraham's press secretary, Joe McMonigle, said the administration is in no position to make such predictions, since it's the governor who will decide how federal Medicaid money is spent in Michigan.

"I would point out that it's impossible for any bureaucrat in the Office of Management and Budget to provide any statistic on how this would affect children in Michigan," McMonigle said. "Any numbers coming from the White House are completely invalid."

According to the White House, the GOP budget plan also would:

- Jeopardize immunizations for Michigan children by its repeal of the Vaccines for Children program.
- Cut Detroit's Healthy Start infant mortality project by 52 percent in 1996. This provides prenatal and health care services to Detroit area women.
- Eliminate federal Supplemental Security Income benefits for as many as 57 percent of the disabled children in Michigan expected to receive SSI cash benefits in 2002.
- Increase taxes on working families with children by reducing the Earned Income Tax Credit.
- Cut nutrition assistance for 509,000 children by reducing food stamp benefits for families with children in Michigan by $900 million over seven years and by nearly 23 percent in 2002.

The massive House and Senate bills would balance the budget over seven years by reducing projected Medicare spending by $270 billion, slowing Medicaid growth by $180 billion, reforming welfare and trimming education programs.

The Senate is scheduled to begin debate on the budget package Wednesday, and the House on Thursday.

The Associated Press contributed to this report.

Date: 10/23/95 Time: 17:46

Democrats Criticize GOP Budget as Tough on Children

WASHINGTON (AP) Focusing on children in an attack on the Republican budget, the Clinton administration said Monday that young Americans would suffer everything from hunger and poor health to polluted air and dirty drinking water if the spending plan became law.

The Republican budget plan ''basically takes the attitude that you have to harm children in order to save them,'' Leon Panetta, White House chief of staff, told reporters. ''The bottom line, kids are getting screwed in these budgets.''

Senate Majority Leader Bob Dole, R-Kan., retorted that the newest charges were ''just the latest in the Clinton administration's transparent campaign to scare Americans one day it's seniors, the next day it's farmers, today it's children.''

For weeks, the administration has scored the GOP's budget blueprint in the name of the elderly, less frequently in the name of the poor and rural residents.

The White House opened the new front Monday by deploying Cabinet members and the first lady to argue that the GOP's budget plans would punish children, especially the poor and disabled.

Congressional Republicans have proposed $245 billion in tax cuts and nearly a trillion dollars in spending reductions from programs such as Medicare, Medicaid, welfare, public housing and nutrition in its effort to balance the federal budget by 2002.

Hillary Rodham Clinton, visiting New York's Mount Sinai Medical Center, said the GOP plan to slow the growth of Medicare and Medicaid spending by $452 billion over seven years ''would undermine the safety net, not just for the poor, but would touch the lives of every American.''

''We want to get our economic house in order,'' she said, ''but not by undermining our most vulnerable younger and older people.''

And Agriculture Secretary Dan Glickman, visiting toddlers eating macaroni and cheese at a day-care center in Newark, N.J., said the health of inner-city children would suffer under GOP plans to overhaul federal feeding programs. ''Nutrition has to remain a national priority,'' he said.

Dole said the GOP's plan is the only one that frees children from the ''crushing burden of debt,'' while other Republicans accused the Democrats of trying to scuttle a balanced budget with a campaign of fear, deception and distorted numbers.

''The American people are looking to the Republican Congress for leadership to balance the budget, reform welfare, protect Medicare from bankruptcy and cut taxes for American families. We're going to deliver that leadership, with or without help from the White House,'' Dole said in a statement.

With representatives of small businesses, home builders and the Christian Coalition at his side, Sen. William V. Roth Jr., R-Del., chairman of the Senate Finance Committee, said the GOP tax cuts would largely benefit middle-income families.

''Today, American families pay over 40 percent of their income in taxes and Republicans want to change that,'' Roth said, adding

that the GOP tax-cut plan includes a $500 per-child credit, relief from the marriage penalty, an adoption tax credit, and a $500 credit for student loans.

Panetta said the president would veto budget-balancing bills moving through the House and Senate. The White House is willing to negotiate with Republicans but only if they back away from the proposed reductions in Medicare, Medicaid and education, and target tax cuts to the middle class.

APNP-10-23-95 1759EDT

E X E C U T I V E O F F I C E O F T H E P R E S I D E

26-Oct-1995 09:51am

TO: Jennifer L. Klein

FROM: Lorraine McHugh
Office of the Press Secretary

SUBJECT: Children's radio completed to date

CHILDREN/BUDGET RADIO

Nancy-Ann Min (Wednesday)
1. WCTC, New Brunswick, NJ, "You and Your Money" LIVE
(This show was broadcasting from DC per an invitation by the DNC).

Chris Jennings (Children/Budget-Monday morning)
1. Minnesota News Network
2. Illinois Radio Network
3. Minnesota Radio Network
4. Wisconsin Radio Network
5. KOTA, Rapid City, SD

Jeremy Ben-Ami (Children/Budget-Monday morning)
1. Kansas Information Network
2. KFBK, Sacramento
3. Pennsylvania Radio Network
4. KBHE, Rapid City, SD
5. KERN, Bakersfield
6. WHO, Des Moines
7. Kentucky Radio Network
8. South Dakota/North Dakota Radio Network

Jeremy Ben-Ami (Children/Budget-Monday afternoon)
1. Talk Radio News Service
2. David Brenner Show, LIVE
3. KPBS, San Diego, CA
4. KVEN, Ventura, CA
5. KSCO, Santa Cruz, CA

Carol Rasco (Children/Budget-Monday)
1. KELO, Rapid City, SD
2. KSOO, Sioux Falls, SD
3. KPAY, Chico, CA
4. KWSN, Sioux Falls, SD
5. KQMS, Redding, CA

6. KASI, Ames, IA
7. KVEC, San Luis Obispo, Ca
8. KSCJ, Sioux City, IA
9. KOKZ, Waterloo, IA
10. KWLO, Waterloo, IA
11. KNEI, Waukon, IA

Alexis Herman (Children/Budget-Tuesday)
1. WAMO, Pittsburgh LIVE
2. WJLB, Detroit
3. WCHB, Detroit LIVE

CHILDREN'S DAY ROLLOUT

October 23, 1995

CABINET/SUB-CABINET TRAVEL AND MEDIA EVENTS

USDA	MI	Ypsilanti	Assistant Secretary Ellen Haas	School breakfast
		Detroit		Event at Project Hope Day Care Center w/ Mayor Archer & Rep. Bonior
HHS	SEE	LIST AT RIGHT	SAMSA Administrator Nelba Chavez	Media in NY, PA, WI, RI, DE, MA
HHS	SEE	LIST AT RIGHT	Assistant Secretary Mary Jo Bane	Media in NY, PA, WI, RI, DE, MA
HHS	SEE	LIST AT RIGHT	Commissioner Olivia Golden	Media in NY, PA, WI, RI, DE, MA
HHS	SEE	LIST AT RIGHT	HRSA Administrator Ciro Sumaya	Media in NY, PA, WI, RI, DE, MA
HHS	IA	Des Moines	CDC Director David Satcher	Speech to Domestic Violence Conference
HHS	NY	Harlem and Brooklyn	Deputy Secretary Walter Broadnax	Two visits to "at-risk" youth centers/Substance abuse and kids event
HHS	CA	Sacramento	Regional Director Grantland Johnson	Child development center visit with Rep. Matsui
HHS	NY	NYC	Regional Director Alison Greene	Cardinal Spellman Head Start Center tour with Phillipines First Lady Ramos
HUD	PA	Philadelphia	General Counsel Nelson Diaz	Head Start event w/children
	NJ	Camden		Children's event
	NY	Queens		October 24: Homeless Children event at shelter
HUD	PA	Harrisburg	Assistant Secretary Nicolas Retsinas	Visit to children's center or hospital
	MO	Kansas City		Visit to public housing/school event with mayor
HUD	NY	New York	Asst Secretary Marilynn A. Davis	Public Housing Daycare Center
HUD	PA	Pittsburgh	Acting Asst Secretary Kevin Marchman	Public Housing Daycare Ctr/Pittsurgh Post Gazette mtg
HUD	NY	Utica and Syracuse	Assistant Secretary Andrew Cuomo	Speech Re: Congressional impact on rural children
HUD	CA	Los Angeles	Acting Dep. Sec. Dwight Robinson	LA media event
HUD	PA	Pittsburgh	Assistant Secretary Michael Stegman	Event w/mayor, families and kids
DOT	IA	Des Moines	Administrator Gordon Linton	Speech at Rural, Public and Intercity Bus Conf. Re: kids impact
Education	TBD	TBD	Deputy Secretary Madeleine Kunin	Media
Education	MO	Kansas City	Asst Secretary Norma Cantu	Speech
Education	HI	Honolulu	Director Bill Modzeleski	Speech
Education	KY	Louisville	Asst Secretary Sharon Robinson	Radio/conference call
Education	NY	Port Chester	Sr Advisor Leo Kornfeld	Speech
EPA	CT	New Britain, Hartford, New Haven	Deputy Administrator Fred Hansen	Interview w/ New Britain Herald, Hartford Courant and New Haven Register
EPA	CA	Oakland	Regional Administrator Felicia Marcus	Event to be covered by LA Times
EPA	WA	Yakima	Regional Administrator Chuck Welch	WA State Dept. of Health children's event
EPA	NY	New York	Regional Administrator Jeanne Fox	Award presenter at Citizens Committee for NYC for help in reducing envir. pollutants
EPA	NE	Lincoln	Regional Administrator Dennis Grams	Meeting with Children's Groundwater Foundation
EPA	IN	TBD	Dep. Reg. Adm. Michelle Jordan	Children's event with Rep. Roemer
EPA	AR	Little Rock	Regional Administrator Jane Saginaw	Arkansas Democrat-Gazette editorial board meeting.
EPA	WA	Yakima	Regional Administrator Chuck Clark	10/25: Announce blood lead levels increase in children report w WA State Dept of Health
ONDCP	CO	Denver	Dep. Director Fred Garcia	Red Ribbon Proclamation with Gov. Romer
ONDCP	NY	Rochester	Assoc. Director Rose Ochi	Criminal Justice Planners Cnfrnc. on Treatment

CHILDREN'S DAY ROLLOUT

October 23, 1995

CABINET/SUB-CABINET TRAVEL AND MEDIA EVENTS

Agency	*State*	*City*	*Cabinet Member*	*Event Description*
Treasury	TBD	TBD	Secretary Robert Rubin	Press
JUSTICE	NA	National	Attorney General Janet Reno	Interview on Good Morning America w/kids focus
USDA	NJ	Newark	Secretary Dan Glickman	Community Center visit w/Torricelli and Payne
Labor	MA	Boston	Secretary Robert Reich	EITC event
HHS	SEE	LIST AT RIGHT	Secretary Donna Shalala	Newspaper and radio media to NY,PA, RI, WI, DE, MA
HUD	CA	San Diego	Secretary Henry Cisneros	Sherman elementary school
Education	TX	Houston	Secretary Richard Riley	Visit to a school
EPA	FL	Miami	Administrator Carol Browner	Speech about environmental health impact on children at FL Int. University
ONDCP	NH	Nashua	Director Lee Brown	Red Ribbon proclamation
DPC	AR	Little Rock	Chair Carol Rasco	Hospital visit
GSA	VA	Manassas	Administrator Roger Johnson	Opening of telecommuting center
SSA	D,RI,KS	TBD	Administrator Shirley Chater	Radio/Media interviews

12.

HOUSTON CHRONICLE, Oct. 24, 1995 p. 12
(Best Copy Available)

2nd warning on aid for schools

By RAB SALLEE
Houston Chronicle

For the second time in two months, U.S. Rep. Gene Green brought a Clinton administration official into a Houston classroom to warn against cuts the Republican-controlled Congress has proposed for direct federal aid to schools.

As an alternative to Department of Education funding, the GOP majority has called for block grants of federal tax money to states and localities, which would decide how to spend it within broad guidelines.

Green's guest, Secretary of Education Richard Riley, was asked whether it is wise to bring the highly politicized issue into a public elementary school and whether he trusts the ability of states and localities to set their own educational priorities.

"I don't think it is politicizing so much as making people aware what is happening," Riley said. "Our whole future is dependent on education, and we are balancing the budget by cutting education."

Riley said that "setting educational priorities is a very important national function." In recent administrations, he said, major educational bills have received bipartisan support.

Green, D-Houston, said poorer

Education chief faults GOP plan

schools, such as Houston Independent School District's Thomas Jefferson Elementary, 5060 Sharman, where the two appeared Monday, would suffer disproportionately under current GOP budget proposals.

He said the campus has already lost $102,000 — more than any other HISD school — as a result of the August rescission bill in which Congress canceled previously appropriated funds.

Principal Armandina Farias said 81 percent of Thomas Jefferson's 750 pupils are economically disadvantaged. Although most public school funding comes from local property taxes, the federal government provides so-called Title I aid based on the number of poor students.

It also provides funds to educate those with disabilities and support for the Goals 2000 program, which is aimed at raising national educational standards.

Riley said Clinton's seven-year plan for balancing the federal budget would increase federal education funding by $40 billion nationwide and $1.8 billion in Texas, while plans being considered by Congress would decrease those levels by $26 billion and $2 billion respectively.

Green said HISD alone would receive about $17 million less in Title I money next year than officials had hoped for and $8.6 million less than currently allotted.

Tony Rudy, press secretary for House Majority Whip Tom DeLay, R-Sugar Land, said such numbers make little sense in view of Republican plans to give federal tax money back to localities in the form of block grants.

"It is silly to suggest that a particular school is going to lose federal funds," he said, "because those decisions would be made locally by people from Houston and not by bureaucrats in Washington."

Since separate House and Senate budget proposals are in conference committee, he said, any such numbers would be at best "a guesstimate."

The House version proposes spending $8.5 billion nationally on education for the disadvantaged next year, he said.

Riley was greeted at the school by HISD Superintendent Rod Paige and district Trustee Paula Arnold.

Before speaking with reporters, Riley and Green read to pupils. They also congratulated 13-year-old Ariel Gonzales, a student at Lanier Middle School, for writing a newly published book for children, The Magic Pencil.

THE BLADE

BUSINESS

FRIDAY OCTOBER 20, 1995

Retraining projects work, Clinton aide says

BY GARY T. PAKULSKI
BLADE BUSINESS WRITER

At first glance, bustling Airport Highway, with its string of labor-hungry fast food spots and retail shops, would seem a poor place to bring the Clinton administration's battle to expand programs for laid-off workers.

But after visiting the area yesterday, Assistant Labor Secretary Timothy Barnicle, who oversees those programs, said he will head back to Washington with plenty of ammunition.

"We're lucky the unemployment rate is good, but if things are so good, how come we feel so bad?" Mr. Barnicle asked after listening to several people, including a middle-age single mother from Wauseon who is losing her job because her employer is relocating to the South.

The stories came pouring out during Mr. Barnicle's visit to a training center operated by the United Auto Workers union in the busy Spring Meadows area. He talked to people undergoing retraining.

Congress, he said, wants to slash funding for worker retraining programs next year from $7.8 billion to $5.7 billion; President Clinton wants to increase spending to $13.5 billion.

If the Republican proposals are adopted — the House has passed them — at least 430 fewer displaced workers in the Toledo area would get retraining, said another meeting participant, Marcia Serio, president of the nonprofit Toledo area Private Industry Council. That would represent a one-third reduction, she said.

Republican lawmakers say their proposals aren't meant to hurt laid-off workers but to reduce duplication and bureaucracy.

"There is a lot of waste in these programs," Joseph McGettigan, a spokesman for Sen. Spencer Abraham (R., Mich.), said in a telephone interview. Republicans want to consolidate programs from 15 to 3 and to turn administration over to the states. Mr. Abraham is a member of the Senate Labor Committee.

The Labor Department official said retraining programs are popular because workers continue to have trouble finding good-paying jobs that provide health benefits. The programs are needed, he added, to teach basic skills and fill a need for skilled trades workers.

Irene Martinez, 41, enrolled in the National Center for Tooling & Precision Components, Toledo, after getting her pink slip from AE Clevite Engine Parts, which is closing its Wauseon plant.

She has worked at the plant since she was in her early 20s and said she was devastated by news of the closing. With one grown child and another in elementary school, she knew she couldn't make ends meet on the pay for jobs open to unskilled workers. She will graduate soon from the tooling program and hopes to land a job as a tool and die apprentice.

See HEAD, Page 39 ▶

BLADE PHOTO BY [illegible]

Barnicle heard Toledoans' accounts.

Training

◀ Continued from Page 37

She is getting the training including tools and books, free of charge, thanks to the federal funds and other programs.

Still, retraining programs are no panacea.

A middle-age woman who worked more than 20 years for Champion Spark Plug recalled how she enrolled in a two-year clerk's training program after the company closed its Toledo plant. She was enthusiastic when she enrolled. "I love to cook," she said. And Champion picked up the training tab.

But now, a few years later, she has turned to the UAW training center, hoping to return to factory work.

"The money wasn't there," she said of her career as a clerk. "I live from paycheck to paycheck. I have no benefits."

A BALANCED BUDGET THAT PUTS CHILDREN FIRST VS. A BUDGET THAT HURTS CHILDREN

President Clinton's Balanced Budget Puts Children First. The President's balanced budget shows that we can balance the budget, lower the projected debt on our children, and still value our commitment to invest in their futures. The President's budget cuts overall discretionary spending by 22% in 2002 in non-priority areas, while still valuing our commitment to children by strengthening and protecting their health care, education, nutrition, drinking water, and the safety net for our poorest children.

The Republican Budget Hurts Children. Their budget seeks to pay for a large tax cut and balance the budget on the backs of our children. The GOP budget slashes important investments in our children, undermining our need to invest in a more productive America and our commitment to ensure that every child has a fair shot at the American dream.

- **Eliminates Medicaid coverage for as many as 4.4 million children in 2002.**
- **Denies 1 million women Healthy Start infant mortality services, affecting the births of 74,000 infants each year.**
- **Raises taxes on the families of more than 23 million children by an average of $415 in 2002.**
- **Denies Head Start to 180,000 children nationwide in 2002.**
- **Denies 1.1 million children basic and advanced skills in 1996.**
- **Denies more than 23 million students safer, drug free schools.**
- **Denies 50,000 young people the opportunity to serve their communities in 1996.**
- **Could force 32 million children to lose nutritional support in 2002.**
- **Leaves children exposed to hazardous waste** by slashing funds to clean 200 hazardous waste sites nationwide by 36% in 2002.
- **Denies 404,000 children child care assistance in 2002.**
- **Cuts child protection for abused and neglected children by 19% in 2002.**
- **Eliminates home energy assistance for 6 million children.**
- **Denies assistance to more than 16,000 homeless children.**
- **Forces the families of 3.4 million children to pay more rent.**

IMPACT OF REPUBLICAN BUDGET CUTS ON CHILDREN IN AMERICA

October 23, 1995

IMPACT OF HEALTH CARE CUTS ON CHILDREN IN AMERICA

Eliminates Medicaid coverage for as many as 4.4 million children nationwide in 2002. Currently, more than 20% of children rely on Medicaid for their basic health needs. Medicaid pays for immunizations, regular check-ups, and intensive care in case of emergencies for about 18 million children in America.

- **The Republican budget cuts federal Medicaid funding by $182 billion over seven years, reducing funding to states by 30% in 2002.**

- **Even if states could absorb half of the cuts by reducing services and provider payments, they would still have to eliminate coverage for 8.8 million people, including 4.4 million children in 2002, based on analysis by the Urban Institute.**

- **Among the children who could be denied coverage, many are disabled.** Medicaid often makes the difference between whether or not a disabled child lives at home with their parents. Medicaid provides for items such as wheelchairs, communication devices, therapy at home, respite care, and home modifications. Without these services, parents may be forced to give up their jobs or seek institutional placement for their children.

Jeopardizes immunizations for children. The Republican budget repeals the Vaccines for Children program, putting at risk at least $1.5 billion over seven years that would otherwise provide vaccinations for children.

Denies 1 million women Healthy Start infant mortality services, affecting the births of 74,000 infants each year. The Healthy Start project provides vital prenatal and health care services to women of childbearing age. The House calls for an excessive 52% cut in 1996.

IMPACT OF CUTS ON CHILDREN WITH DISABILITIES IN AMERICA

Denies as many as 755,000 disabled children SSI cash benefits in 2002. The House welfare bill eliminates federal Supplemental Security Income cash benefits for as many as 55% of the disabled children expected to receive SSI cash benefits in 2002 under current law. Federal SSI cash benefits for children with disabilities will be cut by as much as $21.7 billion over seven years, affecting nearly 1 million disabled children nationwide.

TAX INCREASE ON WORKING FAMILIES WITH CHILDREN IN AMERICA

More than 23 million children in America live in working families that will have their taxes raised by an average of $415 in 2002 under the Republican budget. The Senate Finance Committee has approved a $43 billion tax increase on working families by reducing the Earned Income Tax Credit. Families with two or more children in America will face an average tax increase of $483.

Impact of Education Cuts on Children in America

Denies Head Start to 180,000 children nationwide in 2002. The successful Head Start program helped 750,000 preschool children in 1995.

Denies 1.1 million children basic and advanced skills in 1996. The Republican budget cuts Title I by $1.1 billion -- a 17% cut in 1996 -- denying Title I funding for 1.1 million students in our poorest communities nationwide.

Cuts Safe and Drug Free Schools by 55%, denying more than 23 million students services that keep drugs and violence away from children, their schools, and their communities. The Republican budget walks away from the Safe and Drug Free School state grants program, the only federal program solely dedicated to combating alcohol and drug abuse, and violent behavior in our nation's schools.

Eliminates Goals 2000, denying improved teaching and learning for as many as 5.1 million school children in America in 1996. Under the Republican cuts, 12 million children would be denied improved education by 2002, compared to the President's balanced budget.

Eliminates the AmeriCorps National Service program, denying 50,000 young people the opportunity to serve their communities in 1996.

Eliminates summer job opportunities for nearly 4 million youths over the next seven years. The Republican cuts will prevent millions of youths from participating in meaningful summer job experiences that help prepare them to be active contributors in the workforce and the community. The House plan completely eliminates this program, cutting approximately 600,000 job opportunities in 1996 and nearly 4 million summer jobs by 2002.

Impact of Nutrition Cuts on Children in America

Cuts nutrition assistance for 14 million children in America in 2002. The House Republican budget cuts foods stamp benefits for families with children by $28.1 billion over seven years and by 24.5% in 2002.

Could force 32 million children to lose nutritional support or suffer from diminished food assistance in 2002. The House Republican budget block grants funding for the school lunch and WIC program. Nationally, their budget reduces funding for child nutrition programs by more than $10 billion over seven years and 11% in 2002, compared with current law.

IMPACT OF PUBLIC HEALTH AND ENVIRONMENTAL CUTS ON CHILDREN IN AMERICA

Leaves children exposed to hazardous waste. The Republican budget cuts threaten EPA's efforts to protect the health of children living near more than 200 hazardous waste sites nationwide. Spending on toxic waste cleanups will be reduced by 36% in 1996, $560 million below the President's balanced budget in 1996.

- **Nationally, *five million children* under the age of four live within four miles of a Superfund hazardous waste site.**

Pollutes the air that children living near oil refineries breathe. These refineries emit more than 78,000 tons of toxic air pollution each year, putting children in the surrounding communities at risk of serious health problems, including cancer and respiratory illnesses such as asthma. The Republican budget halts the President's effort to protect the health and safety of children living near these refineries.

Jeopardizes the water that children drink. Republicans are cutting low-interest loans to cities and towns for drinking water treatment facilities by at least $700 million in 1996. This cut will take away the funds needed by states to upgrade facilities to ensure that local drinking water has been treated to eliminate contaminants.

Reduces new funding to keep water clean by more than 33% compared with the President's balanced budget. The Republican cuts will eliminate protections that keep sewage away from waters where children live and play.

IMPACT OF CUTS ON SAFETY NET FOR CHILDREN IN AMERICA

Denies 404,000 children child care assistance in 2002. The House welfare bill block grants and cuts federal child care funding for low-income children by $2.8 billion over seven years.

Cuts foster care and adoption for vulnerable children by $6.3 billion over seven years compared with current law. The House welfare bill cuts child protection for abused and neglected children by 19% in 2002.

Eliminates cash assistance for 77,000 children in America simply because they were born to unmarried mothers under 18, when the House welfare bill is fully implemented in 2005.

Cuts assistance for 3.3 million children in America simply because their paternity has not been established, when the House welfare bill is fully implemented in 2005.

IMPACT OF ENERGY CUTS ON CHILDREN IN AMERICA

Eliminates home energy assistance for about 6 million children in America. The House Republican budget completely eliminates this $1 billion program that helps low-income families with their home heating and cooling bills, leaving families with the tough choice of staying warm in the winter or having enough money to eat.

Denies about 65,000 children in America protection from bad weather conditions. The Republican budget cuts weatherization assistance for families' homes by $118 million in 1996. Lower energy bills allow families to spend more money on basic needs.

IMPACT OF HOUSING CUTS ON CHILDREN IN AMERICA

Denies assistance to more than 16,000 homeless children. The Republican budget cuts homeless assistance by 40% in 1996, cutting funding for the homeless by $444 million in 1996.

Forces the families of 3.4 million children to pay more rent. The Republican budget raises rents by an average of $200 a year for the 1.4 million low-income families with children assisted by Section 8. The median income of these families is only $6,800.

Denies families of 74,742 children the opportunity to move from poor living conditions to adequate privately owned apartments. The Republican budget eliminates funding for new Section 8 certificates and vouchers, denying rental assistance to low-income families and children who wish to live in privately-owned housing.

Eliminates protection for 1 million children nationwide from drugs and drug-related crimes in public housing. The Republican budget zeroes-out the Public Housing Drug Elimination program which protects more than 1 million children living in public housing nationwide from drugs and drug-related crimes. The Republican budget eliminates $290 million for public housing tenant patrols, local law enforcement activities, security personnel, and physical improvements to improve security.

184,000 children will be forced to remain in poor and unsafe housing conditions. The Republican budget cuts public housing modernization nationwide by $350 million, severely hindering efforts by housing agencies to rehabilitate run down public housing projects and provide much needed security and anti-crime programs.

213,000 children will have to go without basic housing needs. The Republican budget cuts public housing operating subsidies nationwide by $400 million -- a cut of 14% in 1996 -- forcing local agencies to neglect basic housing needs, such as fixing leaking ceilings and broken windows and providing security and social services.

Ambulatory Pediatric Association
American Academy of Pediatrics
American Board of Pediatrics
American Pediatric Society
American Pediatric Surgical Association
Association for the Care of Children's Health
Association of Medical School Pediatric Department Chairmen
Association of Pediatric Program Directors
National Association of Children's Hospitals and Related Institutions
National Association of Pediatric Nurse Associates and Practitioners
Society for Adolescent Medicine
Society for Pediatric Research
Society of Pediatric Nurses

As Congress debates proposals to restructure Medicaid. it is essential to consider the enormous importance of the program to the health of our nation's children and adolescents.

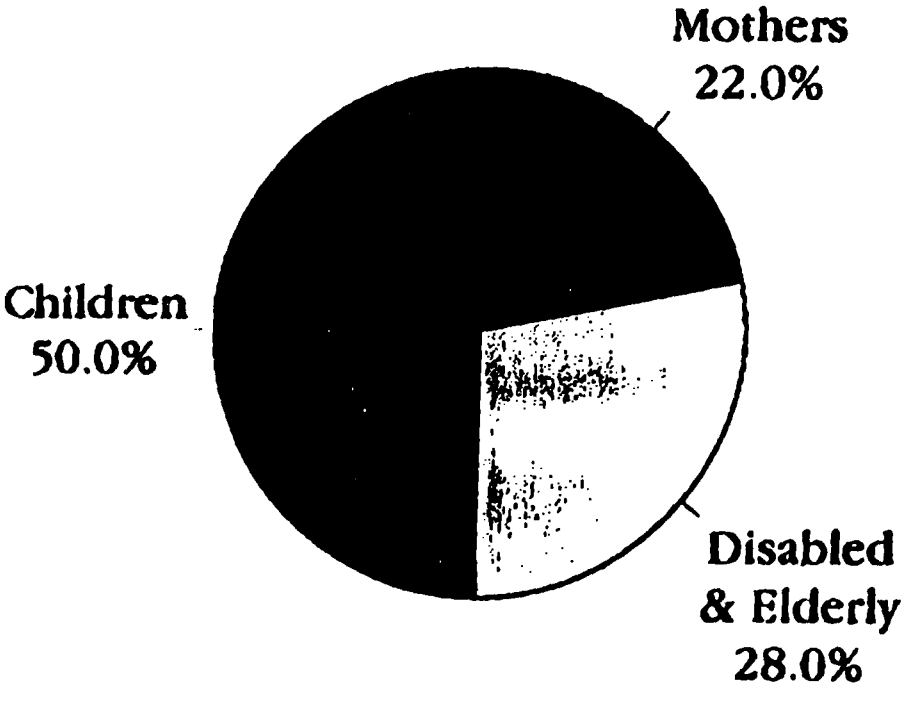
According to the annual American Academy of Pediatrics' analysis of HCFA's 2082 data set, in federal fiscal year 1993, Medicaid financed medical care for nearly one-fourth of all US children under the age of 21, more than one-third of children under age 6, and half of all infants. Medicaid eligibility expansions have helped offset the accelerating erosion of employer-based health insurance coverage of children which has occurred since the early 1980's. Absent Medicaid, nearly 40% of all US children would be uninsured.

According to the Census Bureau's 1994 Current Population Survey data set, nearly 18 million children were Medicaid eligible in 1993. In a very real sense, Medicaid is a children's program since 54% of all beneficiaries are under age 21. However, because children's health care costs are so modest in comparison to adults, the elderly, and eligible nursing home beneficiaries, children's costs represent just 23% of total Medicaid spending.

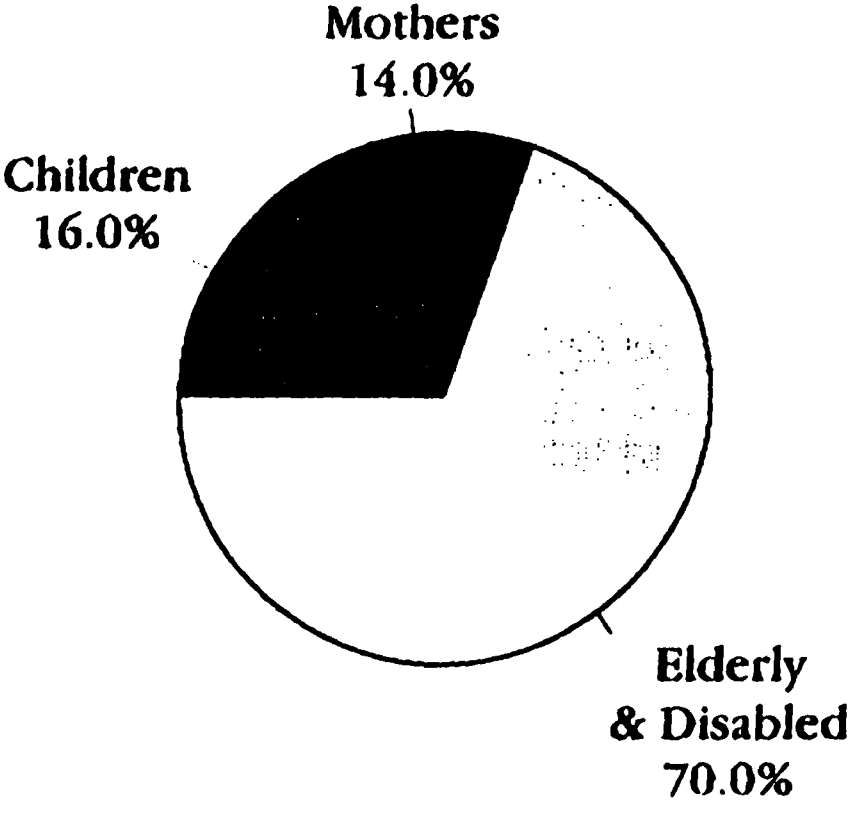
As health care providers who specialize in children's care we know from first hand experience the critical difference Medicaid has made in the health and access to care of children who otherwise would have been uninsured. We also are cognizant of Medicaid's weaknesses. For over 15 years we have conducted research to improve the efficacy of the program and have advocated on behalf of progressive reforms. We remain committed to the goal of Medicaid's improvement.

This year Congress is expected to act on proposals to restructure Medicaid in order to control federal spending and increase state flexibility in the use of federal funds. We believe these goals can be accomplished without sacrificing the quality of the Medicaid program for children and adolescents if the following core principles are honored: (1) low-income children and adolescents must maintain guaranteed Medicaid coverage; (2) the medically necessary care assured by Medicaid through its EPSDT component must not be compromised; and (3) children and adolescents must retain access to appropriately trained and certified providers of pediatric care.

Medicaid Recipients



Medicaid Spending



National Association of
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NACHRI

MEDICAID BUDGET CUTS COULD COST CHILDREN'S HOSPITALS THE EQUIVALENT OF 2 YEARS OF CURRENT ANNUAL MEDICAID REVENUE

The average children's hospital could lose the equivalent of about 2 years worth of current annual Medicaid revenues under the Senate Budget Committee's proposal to cut projected growth in federal Medicaid spending by $175 billion over seven years, according to preliminary analysis by the National Association of Children's Hospitals and Related Institutions (NACHRI).

Children's hospitals serve as a major source of excellence in pediatric care and medical advancements for all of the nation's children. They also are major providers of care to children assisted by Medicaid, which pays for the health care of economically and medically vulnerable children, including children of low income working families.

Since children's hospitals on average devote nearly half of their annual care to children assisted by Medicaid, the loss of the equivalent of two years of current Medicaid revenues over seven years would have enormous implications for their ability to serve all of the children of their communities. The impact of the proposed budget savings would be even greater under the House Budget Committee's proposal to save $184 billion in federal Medicaid spending.

Depending on the hospital and the state, the impact on an individual institution could be greater still. Some of the hospitals with much higher than average volumes of care to Medicaid patients are located in states with much higher than average federal Medicaid matching dollars. The combined impact means that such children's hospitals -- particularly those located in southern states -- will be among the most affected in the country.

The preliminary analysis is based on FY 1993 data, adjusted for inflation, for the majority of free-standing acute care, specialty, and rehabilitation children's hospitals in the United States.

For more information, call Peters D. Willson, NACHRI, 703-684-1355.
May 17, 1995.

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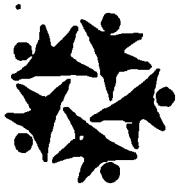

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Testimony of
Mr. J. Dennis Sexton, President and CEO
All Children's Hospital, St. Petersburg, FL
Chairman, Board of Trustees, National Association of Children's Hospitals
Before the House Subcommittee on Health and the Environment
United States House of Representatives, Washington, D.C.
August 1, 1995

I want to thank you, Mr. Chairman, and the rest of the members of the subcommittee for giving me the opportunity to testify before you today.

Mr. Chairman, as President and Chief Executive Officer of All Children's Hospital in St. Petersburg, Florida, and Chairman of the Board of Trustees for the National Association of Children's Hospitals (N.A.C.H.), I am devoted to the health care needs of children.

Today, I am here to talk about being accountable and responsible for the health of our nation's children. Those of us who care about the mission of children's hospitals and the children we serve, strongly appreciate the need for efforts to control federal spending and to increase state flexibility in administering the Medicaid program. But we also believe such efforts should be accompanied by clear and consistent national accountability standards for children's health coverage, their access to medically necessary care, and their access to children's health care specialists.

Children's hospitals are regional and national centers of pediatric care. All Children's Hospital has 168 beds, 1800 employees, and 300 physicians to meet the complex health care problems of children. Currently, 55 percent of our patients are from outside the county. Furthermore, we have treated children from all 50 states and 36 nations. As you can tell from these figures, we are by no means simply a local hospital. We are a regional hospital that serves a large population of families and children who come long distances to us because of their extraordinary needs.

All Children's Hospital is able to stay ahead of the curve in providing care ever more cost effectively because we focus first on the needs of children and their families. For instance, All Children's Hospital recently opened an outpatient clinic in New Port Richey, north of St. Petersburg. By giving families access to specialized care for their children in our outpatient clinic closer to their homes, we enable them to avoid the personal and financial expense of traveling longer distances for inpatient care at our regional tertiary care facilities, except when it is truly necessary. It is more cost effective for the families, the hospital and the insurer.

Our state has also been ahead of the curve. For years, the State of Florida has had standards to protect access to appropriate care for children with special needs and children who rely on Medicaid. Florida has been a leader in setting accountability standards for how we serve children. I am proud that All Children's Hospital consistently meets those standards.

Even though the population of children we see is diverse in every respect, one common characteristic of those children is that they are sick -- often, very sick. In many cases, our physicians are the last hope to help improve the condition of critically ill children. When our physicians first see a child, the child is usually in our intensive care ward. Many will remain there for weeks, sometimes months.

Another common characteristic of the families and children we serve is the source of paying for their care. Medicaid is increasingly essential for helping families to meet the health care needs of their children. Nationally, Medicaid is responsible for the health care coverage of one in every four children, one in every three infants, and nearly half of the inpatient care provided by a children's hospital on average. Sixty percent of the inpatient care provided by our own hospital is covered by Medicaid.

This certainly does not mean that all of the children assisted by Medicaid whom we serve can be classified as "welfare" cases. In Florida, over fifty percent of children receiving Medicaid are from families with at least one working adult. For these families, Medicaid is a safety net, one that has enabled families to work instead of relying on welfare for their children's health care coverage, or facing financial catastrophe in the event of a seriously ill or injured child..

Because Medicaid pays for such a large percentage of care in children's hospitals, all families of children served by our hospital benefit directly or indirectly from the program. Without Medicaid, the number of privately insured children alone would not be large enough to

sustain the regional pediatric specialized providers, equipment and services required by all of the sick children we serve. Without Medicaid, our hospitals could not sustain the educational programs that train many of our country's general pediatricians and most of its pediatric subspecialists.

For children's hospitals, cutting projected growth in Medicaid spending could have a significant impact on children's hospitals. N.A.C.H. estimates that Medicaid savings called for in the budget resolution could translate into the equivalent of about two years of a children's hospital's current annual Medicaid income. The savings required could be the equivalent of the costs of employing 400 people full-time or providing care to 800 inpatient children during a year. Actually, the loss of Medicaid could be even greater because N.A.C.H.'s estimates assume spending will be reduced in proportion to the current share of national Medicaid spending attributed to children's hospitals. However, children and the providers devoted to their care are likely to account for a greater share of Medicaid spending, since Medicaid managed care is largely untested for the disabled and nursing home care for the elderly.

These estimates are also conservative because they assume that disproportionate share hospital (DSH) payments to qualifying children's hospitals will continue. DSH payments represent a badly needed financial safety net for children's hospitals. Without any disproportionate share program, our Medicaid reimbursements would cover on average 16% less of our costs. We believe that it is essential that some amount of DSH payments continue to be targeted towards those hospitals with a significant percentage of Medicaid and uncompensated

patients, however the Medicaid program may be restructured.

As the Committee considers ways to restructure Medicaid and to reduce the growth of the program, we ask that children's health coverage remain a top priority. There is bipartisan support for doing so. For example, Senator Kit Bond (R-MO) along with two Republican and two Democratic colleagues, sponsored an amendment to the Budget Resolution, which directs Congress to make children's health a priority in restructuring Medicaid. The Bond Amendment was unanimously endorsed by the Senate Budget Committee, and included in the final conference agreement. The amendment reminds us that we must be careful about how the Medicaid program is restructured. The goals of deficit reduction and increased state flexibility must be achieved without increasing the number of uninsured children or causing the quality of care for children assisted by Medicaid to suffer.

I would like to offer four recommendations for making sure a restructured Medicaid program is accountable for children's health care.

First, accountability standards for Medicaid should ensure that current coverage for low-income children will not decline. Children are the fastest-growing segment of the uninsured population. Currently, Medicaid is the only program standing in the way of millions more becoming uninsured. In fact, without Medicaid, 40 percent of all children would be uninsured. The leadership of every major national organization of pediatric providers -- including pediatricians, nurses, researchers, educators, and hospitals -- and over 150 maternal and child

health organizations join us in requesting that there be minimum eligibility standards to protect children from loss of health coverage under Medicaid.

Second, there should be accountability standards for demonstrating that children assisted by Medicaid will have access to medically necessary care. Our Medicaid costs in the State of Florida average under $1,000 per child per year, compared to over $5,000 per elderly adult. In the business world, we refer to this as a very wise investment with a high rate of return. Medically necessary care is particularly critical for children with unique health conditions and needs. For medical, ethical, and financial reasons, Congress voted to assure children have medically necessary care under Medicaid in 1989. States should remain accountable for that standard. We should not return to the days when a state could impose arbitrary limits in the hospitalization of seriously ill children.

Third, accountability standards should ensure that children have access to pediatric specialty care. Children's conditions are often much more intense in their duration because of the body's defense systems not being fully developed. When a child becomes ill, what appears to be a relatively harmless medical problem can become very critical in a short time. We know that it makes no more sense to send a seriously ill child to an adult specialist than it makes sense to send a seriously ill grandparent to a pediatrician. States should be accountable for children's access to pediatric subspecialty care, just as we are currently trying to do in Florida. But we need national standards, not just state standards, because children are so much more likely to have to cross state lines to get the pediatric specialty care they need.

Fourth, children with chronic health conditions should receive special consideration. Children's hospitals have recommended that children with chronic health conditions need not be enrolled in Medicaid managed care unless their families choose such a plan or unless it is under a specific demonstration project for managed care for this population. States have very little experience with these children in mandatory managed care. Providing this exception for at least some period of time would allow states to develop guidelines for care, system performance standards and methods of capitation and/or risk adjustment specific to this population. Because the numbers of these children are so small, their needs will be lost without such special attention. because they are so vulnerable, the consequences of such loss can be very grave.

Mr. Chairman, I am proud to have devoted my career to All Children's Hospital and honored to testify on behalf of the nation's children's hospitals. In closing, I would like to re-emphasize one critical message from my testimony: While restructuring Medicaid, we need to produce a system that is accountable for children's eligibility for health care coverage as well as ensuring that low-income children receive medically necessary care and have access to pediatric specialists. Thank you.

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.....FOR RELEASE 1 p.m. JULY 31
Contact: Ira Allen

PEDIATRICIANS, CHILDREN'S HOSPITALS WARN AGAINST MEDICAID SAVINGS WITHOUT STANDARDS FOR CHILDREN'S CARE

New Data Show Impact on Children's Services

WASHINGTON – Without national standards for children's care, proposed restructuring of the federal Medicaid program could force states to reduce access dramatically to health care for millions of children of low income and working families, the nation's leading pediatric providers said today.

Leaders of the American Academy of Pediatrics (AAP) and National Association of Children's Hospitals (N.A.C.H.) urged Congress today to hold states accountable to minimum national standards for children's coverage, access to medically necessary care and access to appropriately trained and certified providers of pediatric care.

"Congress needs to make sure that the same kids who have coverage now remain covered," said Lawrence A. McAndrews, president and CEO of N.A.C.H. "Congress must not let states place arbitrary limits on the services sick children need. And they need to make sure that children can get specialized pediatric care when they need it."

Congress is considering block grant proposals that would eliminate all national Medicaid standards in order to give states the flexibility to absorb reductions in future Medicaid spending growth from 10 percent to 4 percent by 1998.

-more-

Medicaid
2-2-2

"Congress' projected Medicaid savings are dangerously high, especially if attempted without guidelines," said George D. Comerci, M.D., president of AAP, which represents 48,000 pediatricians across the country. "Cuts in the growth of funding could force states to make major changes in their Medicaid programs, jeopardizing health coverage for today's almost 18 million child beneficiaries as well as the more than four million additional Medicaid children by 2002."

Medicaid is a joint federal/state program of financing health care for low income, vulnerable Americans, more than half of whom are children. Medicaid pays for the health care of one in every four children, the majority of whom live in working families. It also pays for nearly half of the care of inpatients of children's hospitals.

In order for states to absorb $182 billion in savings in federal Medicaid spending over the next seven years, children's services would likely be cut significantly, said McAndrews. For example, data released today shows the average children's hospital itself could anticipate absorbing cuts that could equal the current cost of nearly one-fourth of their work force, or almost 400 full-time employees per hospital. It also would be the equivalent of the cost for an average children's hospital of treating more than 800 inpatients per year -- almost 10 percent of the inpatients a hospital serves.

"At a time when children are losing private health care coverage faster than any other age group, we should be taking strong steps as a nation to ensure that the public health insurance safety net remains intact," Comerci said. "The last thing we should be doing is imposing major new financial constraints on Medicaid without safeguards for children. Even with Medicaid, more than 15 percent of all children are uninsured. If there were no Medicaid, nearly 40 percent of children would be uninsured."

"Millions of children might not get the care they need if Congress abandons the minimum eligibility and access standards that are one of the essential aspects of the Medicaid program today, " McAndrews warned.

Medicaid

3-3-3

"It makes little sense to return to the days when Alabama would provide Medicaid to children only if their family's income was $2,000 a year or less; or when Oregon would arbitrarily limit hospitalization of sick children on Medicaid to 18 days a year; or when Alaska and Wyoming did not cover prescription drugs for poor children," he said. "Medicaid affects the health and economic productivity of one-third of the next generation of America's workforce. Children are the nation's future, and Medicaid is an investment in that future."

"Children's health care should not be decided on a state-by-state basis without some national standards," said Peter Holbrook, M.D., a critical care specialist and interim chief medical officer at Children's National Medical Center in Washington, DC. "Children are much more dependent on being able to cross state lines in order to get access to highly specialized pediatric services that often are available only on a very limited basis in a region. Certainly that is the experience of our hospital, which provides the majority of its care to children from outside the District of Columbia. Without national standards, access to services like those at Children's National Medical Center could be jeopardized for all children."

The children's hospitals association represents more than 100 members devoted to the health care of their communities' children, regardless of medical or economic need. Free-standing children's hospitals represent only 1 percent of the nation's hospitals but treat more than 12 percent of hospitalized children and the majority of the children with many chronic or congenital conditions. They also train one quarter of the nation's pediatricians. Overall, half of the nation's pediatricians are trained in freestanding children's hospitals or pediatric units of teaching hospitals.

The federal portion of Medicaid program expenditures is $90 billion annually. A total of $182 billion in federal Medicaid savings over seven years is the equivalent of two years worth of current federal Medicaid spending. Similarly, N.A.C.H. estimates that over the next seven years, the average children's hospital would have to live with less Medicaid reimbursement in amounts equal almost two years worth of their current net Medicaid revenues -- more than $100 million.

Medicaid
~~4-4-4~~

To understand the magnitude of these savings:

- **St. Louis Children's Hospital** translates them into the equivalent of **$11** million annually to the hospital, which devotes almost 50 percent of its care to children assisted by Medicaid. That volume of savings is the equivalent of the direct cost of the hospital's entire outpatient care services, including its emergency room, pediatric transport and its off-site urgent care center for Medicaid patients. It is the equivalent of the direct annual cost of the hospital's operating room, social services, dialysis and pediatric intensive care.

- **Children's Hospital of Alabama** receives about **$63** million in public sector funding. A **$15** million decrease would likely require reduction in services, beginning with non-life-threatening problems such as elective surgery or dental care. A **$30** million reduction could result in a drastic cutback in services or change the mission of the hospital, says CEO Jim Dearth, M.D.

- **Children's Memorial Hospital** in Chicago projects an annual loss of **$11** million in federal dollars, the amount equivalent to running its residency program for nearly three years, about the amount it costs to operate its surgery and recovery rooms for one year or about the amount it costs to operate laboratories for one year.

- **La Rabida Children's Hospital and Research Center** in Chicago, where 85 percent of the patients are on Medicaid, estimates that the proposed growth cap represents the cost of all inpatient nursing services for one year; or all ancillary services, including prescription drugs, laboratories and radiology; rehabilitation, social work, psychology and respiratory care services.

Medicaid

5-5-5

The extent of Medicaid savings children's hospitals could be required to achieve over seven years could not be made up by charitable donations. For example, it is the equivalent of 30 annual Children's Miracle Network telethons. The 1995 telethon raised $133 million in charitable gifts for children's hospitals nationwide – an enormous accomplishment for voluntary giving but only a fraction of the estimated $4 billion in combined federal and state Medicaid savings that could be expected from children's hospitals.

"Most people don't understand that Medicaid does not just benefit the poor," McAndrews said. "It also supports working families. And by enabling a children's hospital to serve a large enough number of children, regardless of families' income, Medicaid makes it possible for the hospital to have the concentration of medical expertise that is achievable only with a high volume of children's medical cases. That ensures high-level medical care is available even for the child of a prosperous family."

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National Association of
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NACHRI

CHILDREN HAVE UNIQUE HEALTH CARE NEEDS

April 1995

Children are not small adults. They have different health care needs, and they stand in a different demographic and economic position in today's fast changing health care market.

Who Are America's Children?

Children are economically vulnerable. One in four children under age 18 lives in a family with income less than the federal poverty standard. One in three pre-school age children is poor.

Children are medically vulnerable. One in five children lives in an urban or rural area that is medically underserved, lacking providers who can meet the community's need.

Children's insurance is vulnerable. More than one in three children is uninsured or relies on Medicaid, a federal/state welfare program that is becoming financially unstable in many states. Children often are the first to experience the loss of private health coverage, because dependent coverage is often the first to be dropped by employers and employees pressed by the rising costs of health insurance.

Children with special health care needs are vulnerable. Only six percent of children have a major illness or injury, or congenital condition that limits their ability to engage in activities of daily living, such as school or play. This makes them especially vulnerable to pre-existing condition exclusions or other limits on private health care coverage.

Children's health care is a low cost investment. Because most children are healthy, their health care needs are comparatively inexpensive. For example, in 1993, Medicaid spent, on average, $1,012 per child under 21, compared to $4,124 per adult age 21 to 64, and $8,220 per elderly adult age 65 and above.

How Do Children's Health Care Needs Differ From Adults' Needs?

Different Illnesses Compared to adults, children are more likely to experience an acute episode of illness and are less likely to need care for a chronic condition. In addition, the care they will need for both acute and chronic illness will vary due to their developmental needs and size. For example, the leading cause of death for children are injury and infant mortality compared to cardiac diseases for adults.

Developmental Needs Children have developmental needs that vary according to age. Their organ systems, bones, and immunologic systems all go through different

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Children's Hospitals: Regional Centers For Children With Special Needs

Children's hospitals are also regional referral centers, meeting the specialized care needs of children from the most distant rural areas as well as the closest inner city neighborhoods. On average, children's hospitals devote three-quarters of their care to children with one or more congenital or chronic conditions. Free-standing children's hospitals represent only one percent of all hospitals, but they care for one-quarter of all hospitalized children with chronic or congenital conditions and the majority of children with special health care needs. Children's hospitals and the pediatric departments of major teaching hospitals together represent only six percent of hospitals, but they care for the vast majority of children with specialized care needs.

- Children's hospitals on average devote more than 68% of their inpatient days and 76% of their inpatient charges to children with at least one chronic or congenital condition.

- Children's hospitals on average devote 66% of their care to children under age six who often require the most intensive nursing and medical care. They devote nearly a quarter of their care to newborns.

- Children's hospitals on average devote about 30% of their beds to intensive care units, compared to only 12% in general hospitals.

- Children's hospitals on average devote over two-fifths of their patient care to "catastrophic cases" – children whose inpatient care results in charges greater than $50,000. That represents proportionately 2.5 times the catastrophic cases that a pediatric program of a general hospital sees.

Children's Hospitals: Major Providers Of Primary And Preventive Care

Although they are highly specialized providers of inpatient care for children, children's hospitals also have been in the vanguard of seeking to reduce hospitalization of children through ambulatory care and promoting primary and preventive care. In 1993, children's hospitals delivered care in an average of 110,000 primary and specialty care visits in ambulatory clinics sponsored by the hospital, 39,000 emergency department visits, and 4,900 outpatient surgeries per hospital.

Children's Hospitals: Medical Education Centers For Pediatric Providers

Children's hospitals represent one percent of all hospitals, but they train over one-quarter of the nation's pediatricians. Together with pediatric departments of major teaching hospitals they train the majority of pediatricians and virtually all pediatric subspecialists.

Children's Hospitals: Centers Of Child Health Research

More than one in three children's hospitals is the formal sponsor of research on the cause, prevention, and treatment of illness in children. Many more participate in research through universities with which they are affiliated. For example, a children's hospital was the first to identify AIDS in children; a children's hospital was the first to culture the polio and measles viruses. Also, the National Institutes of Health devotes more than four percent of its research funding to research involving children's hospitals and pediatric departments of major teaching hospitals.

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CHILDREN AND HEALTH CARE SPENDING

April 1995

Because the overwhelming majority of children are healthy and require mainly primary and preventive care, they account for only a small percentage of national health care spending. Children represent 28% of the population but only account for 14% of individual health care spending. In 1987, children accounted for $49.8 billion of health care spending. This included $24 billion for hospital services, $13 billion for physician and ambulatory services, $8 billion for dental services, and $2 billion for prescription drugs. Consider the following data reported in articles published by the David and Lucile Packard Foundation's Center for the Future of Children, in a report entitled "U.S. Health For Children."

- The average health care expenditure for a child under age 18 was $737 in 1987.
- The average health care expenditure for an adult was $1,826, almost 2.5 times greater than for a child in 1987.
- The average health care expenditure for an individual over age 65 was $4,276, almost six times the amount for a child in 1987.
- While the above data from 1987 remain the most recent national data available regarding children and health care spending, more recent data on Medicaid for adults and children suggest that the gap in spending remains substantial. For example, in FY 1993, Medicaid spent, on average, $1,012 per child under 21, compared to $4,124 per adult age 21 to 64, and $8,220 per adult age 65 and above.*

Only a very small proportion of children have serious health conditions requiring specialized care. Consequently, only a small proportion of children account for the majority of children's health care expenditures.

- One percent of children accounted for 37% of children's health care expenditures in 1987. The average annual health care expenditures for the most costly 1% of children was $27,502 in 1987.
- Five percent of children under age 18 accounted for 59% of children's health care expenditures. The average annual health care expenditures for the most costly 5% of children averaged $8,641 and only $316 for the least costly 95% of children in 1987.

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- Infants represented less than six percent of all children but their health care expenditures accounted for almost 25% of children's health care expenditures in 1987. The average annual health care expenditures for infants in their first year of life were $3,271 per infant.

Because children are constantly developing, they are dependent on different types of health care services than adults and at different stages in their development.

- Dental care accounted for almost 30% of the health care expenditures for children age 6-18, compared to less than 3% of health care expenditures for individuals over age 65 in 1987.

- Inpatient hospitalization and physician services accounted for almost 70% of health care expenditures for children age 0-2 compared to 25% of health care expenditures for children age 3-12 in 1987.

- Ambulatory care accounted for a larger proportion of health care expenditures for children over age 3. For example, ambulatory care accounted for 36% of health care expenditures for children age 3-12, but only 18% of health care expenditures for children age 0-2 in 1987.

Because they are the poorest segment of the population, children rely substantially on public funding of health care. But because they are healthy, children still account for only a small part of public health spending.

- Young children are especially reliant on public funding. Medicaid and other public funds accounted for 45% of health care expenditures for children age 0-2 in 1987.

- Children under 18 represented almost 50% of recipients of Medicaid assistance, but only 16% of all Medicaid spending in 1987.

- Total public expenditures on health care for adults were almost 10 times greater than for children – $117 billion compared to $12 billion in 1987.

* ***"Federal Fiscal Year 1993," U.S. Health Care Financing Administration State Data Tables, September 1993.***

National Association of
Children's Hospitals
and Related Institutions

NACHRI

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

April 1995

Who Are Children with Special Health Care Needs?

The health care needs of all children are special and distinct from those of adults. But the term "children with special health care needs" refers to a group of children who require specialized health care, habilitation, and rehabilitation services. Frequently, children with special health care needs (CSHCN) are limited -- or have potential limitations -- in their ability to function because of one or more chronic or congenital illnesses, a major trauma, a developmental disability, or exposure to a serious or life-threatening condition.

One category of children with special health care needs includes those with a chronic or congenital condition due to an illness, injury, or birth defect who will require ongoing services. Between 10% and 30% of children in the U.S. have one or more chronic health impairments. It is important to realize that the large majority of these conditions, such as respiratory allergies and ear infections, have little impact on a child's daily activities or utilization of health services. However, about 10% of children with chronic illnesses -- about 2 million children or perhaps 2% of all U.S. children -- have severe conditions (such as cystic fibrosis, congenital heart disease, or sickle cell anemia) that require ongoing and extensive health services. *

What Are Their Health Care Needs?

Medical advances over the past two decades have increased the survival rates of children with severe chronic illnesses -- with at least 90% of these children surviving to young adulthood. However, even with these increased survival rates, children with special health care needs require much greater than average use of hospital and ambulatory care than children without a chronic illness. It is estimated that approximately 2% of children with severe illnesses use approximately 25% of the child health dollar, representing in part the higher-than-average utilization of inpatient hospital care by this group of children.

Children with chronic and ability limiting conditions require a great deal of medical and nonmedical services. These children typically make more physician visits, require more hospitalizations, and are more likely to have multiple sources of health care. Services for this population often include complex ongoing care involving: multiple providers, medications, medical supplies, and specialized equipment. These services are most effective when delivered in a coordinated fashion in a variety of settings -- including the home -- and involving the family. Treatment for a high-cost childhood chronic illness usually involves a series of outpatient treatments and hospitalizations that occur over many years, together with routine daily home-care or self-care procedures that are family-centered. The U.S. Office of Technology Assistance (OTA) estimates that 20,000 to 30,000 children with significant technology dependence may require home care.

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What Is the Role of Children's Hospitals in Caring for Children with Special Health Care Needs?

Although children with chronic or congenital conditions represent only a small fraction of all children,children's hospitals devote 56% of inpatient admissions, 68% of inpatient days, and 76% of inpatient dollars to this population. Other important points regarding the care these children receive include the following:

Children's Hospitals and General Hospitals with Pediatric Residencies

- Acute care children's hospitals and general hospitals with pediatric residencies, which represent 1% and 5% of all hospitals respectively, provide care to 70% to 80% of all childre in the U.S. with severe chronic or congenital conditions. The conditions treated most frequently are: malignant neoplasms, cardiovascular anomalies, musculoskeletal deformities, sickle cell disease, spina bifida, and cerebral palsy.

- Acute care children's hospitals and general hospitals with pediatric residencies devote 57% and 38%, respectively, of their inpatient admissions to children with one or more chronic or congenital conditions.

- Acute care children's hospitals and general hospitals with pediatric residences provide approximately 4 to 4.5 times more inpatient admissions to children with one or more chronic or congenital conditions (excluding asthma) -- compared to general hospitals without a pediatric residency program.

Specialty Children's Hospitals

Specialty children's hospitals are those institutions that specialize in serving children with special needs, including those requiring subacute, habilitative, and rehabilitative care. Often children with severe chronic or congenital conditions are referred by acute care children's hospitals to specialty hospitals because of the unique programs and services offered to children and their families by these facilities. Specialty children's hospitals play a critical role as:

- **subacute transitional care facilities** -- bridging the gap for children who no longer need the intensive treatment of an acute care children's hospital, but who are not yet well enough to go home to their families;

- **rehabilitative facilities** -- meeting the physical and psychosocial needs of children for recovery and teaching families the complex details of caring for children and adolescents in preparation for their return to the home and community; and

- **long term care facilities** -- caring for those children who require long-term, specialized care for the rest of their lives.

* Six percent of all children are estimated to have a chronic or congenital condition resulting in limitation of ability to function in at least one activity of daily living; two percent of all children have a chronic or congenital condition that requires extensive health services.

Sample Letter for Hospital Administration

Date

The Honorable (name)
U.S. House of Representatives
Washington, DC 20515

The Honorable (name)
U.S. Senate
Washington, DC 20510

Dear Representative (name):

Dear Senator (name):

As (title) of (name of hospital), I am deeply concerned about continued news reports that congressional leaders may seek to save more than a $100 billion in federal Medicaid spending over the next five years. Our hospital serves more than (number of children) per year and invests $ (amount of money) in (number of) employees. Medicaid pays for (x)% of our services.

As a hospital that serves children from (number) of states, I am also concerned about reports that Congress may repeal federal Medicaid requirements, giving each state the discretion to determine its own standards for eligibility, access, and appropriate care. That would eliminate the nation's health care safety net for medically and economically vulnerable children, including children of low income working families.

I would appreciate very much the opportunity to talk with you and your staff about the impact of proposals to restructure Medicaid before Congress acts upon them. In particular, I would like to encourage you to consider the following facts:

- **Medicaid is a children's program.** It pays for the health care of one in every four children; one in three infants. Children are half of all people covered by Medicaid.

- **Medicaid is vital to low income, working families.** Thanks to changes in Medicaid law made by Congress with bipartisan support between 1986 and 1990, Medicaid covers children of low income, working families, even if their parents' employment disqualifies them for welfare. Nearly 60% of children covered by Medicaid live in working families.

- **Little money can be saved from Medicaid coverage for children.** Although they are half of all Medicaid covered individuals, children account for less than 20% of Medicaid spending. Medicaid's cost for one elderly adult equals the cost for almost eight children.

- **Congress can save Medicaid funds and increase state flexibility in using federal funds without jeopardizing the federal Medicaid safety net for children.** (Name of hospital) would like to talk with you about how that can be done.

I look forward to talking with you and your staff about the future of Medicaid for children.

Sincerely,

Chicago Tribune
FOUNDED JUNE 10, 1847
JACK FULLER, *Publisher* HOWARD A. TYNER, *Editor*
N. DON WYCLIFF, *Editorial Page Editor* ANN MARIE LIPINSKI, *Managing Editor/News* OWEN YOUNGMAN, *Managing Editor/Features*
F. RICHARD CICCONE, *Associate Editor*

Voice of the people

Don't cut into care for kids

CHICAGO—In its search for ways to reduce our country's deficit, Congress is considering major reductions in health-care programs for the elderly and the poor.

As policymakers and accountants ponder how to make such reductions, an even more troubling initiative is underway. Congress may have the federal government give up oversight of the national health-care safety net for the children of low-income families—Medicaid.

Some may think these efforts are on the right track. To our children's hospitals, they could be devastating. Ill-considered belt-tightening, much less federal abdication of Medicaid for children, could jeopardize the health-care system for Illinois children whose families rely on Medicaid. It also could jeopardize our hospitals' mission of serving children regardless of ability to pay

Medicaid is a federal-state partnership for health care for the non-elderly poor. Each state works with the federal government to make sure there is a minimum, federally defined safety net of coverage for people with low incomes. The vast percentage of the care we provide is to children who are covered by Medicaid.

No public program in the country matters more to children's health care. Medicaid pays for health care for millions whose families fall into poverty. It is a safety net for millions more whose private health insurance is only as secure as a parent's job. Three-quarters of all Medicaid recipients are children and mothers. Children alone are half. Medicaid covers one-fourth of all children, one-third of all births. Yet all of these children account for less than 20 cents of every dollar Medicaid spends. The remainder goes for adults and nursing-home care.

Medicaid also plays a critical role in sustaining the pediatric services of our hospitals. And a children's hospital incurs costs many other hospitals do not. Although hospitalized less often than adults, children require more expensive, specialized care when they are sick or injured. In addition, children's hospitals provide training for pediatricians and other care-givers for children. And we conduct research to improve children's health care.

Our hospitals are participating in new ways of treating children more cost-effectively. We are optimistic that leaner government will contribute to a better future for our kids. And we have long advocated reform of Medicaid.

But before Medicaid and other safety-net programs are turned loose from Washington, there must be certain minimum standards for Medicaid coverage for all low-income children, medically necessary care for all Medicaid-eligible children and appropriate access for children to pediatric specialists when they need them.

As a society, we expect minimum standards of quality for our drinking water, our food and our schools. We should do no less when it comes to our children's health. Support Illinois' children by sending a message of caution to our elected leaders: Don't expose children to the risks of hasty lawmaking.

Jan R. Jennings
President and CEO, Children's Memorial Medical Center
Arthur F. Kohrman
President, La Rabida Children's Hospital
Ralph W. Muller
President, Wyler Children's Hospital

Talking Points: PROTECT MEDICAID'S SAFETY NET FOR CHILDREN

RECOMMENDATIONS: Congress should protect the nation's Medicaid safety net for children of low income and working families while controlling the program's growth. Medicaid reform and savings should be achieved by granting states flexibility to use managed care that meets national accountability standards and by reducing disproportionate share (DSH) payments by targeting them only to hospitals that devote a major portion of their care to Medicaid and other low-low income patients. The Medicaid safety net for children can be protected by maintaining federal minimum standards for children's eligibility, medically necessary care, and access to appropriate providers.

Medicaid is critical to the health of our Nation's children and children's hospitals. One in four children and one in three infants are covered by Medicaid. About 15% have disabilities and other challenging conditions that make them often uninsurable. Without the Medicaid safety net for children, the number of uninsured children would increase dramatically, since private coverage continues to decline. As it is, the number of uninsured children increased 8% between 1992 - 93. Children represented 80% of newly uninsured Americans. Children's hospitals provide nearly half of their care to children covered by Medicaid.

Medicaid's minimum federal safety net for children supports employment. With bipartisan support from 1986 - 90, Congress "delinked" Medicaid from welfare for children, setting federal eligibility standards based on income, not welfare status. Over 3/5 of the states had to raise their eligibility limits to comply. Now, nearly 60% of children under Medicaid have low income, working families, most of whom have no employer coverage.

Medicaid provides this children's safety net for only a fraction of the program's costs. Children equal half of Medicaid beneficiaries but less than 1/5 of Medicaid spending. On a per capita basis in 1993, Medicaid spending per enrolled child was 1/2 the cost for adults and 1/8 for the elderly. Expanded coverage for children was only 13% of overall spending growth 1992 - 93.

Congress is considering proposals to block grant the Medicaid program and cap its growth. Key majority leaders in Congress want to cut the annual growth in Medicaid spending from 11% to 5% or less. Managed care alone cannot meet these spending goals, particularly in the near term. States' experience in Medicaid managed care varies widely and is directed mainly to acute care for the non-disabled, which affects only about 20% of Medicaid spending. Consequently, Congressional proponents of low growth caps and some governors want block grants that would allow states to set their own eligibility and benefit standards. That would end the national Medicaid safety net for children.

Children's hospitals recommend that any Medicaid savings or caps protect the national health care safety net for children -- federal minimum standards for children's eligibility, medically necessary care, and access to appropriate care. Savings can be achieved through states' increased flexibility to use managed care according to federal accountability standards and targeting Medicaid DSH payments only to high DSH hospitals. Any caps on growth should be on a per capita basis to preserve the ability of states to respond in times of economic downturn.

Talking Points: PROTECT MEDICAID'S SAFETY NET FOR MEDICALLY VULNERABLE CHILDREN

RECOMMENDATIONS: Congress should protect the nation's Medicaid safety net for vulnerable children while controlling the program's growth. Medicaid reform and savings should be achieved by granting states flexibility to use managed care that meets national standards and reducing DSH payments by targeting them only to hospitals that devote a major portion of their care to Medicaid and other low income patients. The Medicaid safety net for children can be protected by maintaining federal minimum standards for children's eligibility, medically necessary care, and access to appropriate providers.

Medicaid is for vulnerable children. They are half of all Medicaid covered individuals. They include medically vulnerable children needing complex care and economically vulnerable children of low income families. Medicaid pays for health care for one in four children; one in three infants.

Medicaid is the nation's safety net for medically vulnerable children and patients of children's hospitals. About 15% of children covered by Medicaid are medically vulnerable -- "medically needy" children whose costly care can reduce families to poverty, and disabled children with SSI. Children's hospitals devote on average nearly half of their care to children under Medicaid; more than 70% to children with chronic or congenital conditions. Children's specialty hospitals devote an even higher proportion of their care Medicaid covered children.

SSI disabled children covered by Medicaid can have very challenging conditions. E.g., a State of Washington study found that half of Medicaid covered children with leukemia and lymphoma received SSI; 3/4 of Medicaid covered children with spina bifida received SSI.

Medicaid also is the nation's health care safety net for economically vulnerable children. It pays for the health care of children of mothers who qualify for Aid to Families with Dependent Children (AFDC) and children of low income, working families. It covers 80% of children living in poverty and 25% of children with incomes below 200% of the federal poverty standard.

Low income children who qualify for Medicaid also have medical vulnerabilities. Children covered by Medicaid based on AFDC or family income also can be medically vulnerable. E.g., in the State of Washington's Medicaid program nearly 8% of AFDC children and more than 8% of low income children covered by Medicaid had one or more chronic or congenital conditions.

Medically vulnerable children need a national safety net with access across state lines. Children with special needs are a fraction of all children; only about 2% of children have serious conditions that require ongoing, extensive care. That means they depend on specialized services in urban centers, often across state lines. Children's hospitals serve children from multiple states.

Little money can be saved from Medicaid coverage of children alone. Although individual children can have resource intensive health care needs, most children consume little health care. The average cost of Medicaid for one elderly adult equals the cost of care for nearly 8 children. Children are half of Medicaid covered individuals but less than 16% of Medicaid spending.

Talking Points: SUPPORT MEDICAID MANAGED CARE
THAT WORKS FOR CHILDREN

RECOMMENDATIONS: Congress should promote states' development of Medicaid managed care that works for children by establishing federal accountability standards that focus on: children's access to appropriate providers, children with special needs, financing graduate medical education, and targeting disproportionate share (DSH) payments.

Children's hospitals are expert in caring for Medicaid covered children. Children are half of Medicaid recipients. Nearly half of children's hospitals' care goes to these children.

Children's hospitals know managed care has great potential for children covered by Medicaid when it focuses on preventive care and coordinated care. Poor children often have difficulty getting access to preventive care. Children with special needs often face the greatest challenges in getting appropriate care, because they require care from many providers.

Children's hospitals support Medicaid managed care. Children's hospitals are helping their states develop Medicaid managed care that works for children. A children's hospital in Wisconsin was among the first hospitals in the nation to develop a Medicaid managed care plan.

Children's hospitals also know that not all Medicaid managed care works for children. Children's hospitals in California, Pennsylvania, and Ohio have cared for children enrolled in Medicaid managed care plans that went bankrupt. Children's hospitals in Tennessee have seen inexperienced Medicaid managed care plans disrupt carefully established patterns of care for children with special needs.

Children's hospitals have found that Medicaid managed care works for children when states are able to demonstrate managed care meets not only fiscal solvency standards but also specific accountability standards for children:

- Access to Appropriate Care Demonstrate that Medicaid managed care gives children access to appropriate primary and specialty care, including centers of excellence for children. Such access should be coordinated through integrated child health care networks expert, organized, and accountable for meeting children's health care needs.

- Children with Special Needs Demonstrate that the requirements of special needs children can be met. States should carve this population out from capitated Medicaid managed care; or show that capitation rates are risk adjusted for them, that the children can have a pediatric subspecialist as gatekeeper, and that plans account for their care.

- Graduate Medical Education Demonstrate how Medicaid contributes its share of financing for training physicians through graduate medical education.

- Disproportionate Share Payments (DSH) Demonstrate that DSH payments are targeted only to hospitals that devote a major portion of their care to low income patients.

Children's Hospitals' Recommendations for:

CONTROLLING MEDICAID SPENDING AND INCREASING STATE FLEXIBILITY WHILE PROTECTING THE MEDICAID SAFETY NET FOR CHILDREN

RECOMMENDATIONS: Protect the nation's Medicaid safety net for children, while controlling federal spending and increasing state flexibility. Target Medicaid DSH payments to high Medicaid volume hospitals, give states flexibility to use managed care that meets national accountability standards and protect the Medicaid safety net standards for children's eligibility, medically necessary care, and access to appropriate care.

Background

Some Congressional leaders advocate a major restructuring of Medicaid, potentially eliminating the nation's Medicaid safety net for children, in order to save federal funds and enhance the flexibility with which states administer those funds. They want to help balance the federal budget and allow each state to develop programs that work best for its population.

Children's hospitals believe the goals of controlling federal Medicaid spending and increasing state flexibility can be served while still preserving Medicaid as the nation's health care safety net for economically and medically vulnerable children, including children of low income working families. The children's safety net was created in federal law between 1986 and 1990 through a series of bipartisan amendments that delinked Medicaid from welfare. Today nearly 60% of Medicaid-covered children live in working families.

Preserve the Medicaid Safety Net for Children

Federal law should preserve the Medicaid safety net for children by retaining the standards for eligibility, benefits, and access to appropriate care enacted with bipartisan votes in the late 1980s:

Eligibility Standards Federal law requires state Medicaid programs to cover children under age six and pregnant women with family incomes below 133% of the poverty standard, as well as older children born after September 1983 in families with incomes below 100% of poverty.

Medically Necessary Care Standards Federal law requires states to give Medicaid eligible children coverage for all medically necessary health care services.

Appropriate Provider Access Standards Federal law requires states to give Medicaid eligible children and pregnant women access to appropriate pediatric and obstetrical care, and to prohibit arbitrary restrictions on medically necessary hospital care for young children.

Control Federal Medicaid Spending

Federal law can reduce the annual growth in Medicaid spending and save funds with:

Targeted Disproportionate Share Spending The federal government could save $4 billion or more annually if federal law were to target disproportionate share payment adjustments to only those hospitals that devote a major portion of their care (20% to 25%) to low income patients. Currently, a hospital that devotes as little as 1% of its care to patients assisted by Medicaid may qualify for payment adjustments.

Expanded Medicaid Managed Care within National Guidelines Research suggests that depending on the population and the services, capitated managed care can reduce annual health care spending by five to 15%. Increased flexibility for states to enroll people eligible for Medicaid, in keeping with national guidelines, promises important federal savings.

Capitated Federal Medicaid Spending Instead of matching state Medicaid expenditures, the federal government can "capitate" Medicaid spending by guaranteeing to each state a fixed sum of federal funds per Medicaid eligible individual. Such an approach gives the federal government more control while protecting states against changes in eligible population due to economic downturn or natural disaster.

Increase State Flexibility

Expanded Medicaid Managed Care within National Guidelines Federal law can preserve the national Medicaid safety net of eligibility, medically necessary care, and access standards while also giving states new flexibility. For example, Senator John Chafee (R-RI), a former governor, and Senator Daniel Patrick Moynihan each have proposed to allow states to undertake statewide Medicaid managed care, without going through a waiver application process, provided states meet national guidelines. Children's hospitals believe these standards should include:

- **Fiscal Solvency and Quality** States demonstrate that Medicaid managed care plans meet the same standards for fiscal solvency and quality that commercial plans must meet.

- **Funds Used for Health Care** States demonstrate that federal Medicaid funds are used only for health care services for eligible populations.

- **Access Standards** States demonstrate children will have access to appropriate pediatric primary and specialty care, as well as centers of excellence for children, through integrated child health care networks.

- **Children with Special Needs** States demonstrate that special needs children are carved out of capitated managed care; or, if enrolled in managed care, they have pediatric risk adjusted capitation and choice of pediatric subspecialists as primary care gatekeepers.

- **Graduate Medical Education** States demonstrate that the costs of graduate medical education are covered, either through separate state financing or requirements that plans contribute directly to health professional training.

- **Disproportionate Share** States demonstrate that they target disproportionate share funds to only hospitals with high Medicaid and low income utilization rates and make such payment adjustments directly to eligible hospitals, instead of folding them into capitation.

DEAR MEMBER OF CONGRESS:

Your smallest constituents—Our biggest responsibility

Cuts in Medicaid have the biggest impact on some of your smallest constituents

Close to 17 million children rely on Medicaid. And many of those children must turn to hospitals and health systems and the professionals who staff them.

Day in and day out, for everything from routine problems to emergency care, children on Medicaid and their families come to us for the full range of services we provide.

We take our responsibility to these children and to all the people we serve seriously.

And we take threats to Medicaid seriously, too. We know the kind of havoc cutting Medicaid would cause—for children and their families. Spend 24 hours in any emergency room and you'll see what we mean.

Children covered by Medicaid are among your smallest constituents. They can't vote. But we care for them, and we hope you will too.

Dick Davidson, *President*
...can Hospital Association

Virginia Trotter Betts, *President*
American Nurses Asso...

L.A. McAndrews

Lawrence A. McAndrews, *President*
National Association of Children's Hospitals and Related Institutions, Inc.

Marjorie Beyers

Marjorie Beyers, *President*
American Organization of Nurse Exec...

AHA

ANA

nachri

Cuts In Medicaid Funding Hurt Children Throughout The State

Children's hospitals are mainstays in their communities, providing vital health care services to all children. The proposed budget cuts in Medicaid funding will be particularly devastating because it costs more to care for sick children than adults. Children's hospitals are not able to shift these increased costs to adult patients like other hospitals can. Inadequate Medicaid funding will force these hospitals to scale back the many crucial services they provide to the entire community.

The consequences are about much more than dollars and cents... they're about children and families. Consider the following examples:

Amy was severely injured when struck by a car near her suburban home. Her community hospital was not equipped to treat her injuries, so she was immediately transported to a children's hospital with a specialized pediatric intensive care unit.

Without adequate funding for children's hospitals, kids like Amy won't receive the specialized care they need.

Derrick, a diabetic child, was brought to a children's hospital once again for an insulin reaction. The hospital social worker discovered the family didn't have a refrigerator to keep Derrick's insulin cold. She spent hours helping the family locate a refrigerator, warding off another hospital stay and saving the state thousands of dollars.

Without adequate funding for children's hospitals, chronically ill kids like Derrick won't receive the specialized care they need.

Baby Jeremy, born prematurely, was confined to a children's hospital for the majority of his first year of life. He received extensive rehabilitation therapy to ensure that he continued to grow and learn at a normal rate and wasn't disadvantaged when he went home.

Without adequate funding for children's hospitals, babies like Jeremy won't receive the specialized care they need.

If children's hospitals are not adequately funded, you're hurting not only the hundreds of thousands of children in the State of Illinois who are Medicaid recipients, you're also affecting non-Medicaid families who rely heavily on children's hospitals for health care and support services unavailable to them anywhere else.

SOME OF OUR LITTLEST CITIZENS NEED YOU THE MOST.

Children's Memorial Medical Center
La Rabida Children's Hospital and Research Center
Wyler Children's Hospital
Cardinal Glennon Children's Hospital
St. Louis Children's Hospital

Effect on Children's Health Coverage in 2002 of House Proposal to Cut Medicaid by $187 Billion

Projected federal funding cut in 2002 -- $53 billion in cuts to states

	Children covered by Medicaid in FY1994 (actual)/1	House Republican reduction in Medicaid in 2002/2	Estimated uninsured children in 2002 if Medicaid is unchanged/3	Number of children who could lose Medicaid/4	Estimated number of children who would be uninsured in 2002 after House Republican Medicaid cuts
United States	22,972,085	30%	12,225,000	6,891,626	19,116,626
Alabama	346,009	15%	319,000	51,901	370,901
Alaska	52,430	41%	48,000	21,496	69,496
Arizona	457,842	21%	208,000	96,147	304,147
Arkansas	191,297	35%	198,000	66,954	264,954
California	3,805,000	27%	1,750,000	1,027,350	2,777,350
Colorado	215,844	33%	156,000	71,229	227,229
Connecticut	200,300	30%	68,000	60,090	128,090
Delaware	52,720	38%	31,000	20,034	51,034
District of Columbia	84,560	36%	32,000	30,442	62,442
Florida	1,306,100	33%	935,000	431,013	1,366,013
Georgia	695,643	33%	435,000	229,562	664,562
Hawaii	74,052	27%	29,000	19,994	48,994
Idaho	79,084	27%	77,000	21,353	98,353
Illinois	1,099,229	29%	375,000	318,776	693,776
Indiana	386,554	44%	230,000	170,084	400,084
Iowa	179,295	23%	80,000	41,238	121,238
Kansas	163,431	13%	106,000	21,246	127,246
Kentucky	353,998	35%	169,000	123,899	292,899
Louisiana	470,615	27%	316,000	127,066	443,066
Maine	97,458	29%	45,000	28,263	73,263
Maryland	336,578	32%	184,000	107,705	291,705
Massachusetts	412,016	32%	174,000	131,845	305,845
Michigan	811,500	25%	267,000	202,875	469,875
Minnesota	295,615	29%	158,000	85,728	243,728
Mississippi	369,286	23%	184,000	84,936	268,936
Missouri	445,002	7%	275,000	31,150	306,150
Montana	57,800	37%	45,000	21,386	66,386
Nebraska	107,263	35%	53,000	37,542	90,542
Nevada	78,882	30%	108,000	23,665	131,665
New Hampshire	45,936	0%	56,000	0	56,000
New Jersey	463,587	38%	251,000	176,163	427,163
New Mexico	178,960	24%	151,000	42,950	193,950
New York	1,745,568	35%	541,000	610,949	1,151,949
North Carolina	585,673	39%	312,000	228,412	540,412
North Dakota	36,259	30%	18,000	10,878	28,878
Ohio	945,871	30%	232,000	283,761	515,761
Oklahoma	258,236	35%	243,000	90,383	333,383
Oregon	224,304	28%	119,000	62,805	181,805
Pennsylvania	919,544	22%	283,000	202,300	485,300
Rhode Island	43,896	42%	19,000	18,436	37,436
South Carolina	298,075	17%	221,000	50,673	271,673
South Dakota	50,128	27%	50,000	13,535	63,535
Tennessee	495,452	34%	219,000	168,454	387,454
Texas	1,835,095	20%	1,568,000	367,019	1,935,019
Utah	129,081	30%	97,000	38,724	135,724
Vermont	56,995	35%	11,000	19,948	30,948
Virginia	420,687	34%	380,000	143,034	523,034
Washington	449,681	43%	179,000	193,363	372,363
West Virginia	259,408	42%	71,000	108,951	179,951
Wisconsin	359,792	29%	126,000	104,340	230,340
Wyoming	34,286	38%	24,000	13,029	37,029

These estimates are limited to the final year of the proposed seven-year cut. Cumulative cuts over the seven years would result in significantly higher losses in each state.

NOTES: 1/ With the exception of New Hampshire & Rhode Island, children are all persons under 21 years of age covered by Medicaid in FY1994. New Hampshire's data was not available for 1994, so 1993 data was used instead. Rhode Island does not produce counts of children covered by Medicaid. Therefore, recipients in the category "children under 21" (does not include children qualifying by reason of disability) was substituted. 2/ Source: US DHHS based on Urban Institute's Medicaid Expenditure Growth Model, Commerce Commitee's formula as of 9/16/95, GAO's estimates of spending by states under the proposal. 3/ National estimate of uninsured children in 2002 is based on a linear projection of employer coverage trends from the Census, Current Population Survey, March 1988-1994 and on Medicaid growth using the 1994 children's proportion of CBO projections of Medicaid recipients in 2002. State estimates of the uninsured use each state's proportion of the national number of uninsured children for 1990-92 published by the Urban Institute. These proportions were then applied to the pr ed national figure. 4/ Number of children who could Medicaid assumes that children will experience cuts in the same proportion as any other group, that the states will reduce funds in proportion to the federal funding cuts, and that cuts will be made in

Effect on Children's Health Coverage in 2002 of Senate Proposal to Cut Medicaid by $187 Billion

Projected federal funding cut in 2002 -- $52 billion in cuts to states

	Children covered by Medicaid in FY1994 (actual)/1	Senate Republican reduction in Medicaid in 2002/2	Estimated uninsured children in 2002 if Medicaid is unchanged/3	Number of children who could lose Medicaid/4	Estimated number of children who would be uninsured in 2002 after Senate Republican Medicaid cuts
United States	22,972,085	29%	12,225,000	6,661,905	18,886,905
Alabama	346,009	24%	319,000	83,042	402,042
Alaska	52,430	30%	48,000	15,729	63,729
Arizona	457,842	29%	208,000	132,774	340,774
Arkansas	191,297	34%	198,000	65,041	263,041
California	3,805,000	24%	1,750,000	913,200	2,663,200
Colorado	215,844	26%	156,000	56,119	212,119
Connecticut	200,300	39%	68,000	78,117	146,117
Delaware	52,720	19%	31,000	10,017	41,017
District of Columbia	84,560	32%	32,000	27,059	59,059
Florida	1,306,100	31%	935,000	404,891	1,339,891
Georgia	695,643	31%	435,000	215,649	650,649
Hawaii	74,052	27%	29,000	19,994	48,994
Idaho	79,084	28%	77,000	22,144	99,144
Illinois	1,099,229	20%	375,000	219,846	594,846
Indiana	386,554	44%	230,000	170,084	400,084
Iowa	179,295	24%	80,000	43,031	123,031
Kansas	163,431	18%	106,000	29,418	135,418
Kentucky	353,998	35%	169,000	123,899	292,899
Louisiana	470,615	53%	316,000	249,426	565,426
Maine	97,458	25%	45,000	24,365	69,365
Maryland	336,578	24%	184,000	80,779	264,779
Massachusetts	412,016	36%	174,000	148,326	322,326
Michigan	811,500	25%	267,000	202,875	469,875
Minnesota	295,615	18%	158,000	53,211	211,211
Mississippi	369,286	19%	184,000	70,164	254,164
Missouri	445,002	18%	275,000	80,100	355,100
Montana	57,800	35%	45,000	20,230	65,230
Nebraska	107,263	26%	53,000	27,888	80,888
Nevada	78,882	36%	108,000	28,398	136,398
New Hampshire	45,936	39%	56,000	17,915	73,915
New Jersey	463,587	34%	251,000	157,620	408,620
New Mexico	178,960	20%	151,000	35,792	186,792
New York	1,745,568	33%	541,000	576,037	1,117,037
North Carolina	585,673	36%	312,000	210,842	522,842
North Dakota	36,259	30%	18,000	10,878	28,878
Ohio	945,871	27%	232,000	255,385	487,385
Oklahoma	258,236	38%	243,000	98,130	341,130
Oregon	224,304	13%	119,000	29,160	148,160
Pennsylvania	919,544	18%	283,000	165,518	448,518
Rhode Island	43,896	35%	19,000	15,364	34,364
South Carolina	298,075	25%	221,000	74,519	295,519
South Dakota	50,128	19%	50,000	9,524	59,524
Tennessee	495,452	26%	219,000	128,818	347,818
Texas	1,835,095	28%	1,568,000	513,827	2,081,827
Utah	129,081	29%	97,000	37,433	134,433
Vermont	56,995	27%	11,000	15,389	26,389
Virginia	420,687	32%	380,000	134,620	514,620
Washington	449,681	43%	179,000	193,363	372,363
West Virginia	259,408	42%	71,000	108,951	179,951
Wisconsin	359,792	26%	126,000	93,546	219,546
Wyoming	34,286	29%	24,000	9,943	33,943

These estimates are limited to the final year of the proposed seven-year cut. Cumulative cuts over the seven years would result in significantly higher losses in each state.

NOTES: 1/ With the exception of New Hampshire & Rhode Island, children are all persons under 21 years of age covered by Medicaid in FY1994. New Hampshire's data was not available for 1994, so 1993 data was used instead. Rhode Island does not produce counts of children covered by Medicaid. Therefore, recipients in the category "children under 21" (does not include children qualifying by reason of disability) was substituted. 2/ Source: US DHHS based on Urban Institute's Medicaid Expenditure Growth Model, Commerce Committee's formula as of 9/16/95, GAO's estimates of spending by states under the proposal. 3/ National estimate of uninsured children in 2002 is based on a linear projection of employer coverage trends from the Census, Current Population Survey, March 1988-1994 and on Medicaid growth using the 1994 children's proportion of CBO projections of Medicaid recipients in 2002. State estimates of the uninsured use each state's proportion of the national number of uninsured children for 1990-92 published by the Urban Institute. These proportions were then applied to the projected national figure. 4/ Number of children who could lose Medicaid assumes that children will experience cuts in the) proportion as any other group, that the states will reduce funds in proportion to the federal funding cuts, cuts will be ( ) in eligibility rather than services & benefits.

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, THE REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID REFORMS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN, INCLUDING THOSE IN WORKING FAMILIES NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover certain older children (those born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered because they are disabled and receive Supplemental Security Income (SSI).

- In the United States, 21.1% of children under 18 were covered by Medicaid during 1990-92.

- Among children covered by Medicaid, more than half live in working families.

By 1994, at their option, 34 states had gone beyond federal mandates to cover more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), and several go beyond that level.

- Nationally, Medicaid finances care for one out of three babies -- 1.4 million in 1993.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of Medicaid recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Medicaid expenditures for all covered children under age 21 were $1,065 per child, compared to $7,590 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage for women and children. For children and pregnant women, Medicaid expansions offset much of the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In the United States, 17.4 million children under age 21 received Medicaid covered services in 1993, but an estimated 12 million children under age 21 were uninsured.

- The proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- There were 9,586,099 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care was the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID WAS EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- Overall, the U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- The infant mortality rate decreased in every state in the U.S., ranging from a 3.5% to 42% decrease, from 1984 to 1992.

Primary Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, May 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Alabama, 17.2% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Alabama, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Nationally, Medicaid finances care for one out of three babies -- 1.4 million in 1993.

- In Alabama, 24,000 births were financed by Medicaid in 1991, compared to 3,940 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Alabama Medicaid expenditures for all covered children under age 21 were $852 per child, compared to $4,231 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 7.0% of total Medicaid expenditures in Alabama in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Alabama, 281,991 children under age 21 received Medicaid covered services in 1993, but an estimated 247,749 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Alabama, there were 193,222 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Alabama, the percentage of deliveries considered uncompensated hospital care dropped from 27.6% in 1986 to 8.1% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Alabama the infant mortality rate decreased 19% between 1984 and 1992 -- from 12.9 to 10.5 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, April 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($15,740 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Alaska, 19.8% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty.

- In Alaska, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty ($20,934 for a family of three in Alaska).

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Alaska Medicaid expenditures for all covered children under age 21 were $1,631 per child, compared to $8,254 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Alaska, 38,586 children under age 21 received Medicaid covered services in 1993, but an estimated 21,855 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Alaska, there were 20,315 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Alaska the infant mortality rate decreased 23% between 1984 and 1992 -- from 11.2 to 8.6 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, April 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

ETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH DMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID XPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

ILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID OR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal w requires states to cover pregnant women and children under age six with family incomes up 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of overty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups ovided coverage for 3 million low-income children. Additional children are covered on the sis of disability through the Supplemental Security Income (SSI) program.

In Arizona, 19.9% of children under 18 were covered by Medicaid during 1990-92.

Among U.S. children covered by Medicaid, more than half live in a working family.

y 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant omen and infants in low-income, working families. Most (22) states set eligibility at 185% f poverty (about $23,000 per year for a family of three), but several go beyond that level.

In Arizona, the Medicaid eligibility level for pregnant women and infants is set at 140% of poverty.

Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

In Arizona, 25,000 births were financed by Medicaid in 1991, compared to 3,150 in 1985.

HILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO NCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women relatively low and represents only a small fraction of Medicaid payments. While children nd pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, ayments made on behalf of these groups were only 11% of the growth in Medicaid spending.

Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 12.3% of total Medicaid expenditures in Arizona in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Arizona, there were 190,031 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Arizona, the percentage of deliveries considered uncompensated hospital care dropped from 23.5% in 1986 to 15.8% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Arizona the infant mortality rate decreased 12% between 1984 and 1992 -- from 9.5 to 8.4 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, April 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Arkansas, 21.2% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Arkansas, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Arkansas, 13,754 births were financed by Medicaid in 1991, compared to 3,730 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Arkansas Medicaid expenditures for all covered children under age 21 were $1,621 per child, compared to $5,035 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 6.1% of total Medicaid expenditures in Arkansas in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Arkansas, 173,918 children under age 21 received Medicaid covered services in 1993, but an estimated 161,567 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Arkansas, there were 123,379 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Arkansas the infant mortality rate decreased 5% between 1984 and 1992 -- from 10.9 to 10.3 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, April 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In California, 28.3% of children under 18 were covered by Medicaid during 1990-92.
- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In California, the Medicaid eligibility level for pregnant women and infants is set at 200% of poverty.
- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.
- In California, 211,780 births were financed by Medicaid in 1991, compared to 110,720 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.
- In 1993, California Medicaid expenditures for all covered children under age 21 were $589 per child, compared to $3,738 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 8.6% of total Medicaid expenditures in California in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In California, 2,496,224 children under age 21 received Medicaid covered services in 1993, but an estimated 1,848,341 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In California, there were 1,480,573 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In California, the percentage of deliveries considered uncompensated hospital care dropped from 10.5% in 1986 to 7.4% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In California the infant mortality rate decreased 26% between 1984 and 1992 -- from 9.4 to 7.0 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, April 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Colorado, 13.6% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Colorado, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Colorado, 11,482 births were financed by Medicaid in 1991, compared to 2,220 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Colorado Medicaid expenditures for all covered children under age 21 were $1,181 per child, compared to $6,971 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 5.2% of total Medicaid expenditures in Colorado in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Colorado, 161,221 children under age 21 received Medicaid covered services in 1993, but an estimated 139,471 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Colorado, there were 83,453 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Colorado, the percentage of deliveries considered uncompensated hospital care dropped from 22.8% in 1986 to 11.7% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Colorado the infant mortality rate decreased 25% between 1984 and 1992 -- from 10.2 to 7.6 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Connecticut, 13.6% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Connecticut, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Connecticut, 9,938 births were financed by Medicaid in 1991, compared to 2,800 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Connecticut Medicaid expenditures for all covered children under age 21 were $1,255 per child, compared to $17,668 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 3.1% of total Medicaid expenditures in Connecticut in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Connecticut, 167,594 children under age 21 received Medicaid covered services in 1993, but an estimated 57,446 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Connecticut, there were 89,921 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Connecticut, the percentage of deliveries considered uncompensated hospital care dropped from 10.5% in 1986 to 9.0% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Connecticut the infant mortality rate decreased 27% between 1984 and 1992 -- from 10.4 to 7.6 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Delaware, 13.5% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Delaware, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Delaware, 2,350 births were financed by Medicaid in 1991, compared to 1,410 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Delaware Medicaid expenditures for all covered children under age 21 were $1,482 per child, compared to $10,469 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 4.8% of total Medicaid expenditures in Delaware in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Delaware, 42,816 children under age 21 received Medicaid covered services in 1993, but an estimated 29,754 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Delaware, there were 21,785 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Delaware the infant mortality rate decreased 20% between 1984 and 1992 -- from 10.8 to 8.6 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

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MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In the District of Columbia, 41.1% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In the District of Columbia, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In the District of Columbia, 5,000 births were financed by Medicaid in 1991, compared to 3,170 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, the District of Columbia Medicaid expenditures for all covered children under age 21 were $1,489 per child, compared to $8,164 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 4.3% of total Medicaid expenditures in the District of Columbia in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In the District of Columbia, 62,543 children under age 21 received Medicaid covered services in 1993, but an estimated 32,967 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In the District of Columbia, there were 29,820 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In the District of Columbia the infant mortality rate decreased 7% between 1984 and 1992 -- from 21.0 to 19.6 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Florida, 23.8% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Florida, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Florida, 54,280 births were financed by Medicaid in 1991, compared to 19,490 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Florida Medicaid expenditures for all covered children under age 21 were $890 per child, compared to $5,176 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 9.3% of total Medicaid expenditures in Florida in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Florida, 995,422 children under age 21 received Medicaid covered services in 1993, but an estimated 708,172 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Florida, there were 625,599 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Florida, the percentage of deliveries considered uncompensated hospital care dropped from 26.7% in 1986 to 9.9% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Florida the infant mortality rate decreased 19% between 1984 and 1992 -- from 10.8 to 8.8 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Georgia, 22.3% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Georgia, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Georgia, 52,155 births were financed by Medicaid in 1991, compared to 16,000 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Georgia Medicaid expenditures for all covered children under age 21 were $1,106 per child, compared to $5,356 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 13.8% of total Medicaid expenditures in Georgia in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Georgia, 525,168 children under age 21 received Medicaid covered services in 1993, but an estimated 262,675 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Georgia, there were 297,346 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Georgia the infant mortality rate decreased 20% between 1984 and 1992 -- from 12.9 to 10.3 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Hawaii, 17.6% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty.

- In Hawaii, the Medicaid eligibility level for pregnant women and infants is set at 300% of poverty ($43,470 for a family of three in Hawaii).

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Hawaii, 3,012 births were financed by Medicaid in 1990, compared to 1,950 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Hawaii Medicaid expenditures for all covered children under age 21 were $817 per child, compared to $7,605 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 3.9% of total Medicaid expenditures in Hawaii in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Hawaii, 58,665 children under age 21 received Medicaid covered services in 1993, but an estimated 23,522 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Hawaii, there were 21,687 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Hawaii the infant mortality rate decreased 36% between 1984 and 1992 -- from 9.9 to 6.3 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, April 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Idaho, 11.5% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Idaho, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Idaho, 4,324 births were financed by Medicaid in 1991, compared to 1,310 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Idaho Medicaid expenditures for all covered children under age 21 were $1,151 per child, compared to $8,162 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 5.7% of total Medicaid expenditures in Idaho in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Idaho, 60,357 children under age 21 received Medicaid covered services in 1993, but an estimated 60,997 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Idaho, there were 38,935 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Idaho, the percentage of deliveries considered uncompensated hospital care dropped from 24.1% in 1986 to 18.0% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Idaho the infant mortality rate decreased 10% between 1984 and 1992 -- from 9.8 to 8.8 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Illinois, 23.4% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Illinois, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Illinois, 52,000 births were financed by Medicaid in 1991, compared to 36,750 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Illinois Medicaid expenditures for all covered children under age 21 were $1,107 per child, compared to $8,059 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 7.4% of total Medicaid expenditures in Illinois in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Illinois, 778,662 children under age 21 received Medicaid covered services in 1993, but an estimated 382,360 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Illinois, there were 337,750 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Illinois, the percentage of deliveries considered uncompensated hospital care dropped from 13.0% in 1986 to 9.9% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Illinois the infant mortality rate decreased 16% between 1984 and 1992 -- from 12.1 to 10.1 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Indiana, 14.4% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Indiana, the Medicaid eligibility level for pregnant women and infants is set at 150% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Indiana, 33,200 births were financed by Medicaid in 1991, compared to 4,320 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Indiana Medicaid expenditures for all covered children under age 21 were $1,562 per child, compared to $11,379 per elderly adult.

Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

Payments for maternity and newborn care were 7.0% of total Medicaid expenditures in Indiana in 1991.

EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, DICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM PLODING. During the 1980s, as the cost of private insurance rose for employers and ilies, many dropped dependent coverage of women and children. For children and pregnant nen, Medicaid expansions offset the loss of private coverage for a few years. However, by 2, growth in the number of uninsured children outpaced Medicaid.

In Indiana, 315,794 children under age 21 received Medicaid covered services in 1993, but an estimated 221,991 were uninsured.

Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

In Indiana, there were 173,053 uninsured women of childbearing age in 1993.

DICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED SPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were single largest source of hospital uncompensated care costs.

As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

In Indiana, the percentage of deliveries considered uncompensated hospital care dropped from 16.2% in 1986 to 8.2% in 1990.

'ANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR EGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, U.S. infant mortality rate reached its lowest level in history.

The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

In Indiana the infant mortality rate decreased 15% between 1984 and 1992 -- from 11.1 to 9.4 per 1000 live births.

Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, onal Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality ; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, loyee Benefit Research Institute, Children's Defense Fund, and RAND.

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MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Iowa, 13.2% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Iowa, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Iowa, 10,133 births were financed by Medicaid in 1991, compared to 7,920 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Iowa Medicaid expenditures for all covered children under age 21 were $1,292 per child, compared to $6,554 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 3.3% of total Medicaid expenditures in Iowa in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Iowa, 149,855 children under age 21 received Medicaid covered services in 1993, but an estimated 55,752 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Iowa, there were 53,816 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Iowa the infant mortality rate decreased 9% between 1984 and 1992 -- from 8.8 to 8.0 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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.LIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID : HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal requires states to cover pregnant women and children under age six with family incomes up 33% of poverty and to cover older children (born after September 30, 1983) up to 100% of erty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups ided coverage for 3 million low-income children. Additional children are covered on the s of disability through the Supplemental Security Income (SSI) program.

In Kansas, 12.4% of children under 18 were covered by Medicaid during 1990-92.

Among U.S. children covered by Medicaid, more than half live in a working family.

1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant nen and infants in low-income, working families. Most (22) states set eligibility at 185% overty (about $23,000 per year for a family of three), but several go beyond that level.

In Kansas, the Medicaid eligibility level for pregnant women and infants is set at 150% of poverty.

Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

In Kansas, 9,197 births were financed by Medicaid in 1991, compared to 4,900 in 1985.

ILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO CREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women elatively low and represents only a small fraction of Medicaid payments. While children pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, ments made on behalf of these groups were only 11% of the growth in Medicaid spending.

Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

In 1993, Kansas Medicaid expenditures for all covered children under age 21 were $1,114 per child, compared to $6,660 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 6.4% of total Medicaid expenditures in Kansas in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Kansas, 134,528 children under age 21 received Medicaid covered services in 1993, but an estimated 98,919 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Kansas, there were 84,536 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Kansas, the percentage of deliveries considered uncompensated hospital care dropped from 16.2% in 1986 to 7.5% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Kansas the infant mortality rate decreased 14% between 1984 and 1992 -- from 10.1 to 8.7 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Kentucky, 22.4% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Kentucky, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Kentucky, 21,079 births were financed by Medicaid in 1991, compared to 5,510 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Kentucky Medicaid expenditures for all covered children under age 21 were $1,254 per child, compared to $5,653 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 4.3% of total Medicaid expenditures in Kentucky in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Kentucky, 304,407 children under age 21 received Medicaid covered services in 1993, but an estimated 160,946 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Kentucky, there were 111,466 uninsured women of childbearing age in 1993.

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- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Kentucky, the percentage of deliveries considered uncompensated hospital care dropped from 16.2% in 1986 to 7.9% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Kentucky the infant mortality rate decreased 28% between 1984 and 1992 -- from 11.5 to 8.3 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Louisiana, 28.1% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Louisiana, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Louisiana, 31,420 births were financed by Medicaid in 1991, compared to 9,100 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Louisiana Medicaid expenditures for all covered children under age 21 were $1,928 per child, compared to $6,733 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 4.5% of total Medicaid expenditures in Louisiana in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Louisiana, 433,958 children under age 21 received Medicaid covered services in 1993, but an estimated 265,978 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Louisiana, there were 227,873 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Louisiana, the percentage of deliveries considered uncompensated hospital care dropped from 11.2% in 1986 to 8.9% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Louisiana the infant mortality rate decreased 22% between 1984 and 1992 -- from 12.1 to 9.4 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, April 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Maine, 20.2% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Maine, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Maine, 3,715 births were financed by Medicaid in 1991, compared to 2,410 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Maine Medicaid expenditures for all covered children under age 21 were $1,516 per child, compared to $9,446 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 2.5% of total Medicaid expenditures in Maine in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Maine, 82,749 children under age 21 received Medicaid covered services in 1993, but an estimated 39,450 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Maine, there were 39,098 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Maine, the percentage of deliveries considered uncompensated hospital care dropped from 11.1% in 1986 to 6.1% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Maine the infant mortality rate decreased 33% between 1984 and 1992 -- from 8.4 to 5.6 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Maryland, 19.6% of children under 18 were covered by Medicaid during 1990-92.
- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Maryland, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.
- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.
- In Maryland, 19,215 births were financed by Medicaid in 1991, compared to 11,300 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.
- In 1993, Maryland Medicaid expenditures for all covered children under age 21 were $1,359 per child, compared to $8,848 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 6.9% of total Medicaid expenditures in Maryland in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Maryland, 234,309 children under age 21 received Medicaid covered services in 1993, but an estimated 168,372 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Maryland, there were 149,019 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Maryland, the percentage of deliveries considered uncompensated hospital care dropped from 8.7% in 1986 to 2.5% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Maryland the infant mortality rate decreased 17% between 1984 and 1992 -- from 11.8 to 9.8 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Massachusetts, 21.1% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Massachusetts, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Massachusetts, 20,000 births were financed by Medicaid in 1991, compared to 12,550 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Massachusetts Medicaid expenditures for all covered children under age 21 were $1,609 per child, compared to $10,760 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 2.6% of total Medicaid expenditures in Massachusetts in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Massachusetts, 376,198 children under age 21 received Medicaid covered services in 1993, but an estimated 125,067 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Massachusetts, there were 161,484 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Massachusetts, the percentage of deliveries considered uncompensated hospital care dropped from 8.3% in 1986 to 2.7% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Massachusetts the infant mortality rate decreased 27% between 1984 and 1992 -- from 9.0 to 6.5 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Michigan, 22.3% of children under 18 were covered by Medicaid during 1990-92.
- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Michigan, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.
- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.
- In Michigan, 50,000 births were financed by Medicaid in 1991, compared to 33,600 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.
- In 1993, Michigan Medicaid expenditures for all covered children under age 21 were $824 per child, compared to $7,014 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 7.8% of total Medicaid expenditures in Michigan in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Michigan, 624,531 children under age 21 received Medicaid covered services in 1993, but an estimated 220,623 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Michigan, there were 275,095 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Michigan, the percentage of deliveries considered uncompensated hospital care dropped from 7.9% in 1986 to 6.9% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Michigan the infant mortality rate decreased 13% between 1984 and 1992 -- from 11.7 to 10.2 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Minnesota, 16.8% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Minnesota, the Medicaid eligibility level for pregnant women and infants is set at 275% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Minnesota, 20,000 births were financed by Medicaid in 1991, compared to 7,070 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Minnesota Medicaid expenditures for all covered children under age 21 were $994 per child, compared to $13,402 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 5.1% of total Medicaid expenditures in Minnesota in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Minnesota, 223,042 children under age 21 received Medicaid covered services in 1993, but an estimated 91,647 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Minnesota, there were 130,425 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Minnesota, the percentage of deliveries considered uncompensated hospital care dropped from 4.6% in 1986 to 3.4% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Minnesota the infant mortality rate decreased 21% between 1984 and 1992 -- from 8.9 to 7.1 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Mississippi, 28.0% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Mississippi, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Mississippi, 25,000 births were financed by Medicaid in 1991, compared to 3,680 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Mississippi Medicaid expenditures for all covered children under age 21 were $796 per child, compared to $3,305 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 8.6% of total Medicaid expenditures in Mississippi in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Mississippi, 267,998 children under age 21 received Medicaid covered services in 1993, but an estimated 164,601 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Mississippi, there were 118,359 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Mississippi, the percentage of deliveries considered uncompensated hospital care dropped from 12.6% in 1986 to 5.9% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Mississippi the infant mortality rate decreased 17% between 1984 and 1992 -- from 14.4 to 11.9 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Missouri, 19.3% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Missouri, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Missouri, 21,416 births were financed by Medicaid in 1991, compared to 10,170 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Missouri Medicaid expenditures for all covered children under age 21 were $927 per child, compared to $6,076 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 6.2% of total Medicaid expenditures in Missouri in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Missouri, 324,912 children under age 21 received Medicaid covered services in 1993, but an estimated 230,087 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Missouri, there were 181,557 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Missouri the infant mortality rate decreased 18% between 1984 and 1992 -- from 10.4 to 8.5 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, April 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Montana, 18.2% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Montana, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Montana, 3,499 births were financed by Medicaid in 1991, compared to 1,000 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Montana Medicaid expenditures for all covered children under age 21 were $1,376 per child, compared to $10,163 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 5.3% of total Medicaid expenditures in Montana in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Montana, 47,177 children under age 21 received Medicaid covered services in 1993, but an estimated 36,935 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Montana, there were 30,346 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Montana, the percentage of deliveries considered uncompensated hospital care dropped from 19.1% in 1986 to 6.6% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Montana the infant mortality rate decreased 15% between 1984 and 1992 -- from 8.8 to 7.5 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Nebraska, 14.9% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Nebraska, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Nebraska, 6,000 births were financed by Medicaid in 1991, compared to 3,130 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Nebraska Medicaid expenditures for all covered children under age 21 were $1,450 per child, compared to $9,237 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 5.4% of total Medicaid expenditures in Nebraska in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Nebraska, 97,166 children under age 21 received Medicaid covered services in 1993, but an estimated 40,515 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Nebraska, there were 50,610 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Nebraska the infant mortality rate decreased 24% between 1984 and 1992 -- from 9.6 to 7.4 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Nevada, 10.9% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Nevada, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Nevada Medicaid expenditures for all covered children under age 21 were $1,377 per child, compared to $6,102 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Nevada, 49,578 children under age 21 received Medicaid covered services in 1993, but an estimated 63,254 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Nevada, there were 56,444 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Nevada the infant mortality rate decreased 36% between 1984 and 1992 -- from 10.5 to 6.7 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

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MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In New Hampshire, 7.8% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In New Hampshire, the Medicaid eligibility level for pregnant women and infants is set at 170% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In New Hampshire, 1,630 births were financed by Medicaid in 1991, compared to 960 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, New Hampshire Medicaid expenditures for all covered children under age 21 were $979 per child, compared to $15,565 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 1.3% of total Medicaid expenditures in New Hampshire in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In New Hampshire, 41,506 children under age 21 received Medicaid covered services in 1993, but an estimated 30,993 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In New Hampshire, there were 33,568 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In New Hampshire, the percentage of deliveries considered uncompensated hospital care dropped from 11.8% in 1986 to 10.2% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In New Hampshire the infant mortality rate decreased 42% between 1984 and 1992 -- from 10.2 to 5.9 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In New Jersey, 16.2% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In New Jersey, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In New Jersey, 32,740 births were financed by Medicaid in 1991, compared to 12,700 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, New Jersey Medicaid expenditures for all covered children under age 21 were $1,354 compared to $11,135 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 5.7% of total Medicaid expenditures in New Jersey in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In New Jersey, 408,850 children under age 21 received Medicaid covered services in 1993, but an estimated 210,887 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In New Jersey, there were 261,172 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In New Jersey the infant mortality rate decreased 24% between 1984 and 1992 -- from 10.9 to 8.4 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In New Mexico, 21.6% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In New Mexico, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In New Mexico, 8,000 births were financed by Medicaid in 1991, compared to 2,660 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, New Mexico Medicaid expenditures for all covered children under age 21 were $1,232 per child, compared to $4,884 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 11.5% of total Medicaid expenditures in New Mexico in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In New Mexico, 145,684 children under age 21 received Medicaid covered services in 1993, but an estimated 122,858 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In New Mexico, there were 85,692 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In New Mexico the infant mortality rate decreased 21% between 1984 and 1992 -- from 9.6 to 7.6 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In New York, 26.4% of children under 18 were covered by Medicaid during 1990-92.
- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In New York, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.
- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.
- In New York, 98,547 births were financed by Medicaid in 1991, compared to 44,120 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.
- In 1993, New York Medicaid expenditures for all covered children under age 21 were $1,854 per child, compared to $17,428 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 2.5% of total Medicaid expenditures in New York in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In New York, 1,474,713 children under age 21 received Medicaid covered services in 1993, but an estimated 560,171 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In New York, there were 660,264 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In New York, the percentage of deliveries considered uncompensated hospital care dropped from 9.4% in 1986 to 5.4% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In New York the infant mortality rate decreased 20% between 1984 and 1992 -- from 11.0 to 8.8 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, April 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In North Carolina, 20.9% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In North Carolina, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In North Carolina, 40,000 births were financed by Medicaid in 1991, compared to 9,460 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, North Carolina Medicaid expenditures for all covered children under age 21 were $1,129 per child, compared to $5,619 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 11.6% of total Medicaid expenditures in North Carolina in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In North Carolina, 478,765 children under age 21 received Medicaid covered services in 1993, but an estimated 281,099 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In North Carolina, there were 226,718 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In North Carolina, the percentage of deliveries considered uncompensated hospital care dropped from 22.8% in 1986 to 5.6% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In North Carolina the infant mortality rate decreased 19% between 1984 and 1992 -- from 12.4 to 10.0 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In North Dakota, 11.9% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In North Dakota, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In North Dakota, 1,400 births were financed by Medicaid in 1991, compared to 1,000 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, North Dakota Medicaid expenditures for all covered children under age 21 were $1,356 per child, compared to $8,983 per elderly adult.

Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

Payments for maternity and newborn care were 2.1% of total Medicaid expenditures in North Dakota in 1991.

S EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, EDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM XPLODING. During the 1980s, as the cost of private insurance rose for employers and milies, many dropped dependent coverage of women and children. For children and pregnant omen, Medicaid expansions offset the loss of private coverage for a few years. However, by 92, growth in the number of uninsured children outpaced Medicaid.

In North Dakota, 30,887 children under age 21 received Medicaid covered services in 1993, but an estimated 13,867 were uninsured.

Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

In North Dakota, there were 19,736 uninsured women of childbearing age in 1993.

EDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED OSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were e single largest source of hospital uncompensated care costs.

As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

In North Dakota, the percentage of deliveries considered uncompensated hospital care dropped from 6.4% in 1986 to 3.2% in 1990.

FANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR REGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, e U.S. infant mortality rate reached its lowest level in history.

The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

In North Dakota the infant mortality rate decreased 4% between 1984 and 1992 -- from 8.1 to 7.8 per 1000 live births.

y Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, tional Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality ta; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, nployee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Ohio, 20.6% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Ohio, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Ohio, 40,000 births were financed by Medicaid in 1991, compared to 28,350 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Ohio Medicaid expenditures for all covered children under age 21 were $1,152 per child, compared to $12,263 per elderly adult.

Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

Payments for maternity and newborn care were 5.5% of total Medicaid expenditures in Ohio in 1991.

EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, DICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM LODING. During the 1980s, as the cost of private insurance rose for employers and lies, many dropped dependent coverage of women and children. For children and pregnant en, Medicaid expansions offset the loss of private coverage for a few years. However, by , growth in the number of uninsured children outpaced Medicaid.

In Ohio, 832,484 children under age 21 received Medicaid covered services in 1993, but an estimated 305,746 were uninsured.

Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

In Ohio, there were 309,375 uninsured women of childbearing age in 1993.

DICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED SPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were ingle largest source of hospital uncompensated care costs.

As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

In Ohio, the percentage of deliveries considered uncompensated hospital care dropped from 12.7% in 1986 to 5.2% in 1990.

ANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR GNANT WOMEN. During the period of the Medicaid expansions for pregnant women, J.S. infant mortality rate reached its lowest level in history.

The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

In Ohio the infant mortality rate decreased 10% between 1984 and 1992 -- from 10.4 to 9.4 per 1000 live births.

Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, nal Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, oyee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Oklahoma, 19.2% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Oklahoma, the Medicaid eligibility level for pregnant women and infants is set at 150% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Oklahoma, 18,000 births were financed by Medicaid in 1991, compared to 5,010 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Oklahoma Medicaid expenditures for all covered children under age 21 were $1,375 per child, compared to $5,170 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 5.2% of total Medicaid expenditures in Oklahoma in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Oklahoma, 214,412 children under age 21 received Medicaid covered services in 1993, but an estimated 207,086 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Oklahoma, there were 191,303 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Oklahoma, the percentage of deliveries considered uncompensated hospital care dropped from 12.2% in 1986 to 0.7% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Oklahoma the infant mortality rate decreased 20% between 1984 and 1992 -- from 11.0 to 8.8 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Oregon, 16.0% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Oregon, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Oregon, 14,000 births were financed by Medicaid in 1991, compared to 4,640 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Oregon Medicaid expenditures for all covered children under age 21 were $976 per child, compared to $6,537 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 8.5% of total Medicaid expenditures in Oregon in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Oregon, 185,463 children under age 21 received Medicaid covered services in 1993, but an estimated 133,023 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Oregon, there were 112,046 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Oregon, the percentage of deliveries considered uncompensated hospital care dropped from 16.3% in 1986 to 8.1% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Oregon the infant mortality rate decreased 28% between 1984 and 1992 -- from 9.9 to 7.1 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Pennsylvania, 18.9% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Pennsylvania, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Pennsylvania, 31,345 births were financed by Medicaid in 1991, compared to 22,320 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Pennsylvania Medicaid expenditures for all covered children under age 21 were $896 per child, compared to $8,266 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 2.8% of total Medicaid expenditures in Pennsylvania in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Pennsylvania, 639,623 children under age 21 received Medicaid covered services in 1993, but an estimated 331,901 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Pennsylvania, there were 295,337 uninsured women of childbearing age in 1993.

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- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Pennsylvania, the percentage of deliveries considered uncompensated hospital care dropped from 6.2% in 1986 to 2.6% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Pennsylvania the infant mortality rate decreased 14% between 1984 and 1992 -- from 10.4 to 9.0 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Rhode Island, 20.4% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Rhode Island, the Medicaid eligibility level for pregnant women and infants is set at 250% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 1.3% of total Medicaid expenditures in Rhode Island in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Rhode Island, there were 21,378 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Rhode Island, the percentage of deliveries considered uncompensated hospital care dropped from 5.3% in 1986 to 1.8% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Rhode Island the infant mortality rate decreased 25% between 1984 and 1992 -- from 9.9 to 7.4 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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IEDICAID PROTECTS MATERNAL AND CHILD HEALTH

TWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH MINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID PANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

LLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID R HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal requires states to cover pregnant women and children under age six with family incomes up 33% of poverty and to cover older children (born after September 30, 1983) up to 100% of erty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups ided coverage for 3 million low-income children. Additional children are covered on the s of disability through the Supplemental Security Income (SSI) program.

In South Carolina, 18.6% of children under 18 were covered by Medicaid during 1990-92.

Among U.S. children covered by Medicaid, more than half live in a working family.

1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant nen and infants in low-income, working families. Most (22) states set eligibility at 185% overty (about $23,000 per year for a family of three), but several go beyond that level.

In South Carolina, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

In South Carolina, 22,333 births were financed by Medicaid in 1991, compared to 7,300 in 1985.

ILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO CREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women elatively low and represents only a small fraction of Medicaid payments. While children pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, ments made on behalf of these groups were only 11% of the growth in Medicaid spending.

Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

In 1993, South Carolina Medicaid expenditures for all covered children under age 21 were $1,219 per child, compared to $4,562 per elderly adult.

Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

Payments for maternity and newborn care were 6.1% of total Medicaid expenditures in South Carolina in 1991.

EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, DICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM 'LODING. During the 1980s, as the cost of private insurance rose for employers and lies, many dropped dependent coverage of women and children. For children and pregnant ıen, Medicaid expansions offset the loss of private coverage for a few years. However, by :, growth in the number of uninsured children outpaced Medicaid.

In South Carolina, 253,593 children under age 21 received Medicaid covered services in 1993, but an estimated 172,014 were uninsured.

Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

In South Carolina, there were 148,036 uninsured women of childbearing age in 1993.

DICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED SPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were ingle largest source of hospital uncompensated care costs.

As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

In South Carolina, the percentage of deliveries considered uncompensated hospital care dropped from 9.9% in 1986 to 4.5% in 1990.

ANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR EGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, U.S. infant mortality rate reached its lowest level in history.

The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

In South Carolina the infant mortality rate decreased 29% between 1984 and 1992 -- from 14.7 to 10.4 per 1000 live births.

Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, nal Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, loyee Benefit Research Institute, Children's Defense Fund, and RAND.

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MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID EXPANSIONS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In South Dakota, 13.4% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In South Dakota, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In South Dakota, 3,021 births were financed by Medicaid in 1991, compared to 470 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, South Dakota Medicaid expenditures for all covered children under age 21 were $1,450 per child, compared to $8,849 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 5.2% of total Medicaid expenditures in South Dakota in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In South Dakota, 39,851 children under age 21 received Medicaid covered services in 1993, but an estimated 25,595 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In South Dakota, there were 20,872 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In South Dakota the infant mortality rate decreased 7% between 1984 and 1992 -- from 10.0 to 9.3 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Tennessee, 26.4% of children under 18 were covered by Medicaid during 1990-92.
- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Tennessee, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.
- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.
- In 1993, Tennessee Medicaid expenditures for all covered children under age 21 were $946 per child, compared to $4,347 per elderly adult.
- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.
- Payments for maternity and newborn care were 6.1% of total Medicaid expenditures in Tennessee in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Tennessee, 470,657 children under age 21 received Medicaid covered services in 1993, but an estimated 198,282 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Tennessee, there were 152,880 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Tennessee, the percentage of deliveries considered uncompensated hospital care dropped from 16.0% in 1986 to 5.1% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Tennessee the infant mortality rate decreased 20% between 1984 and 1992 -- from 11.8 to 9.4 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Texas, 21.2% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Texas, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Texas, 116,000 births were financed by Medicaid in 1991, compared to 21,820 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Texas Medicaid expenditures for all covered children under age 21 were $1,143 per child, compared to $5,337 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 7.2% of total Medicaid expenditures in Texas in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Texas, 1,429,380 children under age 21 received Medicaid covered services in 1993, but an estimated 1,348,522 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Texas, there were 928,286 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Texas, the percentage of deliveries considered uncompensated hospital care dropped from 17.0% in 1986 to 11.7% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Texas the infant mortality rate decreased 26% between 1984 and 1992 -- from 10.5 to 7.8 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Utah, 8.7% of children under 18 were covered by Medicaid during 1990-92.
- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Utah, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.
- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.
- In Utah, 9,400 births were financed by Medicaid in 1991, compared to 1,850 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.
- In 1993, Utah Medicaid expenditures for all covered children under age 21 were $997 per child, compared to $7,514 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 9.6% of total Medicaid expenditures in Utah in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Utah, 89,029 children under age 21 received Medicaid covered services in 1993, but an estimated 65,881 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Utah, there were 41,684 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Utah, the percentage of deliveries considered uncompensated hospital care dropped from 14.0% in 1986 to 5.1% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Utah the infant mortality rate decreased 35% between 1984 and 1992 -- from 9.1 to 5.9 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Vermont, 17.2% children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Vermont, the Medicaid eligibility level goes beyond the federal standard and is set at 200% of poverty for pregnant women and 225% for infants and children.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Vermont, 1,704 births were financed by Medicaid in 1991, compared to 1,290 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Vermont Medicaid expenditures for all covered children under age 21 were $875 per child, compared to $7,272 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 3.2% of total Medicaid expenditures in Vermont in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Vermont, 39,523 children under age 21 received Medicaid covered services in 1993, but an estimated 15,326 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Vermont, there were 17,627 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Vermont, the percentage of deliveries considered uncompensated hospital care dropped from 12.6% in 1986 to 4.4% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Vermont the infant mortality rate decreased 17% between 1984 and 1992 -- from 8.7 to 7.2 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Virginia, 13.5% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Virginia, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Virginia Medicaid expenditures for all covered children under age 21 were $1,030 per child compared to $6,164 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 5.1% of total Medicaid expenditures in Virginia in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Virginia, 318,892 children under age 21 received Medicaid covered services in 1993, but an estimated 293,461 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Virginia, there were 239,241 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Virginia, the percentage of deliveries considered uncompensated hospital care dropped from 18.6% in 1986 to 15.4% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Virginia the infant mortality rate decreased 22% between 1984 and 1992 -- from 12.1 to 9.5 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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MILLIONS OF CHILDREN AND PREGNANT WOMEN NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE, INCLUDING THOSE IN WORKING FAMILIES. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover older children (born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered on the basis of disability through the Supplemental Security Income (SSI) program.

- In Washington State, 16.5% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Washington, the Medicaid eligibility level for pregnant women and infants is set at 185% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Washington, 27,114 births were financed by Medicaid in 1991, compared to 12,550 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Washington Medicaid expenditures for all covered children under age 21 were $798 per child, compared to $7,964 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 8.1% of total Medicaid expenditures in Washington in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Washington, 334,580 children under age 21 received Medicaid covered services in 1993, but an estimated 138,832 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Washington, there were 178,125 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Washington the infant mortality rate decreased 34% between 1984 and 1992 -- from 10.2 to 6.8 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, April 1995

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

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- In West Virginia, 27.8% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In West Virginia, the Medicaid eligibility level for pregnant women and infants is set at 150% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In West Virginia, 9,209 births were financed by Medicaid in 1991, compared to 5,140 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, West Virginia Medicaid expenditures for all covered children under age 21 were $1,258 per child, compared to $6,985 per elderly adult.

Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

Payments for maternity and newborn care were 5.4% of total Medicaid expenditures in West Virginia in 1991.

; EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, EDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM XPLODING. During the 1980s, as the cost of private insurance rose for employers and nilies, many dropped dependent coverage of women and children. For children and pregnant)men, Medicaid expansions offset the loss of private coverage for a few years. However, by 92, growth in the number of uninsured children outpaced Medicaid.

In West Virginia, 185,819 children under age 21 received Medicaid covered services in 1993, but an estimated 82,444 were uninsured.

Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

In West Virginia, there were 84,399 uninsured women of childbearing age in 1993.

EDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED OSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were : single largest source of hospital uncompensated care costs.

As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

In West Virginia, the percentage of deliveries considered uncompensated hospital care dropped from 13.1% in 1986 to 4.3% in 1990.

IFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR REGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, e U.S. infant mortality rate reached its lowest level in history.

The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

In West Virginia the infant mortality rate decreased 17% between 1984 and 1992 -- from 11.0 to 9.2 per 1000 live births.

:y Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, ıtional Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality ıta; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, nployee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Wisconsin, 15.1% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Wisconsin, the Medicaid eligibility level for pregnant women and infants is set at 155% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Wisconsin, 20,064 births were financed by Medicaid in 1991, compared to 13,410 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Wisconsin Medicaid expenditures for all covered children under age 21 were $762 per child, compared to $9,920 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

- Payments for maternity and newborn care were 5.1% of total Medicaid expenditures in Wisconsin in 1991.

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage of women and children. For children and pregnant women, Medicaid expansions offset the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In Wisconsin, 227,019 children under age 21 received Medicaid covered services in 1993, but an estimated 115,426 were uninsured.

- Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

- In Wisconsin, there were 95,796 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

- In Wisconsin, the percentage of deliveries considered uncompensated hospital care dropped from 7.6% in 1986 to 2.1% in 1990.

INFANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

- In Wisconsin the infant mortality rate decreased 27% between 1984 and 1992 -- from 9.9 to 7.2 per 1000 live births.

Key Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

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- In Wyoming, 13.2% of children under 18 were covered by Medicaid during 1990-92.

- Among U.S. children covered by Medicaid, more than half live in a working family.

By 1994, at their option, 34 states had gone beyond federal mandates to reach more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), but several go beyond that level.

- In Wyoming, the Medicaid eligibility level for pregnant women and infants is set at 133% of poverty.

- Medicaid finances care for one out of three babies -- 1.4 million infants in 1993.

- In Wyoming, 2,400 births were financed by Medicaid in 1991, compared to 390 in 1985.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Wyoming Medicaid expenditures for all covered children under age 21 were $1,109 per child, compared to $9,277 per elderly adult.

Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

Payments for maternity and newborn care were 10.1% of total Medicaid expenditures in Wyoming in 1991.

EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, EDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM PLODING. During the 1980s, as the cost of private insurance rose for employers and ilies, many dropped dependent coverage of women and children. For children and pregnant men, Medicaid expansions offset the loss of private coverage for a few years. However, by 92, growth in the number of uninsured children outpaced Medicaid.

In Wyoming, 27,933 children under age 21 received Medicaid covered services in 1993, but an estimated 18,075 were uninsured.

Nationally, the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.

In Wyoming, there were 15,568 uninsured women of childbearing age in 1993.

EDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED OSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care were single largest source of hospital uncompensated care costs.

As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

In Wyoming, the percentage of deliveries considered uncompensated hospital care dropped from 22.9% in 1986 to 19.0% in 1990.

FANT MORTALITY RATES DECLINED AS MEDICAID EXPANDED FOR REGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, e U.S. infant mortality rate reached its lowest level in history.

The U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.

In Wyoming the infant mortality rate decreased 19% between 1984 and 1992 -- from 11.1 to 8.9 per 1000 live births.

y Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, tional Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality ta; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Guttmacher Institute, nployee Benefit Research Institute, Children's Defense Fund, and RAND.

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Effect of House Proposal to Cut Medicaid by $182 Billion on Children's Medicaid Coverage

Projected Federal Funding Cut in Year 2002 - $53 billion in cuts to states

	People covered by Medicaid FY1994 (actual)	Children covered by Medicaid FY 1994 (actual)	People covered by Medicare July 1, 1994	Percent reduction in 2002	Estimated children who would lose Medicaid in 2002 due to cuts
UNITED STATES	40,348,409	22,972,085	35,779,000	30%	6,891,626
ALABAMA	612,220	346,009	624,000	15%	51,901
ALASKA	86,384	52,430	32,000	41%	21,496
ARIZONA	662,646	457,842	578,000	21%	96,147
ARKANSAS	364,725	191,297	415,000	35%	66,954
CALIFORNIA	6,778,152	3,805,000	3,432,000	27%	1,027,350
COLORADO	367,591	215,844	405,000	33%	71,229
CONNECTICUT	372,817	200,300	493,000	30%	60,090
DELAWARE	83,158	52,720	98,000	38%	20,034
DISTRICT OF COLUMBIA	148,509	84,560	75,000	36%	30,442
FLORIDA	2,202,774	1,306,100	2,574,000	33%	431,013
GEORGIA	1,169,937	695,643	809,000	33%	229,562
HAWAII	132,608	74,052	144,000	27%	19,994
IDAHO	125,899	79,084	146,000	27%	21,353
ILLINOIS	1,884,173	1,099,229	1,589,000	29%	318,776
INDIANA	650,674	386,554	813,000	44%	170,084
IOWA	333,870	179,295	471,000	23%	41,238
KANSAS	280,099	163,431	378,000	13%	21,246
KENTUCKY	684,227	353,998	568,000	35%	123,899
LOUISIANA	799,440	470,615	565,000	27%	127,066
MAINE	196,556	97,458	197,000	29%	28,263
MARYLAND	593,256	336,578	586,000	32%	107,705
MASSACHUSETTS	803,110	412,016	920,000	32%	131,845
MICHIGAN	1,464,923	811,500	1,319,000	25%	202,875
MINNESOTA	507,323	295,615	622,000	29%	85,728
MISSISSIPPI	644,707	369,286	389,000	23%	84,936
MISSOURI	766,938	445,002	819,000	7%	31,150
MONTANA	101,053	57,800	127,000	37%	21,386
NEBRASKA	173,133	107,263	246,000	35%	37,542
NEVADA	130,318	78,882	183,000	30%	23,665
NEW HAMPSHIRE *	–	–	152,000	–	–
NEW JERSEY	859,628	463,587	1,143,000	38%	176,163
NEW MEXICO	292,489	178,960	202,000	24%	42,950
NEW YORK	3,264,090	1,745,568	2,532,000	35%	610,949
NORTH CAROLINA	1,051,854	585,673	999,000	39%	228,412
NORTH DAKOTA	69,098	36,259	102,000	30%	10,878
OHIO	1,648,838	945,871	1,632,000	30%	283,761
OKLAHOMA	448,687	258,236	479,000	35%	90,383
OREGON	454,484	224,304	459,000	28%	62,805
PENNSYLVANIA	1,728,068	919,544	2,051,000	22%	202,300
RHODE ISLAND 4/	114,850	43,896	166,000	42%	18,436
SOUTH CAROLINA	527,641	298,075	490,000	17%	50,673
SOUTH DAKOTA	82,012	50,128	116,000	27%	13,535
TENNESSEE	946,330	495,452	753,000	34%	168,454
TEXAS	2,870,261	1,835,095	2,019,000	20%	367,019
UTAH	203,535	129,081	181,000	30%	38,724
VERMONT	102,475	56,995	81,000	35%	19,948
VIRGINIA	704,742	420,687	789,000	34%	143,034
WASHINGTON	792,441	449,681	668,000	43%	193,363
WEST VIRGINIA	465,064	259,408	326,000	42%	108,951
WISCONSIN	642,240	359,792	752,000	29%	104,340
WYOMING	56,501	34,286	58,000	38%	13,029

These estimates are limited to the final year of the proposed seven-year cut. Cumulative cuts over the seven years would result in significantly higher losses in each state.

NOTES: 1) Based on the Urban Institute's Medicaid Expenditure Growth Model, the Commerce Committee's formula as of September 16, 1995, the GAO's estimates of spending by states under the proposal. Source: U.S. DHHS. 2) with the exception of Rhode Island, children are all persons under 21 enrolled in FY1994; 3) estimates assume that federal cuts would be translated by the states into proportional across-the-board eligibility cutbacks and so child enrollment would be cut by the same percentage as the state's federal Medicaid cut.