CBO MEMORANDUM

EXPANDING HEALTH INSURANCE
COVERAGE FOR CHILDREN
UNDER TITLE XXI OF THE
SOCIAL SECURITY ACT

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The Balanced Budget Act of 1997 provided funds to expand health insurance coverage for children by creating the State Children's Health Insurance Program as part of title XXI of the Social Security Act. This Congressional Budget Office (CBO) memorandum offers preliminary information about how the states are responding to the program and how many children may gain coverage. It also reviews current estimates of the number of uninsured children, characteristics of those children that have important implications for subsidy programs, and the goals of policymakers in seeking to expand coverage.

Linda Bilheimer of CBO's Health and Human Resources Division prepared the memorandum under the direction of Joseph Antos. Carol Frost did the computer programming for the analysis. Amy Weber checked the memorandum for accuracy. A number of people at CBO provided helpful comments and suggestions, including Nabeel Alsalam, Dorothy Rosenbaum, Murray Ross, Jeanne De Sa, and Bruce Vavrichek.

Leah Mazade edited the manuscript, and Christian Spoor proofread it. Sharon Corbin-Jallow prepared the document for publication.

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SUMMARY AND INTRODUCTION

Since the demise of the President's health care reform initiative in 1994, both the President and the Congress have moved away from comprehensive proposals to provide health coverage for the uninsured. Instead, they have sought more incremental approaches that target particular subgroups of the population. The Balanced Budget Act of 1997 expanded health insurance coverage for children by establishing the State Children's Health Insurance Program (S-CHIP) as part of title XXI of the Social Security Act.

Advocates maintain that uninsured children are a logical group for whom to expand coverage. They are relatively inexpensive to insure and could gain considerable benefits from coverage. Uninsured children are less likely than those with insurance to have a regular health care provider, to see a physician during the year, or to be fully immunized.[1] Moreover, despite the expansions in Medicaid coverage for children that occurred in the early 1990s, the proportion of children who are uninsured appears to be growing (see Box 1). Recent estimates suggest that more than 15 percent of children are uninsured, the large majority of whom come from low-income families.

S-CHIP will provide federal matching funds to assist the states in providing coverage for such children. Most states will undoubtedly choose to participate in the program, raising their Medicaid income-eligibility standards for children, establishing separate health insurance programs for them, or, in some cases, doing both. Although those initiatives should reduce the number of uninsured children significantly, some displacement of both private and other publicly financed coverage is likely to occur.

The formula for allocating federal S-CHIP funds among the states depends on estimates of the number of uninsured and low-income children in each state, as derived from the Census Bureau's Current Population Survey (CPS). But even national estimates of the number of uninsured children from the CPS are quite uncertain, and the state-specific estimates can be highly unreliable (even if three-year averages are used, as S-CHIP requires). Volatile estimates of the number of uninsured children, as well as changes in the allocation formula over time and a sharp drop in the overall federal allocation in 2002, could cause some states to experience sudden and relatively large reductions in their annual S-CHIP allocations.

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1. See Families USA Foundation, *Unmet Needs: The Differences in Health Care Between Uninsured and Insured Children* (Washington, D.C.: Families USA, June 1997); and General Accounting Office, *Health Insurance Coverage Leads to Increased Health Care Access for Children,* GAO/HEHS-98-14 (November 1997).

BOX 1.
MEDICAID COVERAGE OF CHILDREN

Under provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), all states are required to provide Medicaid coverage for children under age 6 living in families whose income is below 133 percent of the poverty level. That mandate was followed by another in OBRA-90 requiring states to cover all children under age 19 who live in families with income below the poverty level and who were born after September 30, 1983. That phase-in of coverage for poor children will be completed by October 2002.

Many states have used a variety of mechanisms to expand coverage of children beyond the mandated levels. As of August 1997, 35 states had expanded coverage for infants, 13 states had expanded coverage for children ages 1 to 5, and 28 states had expanded coverage for children ages 6 and over.[1]

Partly as a result of those initiatives, Medicaid coverage of children grew rapidly in the early 1990s. Administrative data from the Health Care Financing Administration's Form 2082 indicate that the number of children under age 21 who were enrolled in the program grew at an annual rate of 10 percent between 1991 and 1993, from 16.0 million to 19.5 million.[2] Growth was much slower after 1993, which was probably a reflection of the improving economy. About 900,000 more children were added to the program between 1993 and 1995. Enrollment then declined slightly, to 20.3 million, in 1996.

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1. National Governors' Association, "State Medicaid Coverage of Pregnant Women and Children," *MCH Update* (Washington, D.C.: National Governors' Association, September 30, 1997).

2. See Patrick Purcell, *Medicaid Spending and Enrollment: A State Chart Book,* CRS Report for Congress 96-839 EPW (Congressional Research Service, revised September 22, 1997). This report does not provide enrollment data for children in other age groups.

This memorandum reviews current estimates of the number of uninsured children, characteristics of those children that have important implications for subsidy programs, and the goals of policymakers in seeking to expand coverage. A discussion of S-CHIP follows—how the program may work, how many children may gain coverage, and how the states are responding.

THE CHALLENGE OF PROVIDING COVERAGE TO UNINSURED CHILDREN

Estimates from the CPS indicate that 11.3 million children under age 19 lacked health insurance coverage in 1996, an increase of almost 800,000 from the previous year (see Table 1). That growth, which boosted the proportion of uninsured children from 14.0 percent to 15.1 percent, occurred despite a small rise in the number of

TABLE 1. HEALTH INSURANCE COVERAGE OF CHILDREN AGE 18 AND UNDER, AS ESTIMATED FROM THE CURRENT POPULATION SURVEY (In millions of children)

	Employer-Sponsored Coverage	Other Private Insurance	Medicaid	Other Public Insurance	Uninsured
1995	47.3	4.5	16.4	1.4	10.5
1996	47.6	4.1	15.3	1.5	11.3

SOURCE: Congressional Budget Office.

NOTES: The coverage estimates are derived from the March supplement to the CPS and nominally represent the number of children who had any coverage in the previous calendar year. That is, the March 1996 estimates reflect children with any coverage in 1995, and the March 1997 estimates reflect children with any coverage in 1996. (Some children may report multiple sources of coverage.) The estimates of the uninsured reflect children who reported no coverage of any type in the previous year; however, the CPS estimates actually appear to be closer to point-in-time than to ever-covered estimates.

The category of other public insurance includes children who receive coverage only through the Indian Health Service.

children with employer-sponsored coverage. The estimated number of children with Medicaid coverage, however, fell significantly.

Those estimates require careful interpretation. The CPS collects information on insurance status from a sample of households in March of each year. Although the survey asks questions about the insurance coverage of household members in the previous year, many analysts believe that the responses more closely reflect insurance coverage at the time of the interview. Under that interpretation, the estimate of 11.3 million is closer to the number of children who were uninsured in March 1997 than to the number who were uninsured throughout 1996. In that case, fewer than 11.3 million children would have been uninsured for the entire year, but many more would have been uninsured for at least part of the year.

Characteristics of Uninsured Children

According to the CPS, more than two-thirds of uninsured children come from low-income families, and the majority have at least one parent who works full time. Uninsured children in low-income families are about equally divided between poor families (those with income that falls below the poverty level) and near-poor families (those with income of between 100 percent and 200 percent of the poverty level).

Only a small fraction of poor children have private coverage. Many near-poor children, by contrast, have employer-sponsored insurance at least part of the time but also experience spells without coverage during the year. The sporadic nature of their coverage reflects the variability of their parents' income and employment status.

The proportion of children who are uninsured varies widely among the states. Differences in socioeconomic conditions and in Medicaid income-eligibility standards for children, and in the other initiatives already established in the state to provide coverage for low-income children and families, contribute to that variation. As a result, children living in the South and Southwest are much more likely to be uninsured than those living elsewhere in the country.[2] That diversity underlies the policy for allocating S-CHIP funds among the states. Hence, reliable estimates of the distribution of uninsured children are of major importance for S-CHIP. But as discussed in the appendix, state-level estimates of uninsured children from the CPS (the basis for the S-CHIP allocations) can be highly inaccurate and variable over time, particularly for smaller states.

Policy Goals

Policymakers have identified several major goals for policies to expand coverage for children. They include the following:

- Participation by low-income, uninsured children without extensive displacement of private coverage;
- Coverage that includes benefits appropriate for children; and
- Continuity of coverage and effective coordination with the Medicaid program.

Targeting Uninsured Children. Policymakers are concerned about the possibility that federal health insurance subsidies might displace private insurance. But if low income is the primary criterion for eligibility, directing subsidies only to children who would otherwise be uninsured is difficult.

Health insurance subsidies are likely to displace private coverage because many near-poor children have such coverage some of the time. (Displacement of private coverage is much less likely among children in poor families.) Considerable

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2. The CPS data suggest, for example, that a child in Texas, New Mexico, or Arizona is three times more likely to be uninsured than a child in Minnesota or Wisconsin. See Patrick Purcell, *Health Insurance: Uninsured Children by State, 1994-1996,* CRS Report for Congress 97-310 EPW (Congressional Research Service, updated on October 3, 1997).

evidence suggests, moreover, that generous subsidies are necessary for any significant reduction in the number of uninsured children. Few uninsured low-income families will purchase coverage for their children if they have to pay more than a small share of the premium. The more generous the subsidy, however, the greater is the likelihood that children who would otherwise have been privately insured will participate.

Efforts to restrict the use of subsidies by families who would otherwise have private coverage may have some success in the short run. A program could, for example, prohibit participation for some period of time following a child's dis-enrollment from any employer-sponsored plan. Although that restriction would be difficult to enforce, it would provide a disincentive for low-income workers to drop family coverage that they currently have.[3] But displacement of private coverage may occur in less obvious ways than when employers or families drop existing coverage in order to gain a subsidy. Over time, labor markets are likely to adapt to the presence of federal subsidies, a phenomenon that is difficult to measure. New low-wage firms, for instance, may choose not to offer family coverage if subsidized coverage for children is available. Or low-wage workers may seek jobs in firms that offer higher wages in lieu of insurance.

Coverage of Appropriate Benefits. Deciding what benefits a children's health insurance plan should cover involves a trade-off between keeping the program affordable and providing additional services that children in particular may need. Examples of those include hearing and vision services, dental care, and enriched mental health benefits—services that are not well covered by many private insurance plans but are covered by Medicaid. For a given level of federal spending, however, a richer package of benefits means that fewer children can be covered.

Cost-sharing provisions reduce the costs per covered child, making it possible to cover more children. Furthermore, requiring beneficiaries to make copayments lowers the public cost of the program; it may also encourage more responsible use of services and lessen any perceived stigma associated with a public program.

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3. Studies of two states, Minnesota and Florida, that currently run health insurance programs for low-income families report that those types of safeguards effectively minimize displacement. In Florida's case, however, most of the children enrolling in the program have family income below 130 percent of the poverty level, and one would not expect much displacement of private coverage at those income levels. The evaluations of both programs focused primarily on whether children had private health insurance before enrolling in the program, and neither study tracked whether children who subsequently became eligible for employer-sponsored insurance continued in the program or switched to private coverage. See Kathleen Thiede Call and others, "Who is Still Uninsured in Minnesota?" *Journal of the American Medical Association*, vol. 278, no. 14 (October 8, 1997), pp. 1191-1195; and Elizabeth Shenkman and others, *The Florida Healthy Kids Program: Are There Indications of Crowdout?* Working Paper Series (Gainesville, Fla.: Institute for Child Health Policy, September 1997).

However, cost-sharing requirements that exceed minimal levels may discourage participation by low-income families.

Continuity of Coverage and Coordination with the Medicaid Program. Advocates generally argue that any expansion of insurance coverage should be "seamless" for beneficiaries and their families. That is, small changes in income should not require families to change their coverage, and all children in a family should be subject to the same income-eligibility standards. Those goals may be difficult to accomplish if a separate health insurance program is established for children but all Medicaid-eligible children are required to enroll in Medicaid. Barring children who are eligible for Medicaid from enrolling in the new program would be a difficult requirement to enforce, necessitating careful checking of eligibility. Moreover, because the income of low-income families tends to vary, their eligibility status may change quite frequently. As a result, children would be required to shift back and forth between Medicaid and the alternative insurance program and in some cases might have to change providers.

Shifting between plans and providers will not be a significant problem if any new initiative is an expansion of the Medicaid program rather than a separate health insurance option. A separate option that runs parallel to the Medicaid program, using the same health plans and providers, would also minimize the difficulty of moving from one program to another. But if the rules differ for newly eligible children, program administration will become more complex, and the new program will be harder for low-income families to understand.

Establishing a separate children's health insurance program will also result in greater enrollment in Medicaid. Outreach efforts to bring children into the program will attract some children who are eligible for but not enrolled in Medicaid. If those children are referred to the Medicaid program, its enrollment will rise.

KEY FEATURES OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

The Balanced Budget Act appropriated about $40 billion in federal funds for S-CHIP over the 1998-2007 period. Unlike the Medicaid program, which is an entitlement, federal funding for S-CHIP will be capped each year. To qualify for S-CHIP funds, states must submit a plan to the Health Care Financing Administration (HCFA) detailing how they intend to expand coverage for children.

Eligibility for the Program

Children's eligibility for S-CHIP will vary by state, reflecting differences in eligibility standards among state Medicaid programs. Family income is the primary criterion for determining eligibility for S-CHIP, with most states having the option to cover children from families with income of up to 200 percent of the poverty level. But states that already provide Medicaid coverage for children with family income of at least 150 percent of the poverty level may have income-eligibility standards for S-CHIP that are as much as 50 percentage points higher than their current standards for Medicaid.

The act also restricts eligibility in other ways. Children who are eligible for Medicaid, for example, and those with private health insurance coverage (either individual or group) are excluded from participating. Also excluded are children who are eligible to enroll in a state health benefits plan through a parent who works for a public agency. That provision has caused considerable concern among some states in which low-income workers in the public sector cannot afford to participate in the state's health benefits program. (Five states make no health insurance contribution at all for the dependents of their employees.) In a recent opinion, HCFA announced that the exclusion will apply only to new health insurance programs for children and not to Medicaid expansions.[4]

As a consequence of provisions in the welfare reform legislation passed in 1996, certain legal immigrant children in low-income families will also be unable to participate in S-CHIP. Because S-CHIP is means-tested, most legal immigrant children who arrived in the country after August 22, 1996, will be ineligible for the program during their first five years of residency. States have the option, however, of covering legal immigrant children who arrived before August 22, 1996. The exclusion of legal immigrants will be particularly significant in states such as California and Texas, which have large immigrant populations, many of whom are uninsured. (The Administration's budget proposal for fiscal year 1999 would modify those provisions, giving states the option to cover all legal immigrant children under Medicaid or S-CHIP.)

Coverage Options

States may use their S-CHIP funds to expand Medicaid, to develop or expand other insurance programs for children, or to provide services directly. But states'

4. Health Care Financing Administration, "Frequently Asked Questions and Answers: State Children's Health Insurance Program Medicaid-Related Provisions," October 10, 1997 (available at www.hcfa.gov/init/qa/q&a10-10.htm).

expenditures for direct service provision, outreach, and program administration may not exceed 10 percent of their total spending under the program. Tax credits for the purchase of health insurance were also widely discussed during the debate over title XXI but were not included in the legislation (see Box 2).

Expanding Medicaid. Using the Medicaid program as the vehicle to extend coverage to more children builds on an existing institutional structure and requires relatively little program modification. Consequently, it is an option with considerable appeal for many states. Some advocates also support that approach because it provides some of the seamlessness of coverage that they are seeking for families and because Medicaid has a comprehensive benefit package for children.

Expanding Medicaid, however, has several disadvantages relative to other options. Enrollment targets may be difficult to reach if some low-income families forgo coverage because of the stigma they perceive to be associated with the program. In addition, some states view Medicaid's generous benefits as a disadvantage: the states believe they could cover more children if the benefit package to be offered was less costly.

Medicaid expansions also pose financial risks for states. Total expenditures under the program cannot be capped under current law, even though S-CHIP funds

BOX 2.
TAX CREDITS FOR CHILDREN'S HEALTH INSURANCE

Although policymakers considered several tax credit options in 1997, the final title XXI legislation did not incorporate them. Most tax credit proposals would provide financial incentives for working parents to participate in their employer's health plan, if such a plan was available to them. Otherwise, a tax credit would provide them with financial assistance to purchase coverage in the small-group market or through a state program. Tax credits lack the stigma that some people associate with Medicaid and, depending on the level of the subsidy, might allow participants a greater choice of health plans than other options could offer.

Tax credits for individual families, however, would probably produce lower participation rates than direct subsidies of the same monetary value. Low-income families could experience cash flow problems if they had to pay insurance premiums during the year but only received the tax credit at the end of the tax year. Moreover, even if the credit was made available at the time a family purchased a health plan, the family would still face the possibility of having to repay part of the credit at the end of the tax year if its income rose during the year. Such uncertainty might discourage some families from participating. Having to deal with the tax system could also pose a challenge for some low-income families, many of whom would not ordinarily file a tax return.

Because of those concerns, some policymakers considered alternative approaches to tax credits, whereby employers would claim the credit on behalf of their low-income employees, who would, in effect, receive a direct subsidy. But those proposals, too, were eventually dropped.

are capped. Thus, if a state expands its Medicaid program and depletes all of its S-CHIP funds, it will still be obligated to cover eligible children at the regular Medicaid matching rate.

Funding Alternative Insurance Programs. Some states will adopt this approach rather than expand Medicaid because they already have programs in place—funded by state and local governments as well as by the private sector—that are providing insurance coverage for children who are not eligible for Medicaid. Other states may also turn to alternative insurance coverage because they believe that they are in a better position than the federal government to design programs to meet the needs of their particular populations. Not having to satisfy all of the requirements of the Medicaid program, such as mandatory benefits and limits on cost sharing, gives the states more flexibility to design effective programs. In addition, because this type of program does not have to be an individual entitlement, program outlays can be capped.

Providing Services Directly. An alternative to demand-based approaches for expanding coverage is to increase the number and accessibility of providers that serve low-income families. That strategy might involve expansions of state and local health department clinics, more funding for federally qualified health centers, or direct contracts with hospitals that serve low-income families. But an approach of that kind would not provide any more insurance coverage for children, although it might be effective in enabling low-income children to gain access to care. Moreover, it would restrict the providers from whom those children could receive services and might limit the benefits they received. In addition, ensuring that the funds were used only for children's health care would be difficult. That concern was an important consideration in restricting the proportion of S-CHIP funds that could be used for direct services.

Required Benefits and Cost-Sharing Limitations

The benefits for which children are eligible depend on the program options that the states select. States that choose to expand their Medicaid program must offer the full Medicaid benefit package; those that choose alternative approaches must meet the standards for minimum benefits specified in title XXI. The resulting set of choices is complicated, however, and the standards could prove difficult to enforce (see Box 3). Moreover, the minimum-benefits standards will vary among the states.[5]

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5. See, for example, Bureau of National Affairs, "Benchmark Plans for Kid Care Program Vary Widely in Mental Health Coverage," *BNA Health Care Daily* (November 19, 1997).

BOX 3.
COVERAGE OPTIONS FOR STATE CHILDREN'S HEALTH INSURANCE PROGRAMS

Under title XXI, states that elect to develop separate health insurance programs for children, rather than expand Medicaid, may choose from several options for covered benefits.

Option 1

States may choose one of three benchmark packages: the Blue Cross/Blue Shield standard option in the Federal Employees Health Benefits Program; a health benefits plan that is offered and generally available to state employees; or the benefits offered by the health maintenance organization with the highest commercial enrollment in the state.

Option 2

Alternatively, states may select a benefit package that is actuarially equivalent to one of the benchmark packages. States that adopt that option must provide coverage for inpatient and outpatient hospital services, physicians' services, laboratory and x-ray services, and well-baby and well-child care. In addition, if the benchmark package that they are using to establish actuarial equivalence covers prescription drugs, mental health services, hearing services, or vision services, the package must cover those services at a level of at least 75 percent of the actuarial value in the benchmark.

Option 3

Florida, New York, and Pennsylvania may use the benefit packages in their existing children's health programs, but they must adapt those packages, if necessary, to meet the title XXI cost-sharing limitations.

Option 4

States may apply to the Secretary of Health and Human Services for approval of an alternative benefit package.

The act also limits the premiums and cost sharing that states may require. No cost sharing is permitted for preventive services. In addition, for families with income below 150 percent of the poverty level, states may not impose premiums or enrollment fees that would be impermissible under Medicaid, and out-of-pocket payments may be no more than nominal. States may, however, require families with income above 150 percent of the poverty level to pay premiums and share costs (not to exceed 5 percent of income).

Payments to the States

Title XXI establishes annual federal allocations for S-CHIP for the 1998-2007 period. About $4.3 billion will be available each year from 1998 through 2001. But to ensure a balanced budget in 2002, the annual amount was reduced to about $3.2 billion for the following three years, before increasing again in 2005 (see Table 2).

Certain features of the S-CHIP program (discussed below) will mean that states will experience relatively large variations in their allocations of federal funds from year to year. Those variations will be compounded by the drop in annual federal allocations from 2002 through 2004. Consequently, states will need to manage their programs carefully and take advantage of the option to roll over part of any year's allocation for up to two succeeding years. But because of the start-up time necessary for states to develop their programs, submit plans to HCFA, and have those plans approved, most states will probably not be able to spend their full allotments for the first two years of the program anyway. The slow start in effect provides an automatic cushion for the leaner years of the program. The Congressional Budget Office (CBO) estimates that federal outlays for S-CHIP will be 25 percent of the total allocation in 1998 and 75 percent in 1999, reaching about $4 billion a year by 2000.

Allocations to the States. Each state's share of the total federal funds available is based on a formula that attempts to take into account its relative need and health care

TABLE 2. FEDERAL PAYMENTS FOR THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Budget Authority	4.3	4.3	4.3	4.3	3.2	3.2	3.2	4.1	4.1	5.0	5.0
Outlays	1.1	3.2	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.4	4.7

SOURCE: Congressional Budget Office.

NOTE: Under the baseline rules specified by the Balanced Budget and Emergency Deficit Control Act of 1985, CBO's projections assume that the same level of funding will be provided in 2008 as in 2007.

costs (see Table 3).[6] For the first three years of the program, relative need is determined by a state's share of the total number of low-income children who lack insurance coverage. Thus, California and Texas together are eligible to receive one-third of S-CHIP funds in 1998.[7]

But that approach to determining relative need puts states that have already expanded Medicaid eligibility for higher-income children or that have developed their own state-funded programs at an apparent disadvantage because of their generosity.[8] Consequently, the basis of the relative-need index will change in 2001 to a blend of 75 percent of the number of low-income uninsured children and 25 percent of the number of low-income children. The index will be based on a 50/50 blend in 2002 and thereafter.

If the relative distribution of uninsured children does not change much among the states, the switch to a blended index will shift funding significantly from the southwestern states to the northeastern and midwestern states. If the 50/50 blend was in place in 1998, for example, the allocations for some southwestern states would be from about 10 percent to 20 percent lower, and those for some midwestern states would be more than 30 percent higher.

Moreover, when the 50/50 blend comes into effect in 2002, the overall federal allocation for S-CHIP will drop by $1.1 billion, or almost 25 percent. Consequently, some states may face major reductions in their allocations that year. States that gain under the blended rate, however, will be cushioned from the full effects of the reduction in federal funds.

An additional, unforeseen factor compounds the uncertainty about states' future funding allocations. Those allocations hinge on the use of data from the Current Population Survey to determine the distribution of low-income and uninsured children among the states. Yet the CPS's estimates of the number of uninsured children by state are quite unreliable. S-CHIP uses three-year averages, rather than single-year estimates, to overcome the annual variability resulting from small

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6. Commonwealths and territories are eligible to receive 0.25 percent of the total federal S-CHIP appropriation. A further $60 million a year will be channeled to diabetes grant programs from 1998 to 2002. The remainder will be allocated to the states and the District of Columbia according to the formula.

7. Because newly arrived legal immigrants are excluded from coverage, significant numbers of uninsured children who are ineligible for S-CHIP may count toward the determination of relative need in California and Texas (and in other states with large numbers of immigrants).

8. Note, however, that program "generosity" is itself relative. That is, a high-income state that is covering children with family income of up to 185 percent of the poverty level may be covering a smaller percentage of its children than a low-income state that is covering children with income of up to 133 percent of the poverty level.

TABLE 3. ALLOTMENTS FOR THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM, FISCAL YEAR 1998

State	Number of Low-Income Children (Thousands)	State Cost Factor	Percentage of Total	Allotment (Millions of dollars)
Alabama	154	0.9510	2.05	86.4
Alaska	9	1.0669	0.13	5.7
Arizona	184	1.0472	2.69	113.7
Arkansas	90	0.8871	1.12	47.1
California	1,281	1.1365	20.33	858.9
Colorado	72	0.9888	0.99	42.0
Connecticut	53	1.1237	0.83	35.1
Delaware	13	1.0553	0.19	8.1
District of Columbia	16	1.2857	0.29	12.1
Florida	444	1.0368	6.43	271.6
Georgia	214	0.9923	2.97	125.3
Hawaii	13	1.1722	0.21	9.0
Idaho	31	0.8726	0.38	16.0
Illinois	211	0.9892	2.92	123.1
Indiana	131	0.9169	1.68	70.9
Iowa	67	0.8253	0.77	32.6
Kansas	60	0.8704	0.73	30.8
Kentucky	93	0.9146	1.19	50.2
Louisiana	194	0.8934	2.42	102.2
Maine	24	0.8863	0.30	12.5
Maryland	100	1.0498	1.47	61.9
Massachusetts	69	1.0576	1.02	43.1
Michigan	156	1.0001	2.18	92.0
Minnesota	50	0.9675	0.68	28.5
Mississippi	110	0.8675	1.33	56.3
Missouri	97	0.9075	1.23	51.9
Montana	20	0.8333	0.23	9.8
Nebraska	30	0.8440	0.35	14.9
Nevada	43	1.2046	0.72	30.6
New Hampshire	20	0.9760	0.27	11.5
New Jersey	134	1.1241	2.10	88.9
New Mexico	107	0.9169	1.37	57.9
New York	399	1.0914	6.08	256.9
North Carolina	138	0.9815	1.89	79.9
North Dakota	10	0.8587	0.12	5.1
Ohio	205	0.9617	2.75	116.3
Oklahoma	161	0.8588	1.93	81.6
Oregon	67	0.9947	0.93	39.3

(Continued)

TABLE 3. CONTINUED

State	Number of Low-Income Children (Thousands)	State Cost Factor	Percentage of Total	Allotment (Millions of dollars)
Pennsylvania	200	1.0005	2.79	118.0
Rhode Island	19	0.9580	0.25	10.7
South Carolina	110	0.9843	1.51	63.9
South Dakota	15	0.8559	0.18	7.6
Tennessee	115	0.9799	1.57	66.5
Texas	1,031	0.9275	13.35	564.1
Utah	46	0.8977	0.58	24.4
Vermont	7	0.8604	0.08	3.6
Virginia	118	0.9862	1.63	68.7
Washington	85	0.9352	1.11	46.9
West Virginia	45	0.8937	0.56	23.7
Wisconsin	71	0.9229	0.92	38.7
Wyoming	15	0.8758	0.18	7.8
Total, States Only			100.00	4,224.3

SOURCE: Health Care Financing Administration.

NOTE: Numbers may not add up to totals because of rounding.

samples in the less populous states. But multiyear averages do not address all of the apparent underlying problems with the CPS's state-level estimates and the associated volatility in those estimates (see the appendix). Consequently, large year-to-year variations in state funding allocations may partly reflect statistical errors rather than substantial changes in states' actual rates of insurance coverage for children.

Matching Rates and Maintenance-of-Effort Requirements. Under S-CHIP, all states will benefit from higher federal matching rates than they have in the Medicaid program, but states with the lowest matching rates for Medicaid will receive the largest absolute and relative increases. Under the formula, for example, states such as New York and Connecticut, which have federal matching rates for Medicaid of 50 percent, will have matching rates of 65 percent for S-CHIP—a relative increase of 30 percent.[9] By contrast, Louisiana and Kentucky will see their federal matching

9. The formula for determining the federal matching rate in S-CHIP is FMAP + 0.3(100 - FMAP), where FMAP is the federal medical assistance percentage in the Medicaid program. A state's matching rate under S-CHIP may not exceed 85 percent.

rates rise from about 70 percent to 79 percent—a relative increase of only 13 percent. Mississippi will have the smallest relative increase of all the states—about 9 percent.

The maintenance-of-effort requirements relate primarily to Medicaid eligibility. In general, states will be unable to draw down federal S-CHIP funds to cover children who would have been eligible for Medicaid before title XXI was passed.[10] In addition, three states (Florida, New York, and Pennsylvania) must meet special maintenance-of-effort requirements regarding expenditures. Those states have existing state-funded child health programs on which their S-CHIP initiatives will build, and the act allows them to claim federal matching dollars for their state expenditures in those programs, providing their expenditures equal at least the amounts they spent in 1996. HCFA has expressed concern about singling out those three states for maintenance-of-effort requirements on state-only programs and intends to work with the Congress to clarify whether such requirements should apply to all state-only programs.[11]

Complementary Medicaid Policies

Besides establishing S-CHIP, the Balanced Budget Act made wide-ranging changes to the Medicaid program, adding several options for the states that will facilitate the implementation of S-CHIP. Because states may not enroll children who are eligible for Medicaid in alternative programs under S-CHIP, simplifying the process of enrolling children in Medicaid is important. The act gives states the option of allowing low-income children to receive Medicaid services during a period of presumptive eligibility—that is, if a preliminary assessment indicates that their family income is below the Medicaid income threshold. That provision will enable states to enroll children in Medicaid quickly, before a final determination of their eligibility status is made. (Before the act was passed, states could grant presumptive eligibility only to pregnant women, a policy that more than half the states have adopted.)

In addition, states may obtain an enhanced match rate under S-CHIP to speed up the phasing of poor children into the Medicaid program. Under current law, states

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10. The actual dates for establishing the maintenance-of-effort standards depend on whether the state chooses to expand Medicaid or establish a separate children's health insurance program. If the state expands Medicaid, it may not reduce eligibility standards below those in effect on March 31, 1997. If it establishes a separate program, the maintenance-of-effort date is June 1, 1997. (The act originally established a maintenance-of-effort date of April 15, 1997, for states that decided to expand Medicaid. The date was subsequently changed in a technical amendment to the act to enable the state of Tennessee to participate in S-CHIP.)

11. Health Care Financing Administration, "Frequently Asked Questions and Answers: State Children's Health Insurance Program," September 11, 1997 (available at www.hcfa.gov/init/qa/q&a9-11.htm).

must cover all children under age 19 who have family income below the poverty level and who were born after September 30, 1983. Thus, 14-year-old children are being phased in during fiscal year 1998, and another age cohort is added each year. Some states have already brought all poor children into the program, but almost half of the states are covering poor children only through age 14. Title XXI allows states that are not covering all poor children to obtain an enhanced federal matching rate for covering them up until the date on which they are required to be covered under current law. Without such a provision, some older poor children might have to enroll first in a separate program under S-CHIP and subsequently switch to Medicaid when they became eligible as a result of the phase-in.

Another provision of the Balanced Budget Act that could help to reduce the volatility of a child's health insurance status is an option for states to allow children to remain eligible for Medicaid, once they are deemed eligible, for a full 12 months regardless of subsequent changes in their family income. States already have the option to grant children up to six months of continuous eligibility, but few have taken advantage of it. It seems unlikely, therefore, that this expanded option will be widely adopted.

In addition to these optional provisions, the act requires states to continue Medicaid eligibility for a group of disabled children who might otherwise have lost their Medicaid coverage. The 1996 welfare reform act established a new definition of childhood disability for qualifying for Supplemental Security Income (SSI). Under that definition, some children would no longer be eligible for SSI and, were it not for the mandate in the Balanced Budget Act, could lose their Medicaid coverage as well. If the children had lost their Medicaid coverage, they would probably have been eligible for S-CHIP. By requiring states to continue their Medicaid coverage, the act precludes states from claiming the higher S-CHIP matching rate for them.

ESTIMATES OF COVERAGE UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

CBO estimates that S-CHIP will provide coverage to an average of about 2.3 million children a year after 1999, including newly covered children and some children who would have been insured anyway. The estimate reflects potential actions by the states that would reduce the total number of children covered by the program. S-CHIP is likely to displace private insurance for some children, as well as private or public funds that provide coverage through special programs. However, the participation of children in Medicaid will rise.

States' Use of Federal Funds

States are likely to use some of the federal funds available under S-CHIP for purposes other than covering newly eligible children. Although the act restricts spending for direct services, outreach, and administration to 10 percent of a state's expenditures under the program, states can obtain a waiver from that restriction if the Secretary of Health and Human Services deems it cost-effective to grant it. As noted earlier, to the extent that states use their funds to provide direct services, insurance coverage will not expand, although access to health care may. Moreover, payments to disproportionate share hospitals (DSH) are considered direct services, and some states may use S-CHIP funds to make up some of the significant cuts in DSH payments imposed by the Balanced Budget Act.

States may also apply for waivers to allow them to use the funds to supplement employer-sponsored coverage for families—a strategy that some states are interested in pursuing—provided that such an approach would be cost-effective. However, a provision of that kind would not necessarily increase the number of covered children, although it might reduce the cost of employer-sponsored insurance.

In addition, federal funds are likely to substitute for state, local, and private funds that are already paying for children's health coverage because the maintenance-of-effort provisions in the act are not extremely stringent. As described earlier, only three states have maintenance-of-effort requirements relating to expenditures in their state-only programs, and there are no such requirements for private initiatives. Furthermore, current expenditures in existing state and private programs may be used to match federal S-CHIP funds, so not all of the state's matching funds will be new dollars coming into the system.

Total funding for the program may also be lower than the sponsors anticipated because of other ways in which states may generate their matching share of the funds. The Medicaid program has had many problems over the past several years as a result of states' use of various mechanisms to create illusory matching funds. Those mechanisms include so-called voluntary donations from providers, taxes on providers, and intergovernmental transfers. Legislation enacted in 1991 restricted the states' use of taxes and donations but did not affect intergovernmental transfers. According to HCFA, title XXI permits states to use intergovernmental transfers to generate their share of S-CHIP funds, raising the possibility that some of the states' matching funds in that program will not represent actual health expenditures for children.[12]

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12. Health Care Financing Administration, "Frequently Asked Questions and Answers: State Children's Health Insurance Program," October 3, 1997 (available at www.hcfa.gov/init/qa/q&a10-03.htm).

Displacement of Private Insurance

Despite provisions in the legislation requiring that insurance programs established under S-CHIP not displace private insurance, some displacement is inevitable. That outcome does not necessarily mean that low-income families or their employers will immediately drop coverage of dependents. But over time, labor markets will adapt to the existence of federal subsidies, with low-income workers receiving more compensation in the form of cash wages and less in the form of health insurance.

Any estimates of displacement are highly uncertain. On the basis of a review of the literature and analyses of participation in the Medicaid program, CBO estimates that 60 percent of the participants in S-CHIP would otherwise have been uninsured. The remaining 40 percent would have had some other form of coverage.[13]

Greater Participation in Medicaid

As noted earlier, children's participation in the Medicaid program is likely to increase as a result of S-CHIP. Although the presumptive-eligibility and 12-month-eligibility options will probably not have a large impact on the average number of children enrolled, the states, as they seek to expand coverage, may identify a significant number of children who are already eligible for the program. Several hundred thousand more children are likely to gain coverage as a result.

INITIAL RESPONSES BY THE STATES

The enactment of the Balanced Budget Act in August 1997 left the states with little time to develop their plans for the title XXI program before fiscal year 1998 began. The shortage of time was further complicated for those states whose legislatures were out of session. Difficulties in developing state plans may have been compounded in states such as Texas and Oregon, whose next regular legislative session is not until 1999. Yet because they may roll over funding from one year to the next, states have time to consider alternative strategies and to develop their plans carefully. (States have up to three years in which to spend each year's allocation.) In addition, HCFA has ruled that states may submit limited first-year plans that commit only a portion of their annual allocation. If those plans are approved, the states will be able to draw down their remaining first-year allocation at a later date.

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13. CBO's analyses of participation in Medicaid draw on data from the March supplement to the Current Population Survey and the Survey of Income and Program Participation.

By the end of January 1998, 16 states had submitted S-CHIP plans to HCFA, of which only one—Alabama's—had been approved. Taking advantage of the flexibility granted by HCFA, some states have submitted partial plans to secure their 1998 funds, with the understanding that further program development will occur. Alabama, for example, proposes first to expand Medicaid for all poor children through age 18, with a private health insurance program for children or further expansion of the Medicaid program to come later. Likewise, Florida has submitted a plan that accounts for only about 10 percent of its S-CHIP allocation for 1998.

Regardless of whether they have submitted an S-CHIP plan to HCFA, however, more than half of the states have either decided on an approach or are leaning in a particular direction. And the diversity of their approaches is striking.

At least 20 states are considering Medicaid expansions of widely differing dimensions. New Mexico, for instance, which is already covering all children with family income of up to 185 percent of the poverty level, plans to expand eligibility to up to 235 percent of the poverty level, the maximum allowed for a state with its existing eligibility standards. Missouri is seeking a Medicaid waiver to expand coverage for children with income of as much as 300 percent of the poverty level, and Rhode Island has used its existing waiver to cover all children with income of up to 250 percent. Ohio and South Carolina, by contrast, are planning to expand more cautiously, raising the income-eligibility standard to only 150 percent of the poverty level. Likewise, Illinois wishes to raise the Medicaid income-eligibility standard to 200 percent of the poverty level for pregnant women and infants—but to only 133 percent for older children.

Such caution is understandable. Broad program expansions may become more difficult to support in the future if the economy turns down, bringing reduced state revenues and increased demands on the Medicaid program. Because Medicaid is an entitlement, states cannot cut off enrollment simply because they deplete their S-CHIP allotments. Moreover, at that point, the federal matching rate reverts to its regular level, increasing the costs of the program considerably in some states.

Perhaps in response to that potential problem, almost half of the states that are weighing Medicaid options for children are considering only limited expansions, which they plan to combine with alternative children's health insurance programs that would not be entitlements. California, for one, is planning a small expansion of Medicaid for teenagers with income below the poverty level and a major new nonentitlement program for children with income of up to 200 percent of the poverty level who are not eligible for Medicaid. New Jersey is also combining a relatively modest Medicaid expansion (for all children whose income is as much as 133 percent of the poverty level) with a new state program to cover children with income of between 133 percent and 200 percent of the poverty level. Connecticut has raised its

Medicaid income-eligibility standard for children to 185 percent of the poverty level; the state also proposes to create a separate program for children with income of up to 300 percent of the poverty level.

Another group of states has announced plans to devote all of their S-CHIP allocations to establishing or expanding separate health insurance programs for children, thus bypassing the Medicaid program altogether. Pennsylvania, New York, and Colorado, for example, will enlarge their existing children's health insurance programs; Michigan, Nevada, North Carolina, and Utah will all establish new programs to provide coverage for children with income of up to 200 percent of the poverty level.

Although the majority of states have moved quickly to develop their children's health insurance plans, almost one-third are still undecided on the strategy that they will adopt. Some of the undecided states are apparently waiting for the recommendations of specially appointed task forces or commissions. For varying reasons, however, a few of them may choose not to participate in S-CHIP at all. West Virginia, for instance, is having difficulty financing its existing Medicaid program; Arkansas is concerned about conflicts between Medicaid program requirements negotiated through a Section 1115 waiver and S-CHIP requirements; and Hawaii, which has already expanded Medicaid coverage for all children with family income of up to 300 percent of the poverty level, has not indicated whether it plans to expand further under S-CHIP.

In some cases, indecision may reflect the many unanswered questions that states still have about the program. States that are operating their Medicaid programs under statewide Section 1115 waivers, for example, want to know whether and how they will be able to integrate those waiver programs with S-CHIP. Some states want to obtain waivers exempting them from various S-CHIP provisions, including those limiting the percentage of S-CHIP funds that can be used for outreach and those restricting subsidies for family coverage. HCFA is attempting to respond to questions from the states on these and other issues and to provide them with the guidance necessary to implement at least the first stages of their programs in 1998.

CONCLUSION

As policymakers discovered during the extensive debates over whether and how to expand health insurance coverage for children, achieving significant expansions of coverage involves important policy trade-offs. Targeting subsidies only toward children who would otherwise be uninsured is not possible, and generous subsidies are necessary to encourage low-income families to cover their uninsured children. As a result, some displacement of private coverage is likely to occur. Giving the

states sufficient flexibility to develop programs to meet the needs of their populations means that displacement of publicly financed coverage is also likely. Thus, the cost per newly insured child under S-CHIP could be considerably higher than the nominal cost of a children's health insurance policy.

Most states will undoubtedly choose to participate in S-CHIP, expanding coverage for children through both Medicaid and separate health insurance programs. Although expansion of the Medicaid program may appear to be the simpler option, it potentially involves more financial risks for states. It will also require many of them to develop new approaches for establishing eligibility, which are needed to facilitate the enrollment of children from working families in an era when growing numbers of uninsured children are in families with no other ties to the welfare system. Even without S-CHIP, designing and implementing effective outreach systems have become major policy concerns for the states.

From a policy development perspective, title XXI and S-CHIP highlight the need for reliable sociodemographic data on public and private insurance coverage at both the national and state levels. The primary source of such data is the CPS; yet at present, even national estimates of the number of uninsured children from the CPS are quite uncertain, as are trends in the proportion of children who lack coverage. CPS data on children's health insurance coverage at the state level are so questionable that they probably should not be used at all. Lacking other alternatives, however, policymakers have little choice but to use them as the basis for program decisions.

APPENDIX: ESTIMATES OF HEALTH INSURANCE COVERAGE OF CHILDREN

The Current Population Survey is the most widely used source of information on the insurance status of children. It is also the survey that the Congress designated as the basis for allocating federal funds to the states under the State Children's Health Insurance Program. Initially, a state's S-CHIP allocation depends on its share of low-income, uninsured children (with adjustments for geographical differences in costs). After three years the allocation formula will switch to a blended rate that incorporates the state's share of both uninsured low-income children and all low-income children regardless of insurance status. Thus, the reliability of the CPS estimates of uninsured children has major policy significance.

According to the CPS, between 1995 and 1996 the proportion of children under age 19 who lacked health insurance rose from 14.0 percent to 15.1 percent. Although insurance coverage of children declined in the early 1990s as well, that drop reflected the erosion of employment-based coverage for workers' dependents.[1] More recently, employer-sponsored coverage of children seems to have stabilized or begun increasing slightly (consistent with falling unemployment rates), and it is now public, not private, coverage that may be eroding. The 1996 decline in the number of insured children was largely attributable to reductions in those reporting Medicaid coverage.

Is the apparent drop in Medicaid coverage of over a million children accurate? Certainly, given the booming economy and rapidly changing welfare systems, lower rates of Medicaid participation would come as no surprise, especially in those states that have moved aggressively to reduce their welfare rolls. Cutbacks in welfare programs and the associated shift of low-income parents into the labor force could cause some children to lose their eligibility for Medicaid. A more likely outcome for many children, however, is that they are joining the ranks of those with contingent coverage: as families sever their ties to the welfare system, they have less opportunity to enroll their children in Medicaid—if, indeed, they are even aware that their children may still be eligible for the program. Although such children are not currently enrolled, they are still likely to use the program if they become sick.

One can make a compelling argument to explain declining Medicaid coverage of children, but the CPS estimates of that decline seem unrealistically high when compared with administrative data on Medicaid enrollment in the states. The Health Care Financing Administration publishes annual data on Medicaid enrollment in the states, as reported on HCFA Form 2082. Compared with the CPS, those data indicate a smaller decline nationwide in the Medicaid enrollment of children (see

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1. See, for example, John Sheils and Lisa Alecxih, *Recent Trends in Employer Health Insurance Coverage and Benefits* (Fairfax, Va.: Lewin Group, prepared for the American Hospital Association, September 3, 1996).

Table A-1). Because they depend on state reporting, however, the Form 2082 data are also subject to inaccuracies. For example, some double-counting probably occurs among children who rotate on and off the program during the year or who move from one state to another—problems that would result in overestimates of enrollment. Nonetheless, although not a gold standard, the HCFA data represent the states' best estimates of Medicaid enrollment.

The disparities between the CPS and HCFA estimates of Medicaid enrollment are striking. The CPS indicates about 25 percent fewer children enrolled in Medicaid than the states report. A significant part of that undercount could be explained if the CPS measure of insurance coverage was, indeed, closer to a point-in-time estimate than to an estimate of coverage at any time during the year, which the HCFA data reflect. Double-counting by the states might also contribute to the higher Form 2082 counts. But lacking any independent source of verification, one is left to conclude that the CPS may underestimate Medicaid enrollment and the HCFA data may overstate it.

TABLE A-1. MEDICAID COVERAGE OF CHILDREN THROUGH AGE 14, 1995 AND 1996
(In millions of children)

	1995	1996	Percentage Change
Current Population Survey[a]	14.2	13.2	-6.9
HCFA Form 2082[b]	19.4	19.2	-1.0

SOURCE: Congressional Budget Office calculations based on the March supplements of the Current Population Survey (CPS) and Health Care Financing Administration (HCFA) Form 2082.

NOTE: The data are for children age 14 and under because the HCFA form does not provide specific enrollment data for the 18-and-under population.

a. The CPS coverage estimates nominally represent the number of children who had any coverage in the previous calendar year. That is, the March 1996 estimates reflect children with any coverage in 1995, and the March 1997 estimates reflect children with any coverage in 1996. (Some children may report coverage from multiple sources.) However, the CPS estimates actually appear to be closer to point-in-time than to ever-covered estimates.

b. The estimates from HCFA Form 2082 represent children with Medicaid coverage at any time during the year.

The Form 2082 data also show a much smaller relative reduction between 1995 and 1996 in the number of children enrolled in Medicaid. The differences are even greater at the state level. Because of small samples, CPS estimates for individual states are imprecise and should be used cautiously. But one might expect estimates for the largest states to be reasonably reliable. Instead, estimates from the CPS of changes in Medicaid coverage of children in the 10 largest states between 1995 and 1996 differ dramatically from the HCFA enrollment data, demonstrating much larger, and less plausible, relative changes and sometimes even differing in the direction of change (see Table A-2).

What are the implications of these findings for policymakers? First, one should be cautious in using the CPS data to estimate changes in children's health insurance coverage. Those data indicate that the proportion of children lacking

TABLE A-2. MEDICAID COVERAGE OF CHILDREN THROUGH AGE 14 IN THE 10 LARGEST STATES, 1995 AND 1996 (In thousands of children)

	CPS[a]			HCFA FORM 2082[b]		
State	1995	1996	Percentage Change	1995	1996	Percentage Change
California	2,352	2,108	-10.4	3,066	2,957	-3.6
Texas	1,156	1,019	-11.9	1,624	1,620	-0.2
New York	1,159	1,218	5.1	1,429	1,420	-0.7
Florida	724	748	3.3	1,079	1,050	-2.7
Illinois	763	567	-25.6	951	938	-1.3
Pennsylvania	553	410	-25.9	750	745	-0.7
Ohio	535	478	-10.7	758	726	-4.1
Michigan	499	550	10.4	667	665	-0.3
Georgia	326	395	20.9	617	635	2.8
North Carolina	363	291	-19.9	519	532	2.5

SOURCE: Congressional Budget Office calculations based on the March supplements of the Current Population Survey (CPS) and Health Care Financing Administration (HCFA) Form 2082.

NOTE: The data are for children age 14 and under because the HCFA form does not provide specific enrollment data for the 18-and-under population.

a. The CPS coverage estimates nominally represent the number of children who had any coverage in the previous calendar year. That is, the March 1996 estimates reflect children with any coverage in 1995, and the March 1997 estimates reflect children with any coverage in 1996. (Some children may report coverage from multiple sources.) However, the CPS estimates actually appear to be closer to point-in-time than to ever-covered estimates.

b. The estimates from HCFA Form 2082 represent children with Medicaid coverage at any time during the year.

coverage rose between 1995 and 1996, with declining Medicaid enrollment being primarily responsible. But if, as the Form 2082 data suggest, Medicaid coverage did not decline as much as the CPS indicates, then the chances are that the proportion of children who were uninsured did not rise as much either.

Second, the discrepancies between the CPS and the Medicaid administrative data may be in part the result of the effects of welfare reform on responses to the CPS. Not only is the changing welfare environment causing some children to drop off the Medicaid rolls, but the loosening of ties between Medicaid eligibility and receipt of cash welfare benefits may be making it more difficult to count Medicaid enrollees on the CPS. The reason is that the data on insurance coverage in the CPS do not always reflect what survey participants actually report. Sometimes estimates replace reported values if there are strong indications that the reported values are incorrect or incomplete. The Census Bureau, for example, imputes Medicaid coverage to families who receive Aid to Families with Dependent Children, regardless of whether they report it themselves. But as families are dropped from cash welfare programs, such imputations may increasingly understate Medicaid coverage. Those difficulties could increase as states continue to implement the federal welfare reform requirements of 1996 and welfare rolls decline further.

Third, and more fundamentally, whether the CPS should be used at all for state-specific estimates of poor and uninsured children is questionable. In some states (including large ones), CPS estimates of the total number of children, not just those with Medicaid coverage, changed significantly from 1995 to 1996. That finding reflects an underlying methodological limitation of the CPS, which results in potentially large random fluctuations from year to year in the estimates of the number of children by state. Those fluctuations arise because the Census Bureau does not calibrate the numbers of children estimated from the sample to external control totals at the state level. Taking three-year averages, as title XXI requires, should help to smooth out such fluctuations, but the estimates could still be biased if the CPS sample comes from unrepresentative sites in a state—an outcome that is quite likely in the smaller states.

Problems with estimates from the CPS of the uninsured children in each state are even more complex than those associated with estimates of all children. The estimates of the number of children with Medicaid coverage in each state partly drive the estimates of the number of uninsured children. Yet the Medicaid coverage estimates are quite volatile, reflecting a combination of real changes in Medicaid enrollment in a rapidly changing welfare environment, the limitations of imputation techniques, underlying sampling biases, and random variation. Sorting out the relative contribution of those factors is a difficult task.