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MEDICAID:
Improving Health, Saving Lives

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This paper provides a brief review of research on the effects of the Medicaid program, which turns 40 this month,[1] and its smaller counterpart, the State Children's Health Insurance Program (SCHIP). Extensive evidence demonstrates that Medicaid and SCHIP have greatly reduced the number of people without health insurance, substantially facilitated access to medical care and long-term care, and improved health for large numbers of low-income people. Medicaid also has helped support health care providers, particularly those in low-income and medically underserved areas, and reduced the amount of uncompensated care. Also of note, while Medicaid costs are rising significantly, recent studies have shown both that Medicaid provides health care at a lower cost per person than private health insurance does and that Medicaid costs have been rising less rapidly in recent years than private insurance costs.

Prior to Medicaid's creation in 1965, poor uninsured Americans depended on a patchwork system of care and relied primarily on the charity of public and nonprofit hospitals, clinics, nursing homes, and certain physicians. Although the poor were typically sicker than those with higher incomes, they received much less medical care because they lacked insurance coverage. Furthermore, the care they did receive was much more fragmented than the care received by people who were better off.[2]

Had Medicaid and SCHIP not grown in recent years, millions more Americans would have fallen into the ranks of the uninsured and been unable to afford health care.

Today, Medicaid and SCHIP (which began in 1998) provide more than 50 million economically vulnerable children, senior citizens, people with disabilities, and other adults with access to life-saving and life-preserving health care. (See the Appendix for state data on Medicaid caseloads.) In the past several years, as the nation's economy weakened and employer-sponsored health insurance eroded, enrollment in Medicaid and SCHIP expanded in response. This enabled many low-income people who lost employer-sponsored coverage to maintain health insurance. Had Medicaid and SCHIP not grown in response in recent years, the number of Americans joining the ranks of the uninsured would have been considerably higher.

This report is part of a series that reviews the accomplishments of public benefit programs, including the Supplemental Security Income program, food and nutrition programs, and the EITC. The other reports can be found at www.cbpp.org.

Medicaid provides health care to more than 50 million Americans. Medicaid provides preventive care, primary care, acute care, long-term care, and prescription drugs to millions of low-income Americans. Most Medicaid beneficiaries have incomes below the poverty line ($16,090 for a family of three in 2005). The program's beneficiaries include children, parents, pregnant women, senior citizens, and people with permanent disabilities. SCHIP complements Medicaid by providing health care coverage to more than five million low-income children, who typically have family incomes between 100 percent and 200 percent of the poverty line. Because of their low incomes, people eligible for Medicaid or SCHIP are at greater risk of poor health than more affluent Americans. In many cases, their health problems have contributed to their low-income status.

Medicaid covers people during periods of growing need. Medicaid is designed to cover more low-income people when need increases, such as during the recent economic downturn when many Americans lost employment-based coverage. Like certain other entitlement programs such as Food Stamps, Medicaid provides a measure of countercyclical protection during downturns that both assists vulnerable people and boosts the weakened economy. Had Medicaid and SCHIP enrollment not grown in response to the erosion of employer coverage between 2000 and 2003, the ranks of the uninsured would have grown more rapidly.

- As more adults lost their jobs between 2000 and 2003 and health insurance became less affordable for workers, Medicaid cushioned the loss of employer-sponsored coverage. During this period, the share of low-income adults (i.e., adults below 200 percent of the poverty line) with job-based insurance fell from 31.9 percent to 27.5 percent. This decline was partially offset by a modest increase in the percentage of low-income adults with Medicaid coverage, from 18.9 percent to 19.9 percent.[3] Had Medicaid coverage not increased in response, more than one million additional adults would have become uninsured.

KEY FEDERAL HEALTH PROGRAMS

Medicaid provides health and long-term care to low-income families and individuals, including children, parents, the elderly, and people with disabilities. Medicaid is funded jointly by states and the federal government.

SCHIP supplements Medicaid by providing funding to states to provide health care to children with family incomes modestly above the Medicaid limits.

Other federal programs also provide or subsidize health insurance for tens of millions of people. These other programs are not targeted on people with low incomes. The federal government spends substantially more on the other programs than on Medicaid and SCHIP. The other programs include:

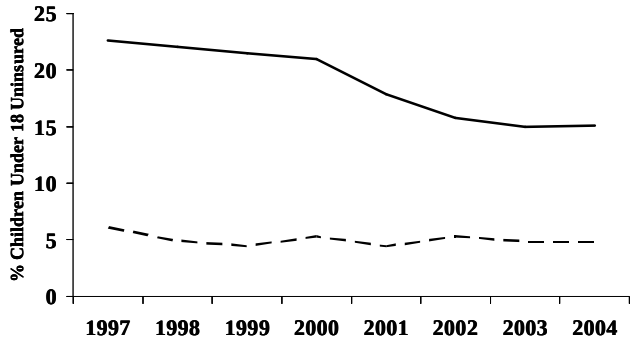
- **Medicare, the universal health insurance program for older Americans and people with permanent disabilities. Medicare provides coverage regardless of income.**
- **The health care programs for federal employees, current and retired military personnel, veterans and many of their dependents.**
- **The health insurance subsidies provided through the federal tax code to the majority of Americans. These subsidies are provided primarily through tax deductions for the costs of private health insurance. The deductions are of greatest value to people with the highest incomes.**

- Medicaid was most effective in preventing increases in the number of uninsured children. Indeed, coverage gains by Medicaid and SCHIP have resulted in a reduction in the percentage of low-income children who lack insurance, despite the decline in private health coverage. Data from the Centers for Disease Control and Prevention show that the percentage of low-income children who are uninsured has fallen by more than one-third since 1997. During this period, SCHIP was established, and numerous states acted to make it simpler for children to enroll in

Medicaid (see Figure 1). This improvement in coverage for low-income children is due entirely to higher enrollment in Medicaid and SCHIP; private insurance coverage for children has been slipping since 1999.

FIGURE 1

Percentage of Low-income Children Without Health Insurance Has Fallen About One-third Due to SCHIP and Medicaid Expansions



Source: Analysis of CDC's National Health Interview Survey, Oct. 2004

Medicaid improves access to doctors and preventive care. Medicaid and SCHIP have enabled millions of low-income Americans to obtain access to health care services.[4] Those whom the programs cover have access to care that is substantially superior to the care that uninsured people generally receive:

- An Urban Institute study found that 86 percent of the children on Medicaid or SCHIP have seen a doctor or other health professional in the past 12 months, while only 58 percent of uninsured children have done so.

- This study also found that 75 percent of children in Medicaid or SCHIP had a preventive or well-child health visit within the past 12 months, compared to 46 percent of uninsured children.[5]

- Data from the Centers for Disease Control show that 91 percent of nonelderly adults in Medicaid have a usual place to get health care, such as a doctor's office or clinic, as compared to 55 percent of uninsured adults. Some 88 percent of nonelderly adult Medicaid beneficiaries have seen a doctor or other health professional within the last 12 months, compared to 58 percent of uninsured adults.[6]

- A recent study by researchers at the Urban Institute found that Medicaid beneficiaries had similar access to physician services and key preventive services such as breast exams and Pap smears as low-income people with private insurance, after controlling for income, health status, and other characteristics.[7]

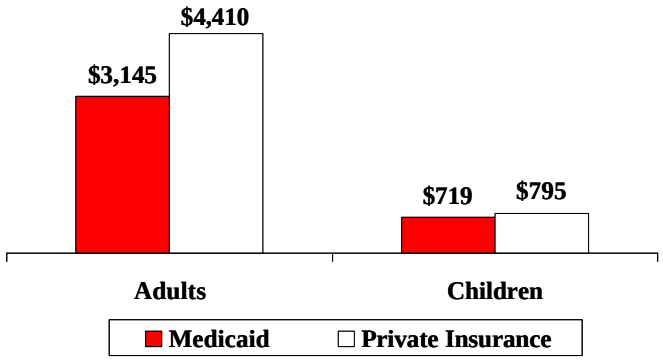
- Other studies have shown that Medicaid helps patients with chronic diseases receive medical care that can prevent their conditions from worsening. Among adults who have chronic diseases — including heart disease, high blood pressure, diabetes and asthma — those covered by Medicaid are more likely to obtain and use needed medications than are people who are uninsured.[8] Similarly, low-income diabetics who are covered by Medicaid are more likely to receive recommended types of care, such as periodic eye exams, foot exams or blood tests, than low-income diabetics who are uninsured.[9]

Medicaid and SCHIP coverage can lead to improved education opportunities for disadvantaged children.

Medicaid improves the health of low-income Americans. By making preventive and primary care more readily available, and by protecting against and providing care for serious diseases, Medicaid has improved the health of millions of Americans. Research has found that:

FIGURE 2

Medicaid Costs 30% Less for Adults and 10% Less for Children, Than Private Insurance



- Expansions of Medicaid eligibility for low-income children in the late 1980s and early 1990s led to a 5.1 percent reduction in childhood deaths.[10]

- Expansions of Medicaid coverage for low-income pregnant women led to an 8.5 percent reduction in infant mortality and a 7.8 percent reduction in the incidence of low birth weight.[11]

- A major federal study also found that those who live in areas with broader Medicaid eligibility experienced lower average rates of preventable hospitalizations; this finding held true for children, younger adults and older adults alike.[12] These findings suggest that when people have better access to primary and preventive care through Medicaid, they are less likely to be hospitalized for diseases such as asthma or diabetes.

- Research also has documented that after people *lose* Medicaid, they experience more difficulty obtaining medical care, and their health status often deteriorates. For example, adults who have lost Medicaid coverage have greater problems controlling their high blood pressure — which is known to increase the risk of heart disease and stroke — than those who retain Medicaid.[13]

- In a recent study, adults diagnosed with high blood pressure were much more likely to have their blood pressure under control if they were enrolled in Medicaid than if they were uninsured or on Medicare alone. (Medicare does not currently cover prescription drugs; it will begin to do so in 2006.)[14]

The improvements in health status that Medicaid and SCHIP have brought about have broader social consequences. For example, children with Medicaid coverage have been found to miss fewer school days due to sickness and have fewer restricted activity days than comparable children who lack health care coverage.[15] A study of children in California's SCHIP program found that the school performance of high-risk children improved after being insured for a year.[16] In this manner, Medicaid and SCHIP coverage may improve educational opportunities for disadvantaged children.

Medicaid provides medical care at a lower cost than private insurance. In light of concerns about the rising costs of health care, it is noteworthy that Medicaid provides health care at a lower per-person cost than private health insurance and that the per capita costs of Medicaid have been rising more slowly in recent years than the per capita costs of private insurance.

A recent study by economists Jack Hadley and John Holahan of the Urban Institute found that after adjusting for differences in health status and other characteristics, medical expenditures for adults in Medicaid were 30 percent lower than these adults' medical costs would be under private health insurance. Expenditures for children enrolled in Medicaid were 10 percent lower than such costs would be under private health insurance (Figure 2).[17] In addition, administrative costs for Medicaid (at 6.9 percent of total costs) are about half as large as administrative costs under private health insurance (which average 13.6 percent of costs), according to estimates by the Centers for Medicare and Medicaid Services.[18]

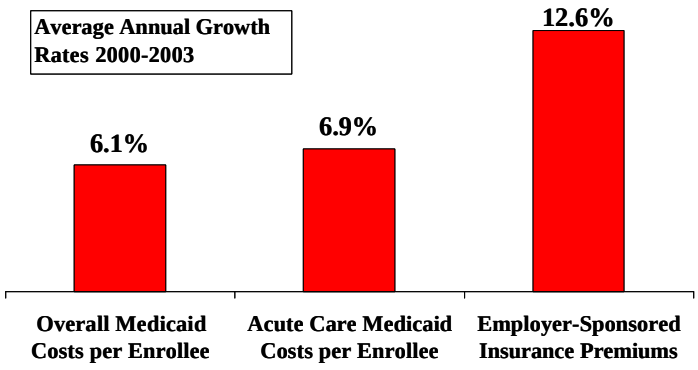
The key factors that are causing Medicaid costs to rise are affecting all sectors of health care, including private health insurance and Medicare. Health care costs are being driven up in substantial part by advances in medical technology and increases in health care usage, both of which can improve health status and prolong life but which also increase health care costs. The aging of the population also is pushing us down the path of higher health care costs, since health care needs and costs are greater, on average, for older people than for younger ones. These factors are not caused by Medicaid's design but by broader economic and demographic forces.

Indeed, Medicaid costs have risen less in recent years than the costs of private insurance. Another Urban Institute analysis has found that Medicaid acute care costs per enrollee rose an average of 6.9 percent per year between 2000 and 2003 (Figure 3), or a little more than half of the 12.6 percent annual growth during this period in private health insurance premiums.[19] (If costs for long-term care are included, overall Medicaid costs rose at an annual 6.1 percent rate.)

Medicaid provides essential health care services for low-income senior citizens and people with disabilities. About 70 percent of Medicaid spending goes toward care for low-income senior citizens and people with disabilities. For senior citizens, Medicaid fills gaps in coverage left by Medicare, such as the lack of long-term care. Medicaid is the nation's largest funding source for nursing home care. In recent years, some state Medicaid programs have pioneered innovative approaches to improving and diversifying long-term care and caring for frail seniors in their own homes rather than in nursing homes.[20] In addition, Medicaid helps make medical care more affordable and accessible for millions of low-income seniors by paying the premiums, deductibles, and coinsurance charged under Medicare. Low-income senior citizens covered by both Medicaid and Medicare are more likely to see a physician than low-income seniors with Medicare alone.[21]

FIGURE 3

Medicaid Expenditures Per Person Have Grown More Slowly Than Private Insurance Costs



Medicaid covers people who can't get private coverage at any price. Millions of people who have permanent disabilities are unable to work and are therefore unable to secure employer-sponsored health insurance. Their severe health conditions also render them unable to obtain

individual health insurance. Since they are effectively shut out of the private health insurance market, Medicaid can be their only health insurance option. For these individuals, Medicaid coverage provides access to critical health care, including new medical technologies that can improve their health and well-being.[22]

Similarly, for those with HIV/AIDS, Medicaid provides access to anti-retroviral therapies, saving lives and reducing related illness,[23] while for people with severe mental illness, Medicaid provides access to medications that help them function in the community and stay out of mental institutions or prisons. As private health insurance coverage for mental health care has faded over the past decade, Medicaid financing has helped fill the resulting gap.[24]

Medicaid and SCHIP support health care providers. Medicaid and SCHIP provide about one-sixth of all of the health care funding in the United States and have become an important source of financial support for hospitals, physicians, pharmacists, nursing homes, and other components of the American health system.[25] Medicaid has become a particularly critical source of support for various safety net health care providers that serve low-income and vulnerable patients, such as community health centers, public and charity hospitals, mental health centers, and nursing homes. Medicaid funding often helps these providers keep their doors open and provide services to broad segments of their communities.

The coverage provided by Medicaid and SCHIP provides particular help to hospitals and other facilities by reducing the uncompensated care costs that result when uninsured patients are treated. For example, one study found that expansion of public health insurance programs in Minnesota led to a large reduction in hospitals' uncompensated care expenses.[26] This suggests that substantial reductions in Medicaid funding could have serious financial consequences for hospitals and could trigger significant staff layoffs, since cutbacks in Medicaid coverage cause hospitals to lose Medicaid revenue even as newly uninsured patients start to seek medical care on an uncompensated basis.[27]

Health Coverage Gaps Remain

Although Medicaid and SCHIP have resulted in substantial progress in the provision of health care and long-term care coverage, large numbers of low-income Americans remain uninsured. The most recent Census data indicate that about 24 million people with incomes below 200 percent of the poverty line were uninsured in 2003. This includes approximately 18 million adults under the age of 65, as well as six million children.

Most of the low-income adults who are uninsured are not eligible for Medicaid.[28] Unless they are elderly or disabled, adults without dependent children are typically ineligible for Medicaid regardless of how poor they are. Medicaid does cover low-income parents, but the income limits for parents are typically set far below the poverty line. In the median state, a parent is eligible for Medicaid only if her income is less than 69 percent of the poverty line ($11,100 for a family of three).[29]

Most children with family incomes up to 200 percent of the poverty line are eligible for Medicaid or SCHIP. Many eligible children do not participate and remain uninsured, however, either because they are unaware of the programs (or unaware that their children are eligible) or because the enrollment and retention processes are too complicated.

Exacerbating this problem, the number of uninsured Americans is likely to rise in the years ahead. Economists at the University of California at San Diego project that the number of uninsured people could rise from 45 million in 2003 to 56 million by 2013, primarily because of continued increases in health insurance premiums and the continuing erosion of employer-based coverage.[30]

State and federal policymakers are understandably concerned about the rising costs of Medicaid. It is important to remember, however, that Medicaid has proven to be a highly effective mechanism for providing health care coverage to low-income families and individuals and that, contrary to the impression of some policymakers, Medicaid tends to cost less than private insurance. Deep cuts in the Medicaid program could close the doors to health care for large numbers of less fortunate Americans at a time when the ranks of the uninsured already are rising.

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[1] Both Medicaid and Medicare were signed into law by President Lyndon Johnson on July 30, 1965.

[2] Diane Rowland and Rachel Garfield, "Health Care for the Poor: Medicaid at 35," *Health Care Financing Review,* 22(1) (2000)*:* 23-34.

[3] Center on Budget and Policy Priorities analysis of March 2001 and 2004 Current Populations Surveys.

[4] See Ellen O'Brien and Cindy Mann, "Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP" (Washington: Health Policy Institute, 2003) or Leighton Ku and Sashi Nimalendran, "Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP" (Washington: Center on Budget and Policy Priorities, 2004).

[5] Lisa Dubay and Genevieve M. Kenney, "Health Care Access and Use Among Low-income Children: Who Fares Best?" *Health Affairs* 20(1)(2001): 112-21. These are based on analyses of the National Survey of America's Families.

[6] National Center for Health Statistics, Centers for Disease Control, *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2002,* DHHS Publ. (PHS) 204-1550, July 2004, Tables 33 and 35, age-adjusted distributions.

[7] Teresa Coughlin, Sharon Long and Yu-Chu Shen, "Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs,* 24(4):1073-1083, July/August 2005.

[8] Thomas Rice and others, "The Impact of Private and Public Health Insurance on Medication use for Adults with Chronic Disease," *Medical Care Research and Review* 62(2) (2005): 231-249.

[9] K.M. Nelson and others, "The Association between Health Insurance Coverage and Diabetes Care: Data from the 2000 Behavioral Risk Factor Surveillance System," *Health Services Research,* 40(2) (2005): 361-72.

[10] Janet Currie and Jonathan Gruber, "Health Insurance Eligibility, Utilization of Medical Care and Child Health" *Quarterly Journal of Economics* 11 (1996): 431-66.

[11] Janet Currie and Jonathan Gruber, "Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women" *Journal of Political Economy* 104(6) (1996): 1263-96. Jonathan Gruber, "Health Insurance for Poor Women and Children in the U.S.: Lessons from the Past Decade." In James M. Poterba, ed., *Tax Policy and the Economy,* vol. 11 (Cambridge, MA: MIT Press, 1997).

[12] John Billings and Robin Weinick, *Monitoring the Health Care Safety Net. Book I. A Data Book for Metropolitan Areas.* Chapter 7 (Rockville, MD: Agency for Healthcare Research and Quality, 2003).

[13] See Nicole Lurie and others, "Termination from Medi-Cal: Does it Affect Health?" *New England Journal of Medicine.* 311(1984):480-84; Nicole Lurie and others, "Termination from Medi-Cal Benefits: A Follow-up Study One Year Later,"

New England Journal of Medicine 314 (1986): 1266-8; Judith Kasper and others, "Gaining and Losing Health Insurance: Strengthening the Evidence for Effects on Access to Care and Health Outcomes," *Medical Care Research and Review* 57(3)(2000): 298-318.

[14] G. Gandelman, W.S. Aronow and R. Varma, "Prevention of Adequate Blood Pressure in Self-Pay or Medicare Patients Versus Medicaid or Private Insurance Patients with Systemic Hypertension Followed in a University Cardiology or General Medicine Clinic," *American Journal of Cardiology,* 15:94(6) (2004):815-6.

[15] Kristine Lykens and Paul Jargowsky, "Medicaid Matters: Children's Health and the Medicaid Eligibility Expansions, 1986-91," Working Paper 00-01 (University of Texas at Dallas, 2000).

[16] California Managed Risk Medical Insurance Board, "The Healthy Families Program Health Status Assessment (PedQL) Final Report," revised Sept. 2004.

[17] Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry,* 40 (2003/2004): 323-42. Similar findings were reached by federal researchers, see Edward Miller, Jessica Banthin, and John Moeller, "Covering the Uninsured: Estimates of the Impact on Total Health Expenditures for 2002" Working Paper No. 04407 (Agency for Healthcare Research and Quality, 2004). These differences primarily reflect the lower payment rates that Medicaid makes to health care providers.

[18] Cynthia Smith, et al. "Health Spending Growth Slows in 2003," Health Affairs, 24(1): 185-194, Jan./Feb. 2005. Medicaid administrative costs include both state administrative expenses and the administrative costs of Medicaid managed care organizations.

[19] John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs* web exclusive*,* January 26, 2005; Kaiser Commission on Medicaid and the Uninsured news release, "A Sharp Rise in Enrollment During the Economic Downturn Triggered Medicaid Spending to Increase by One-Third from FY 2000-03," January 26, 2005.

[20] Joy Cameron, "Changing State Long Term Care Systems to Support Community Living," National Governors Association, available at http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF%5ED_2264,00.html.

[21] National Center for Health Statistics, Centers for Disease Control, *op cit.*

[22] Bruce Vladeck, "Where the Action Really Is: Medicaid and the Disabled," *Health Affairs,* 22(1) (2003): 90-100.

[23] Dana Goldman and others. "Effect of Insurance on Mortality in an HIV-Positive Population in Care," *Journal of the American Statistical Association* 96 (2001): 883-94.

[24] Tami Mark and others, "U.S. Spending for Mental Health and Substance Abuse Treatment," *Health Affairs* web exclusive, March 29, 2005.

[25] Cynthia Smith, *op cit.*

[26] Lynn Blewett and Gestur Davidson, "Hospital Provision of Uncompensated Care and Public Program Enrollment," *Medical Care Research and Review*, 60(4): 509-527 (2003).

[27] See, for example, WVLT news report, "University of Tennessee Medical Center cutting jobs in response to TennCare changes," Knoxville, TN, June 8, 2005.

[28] Some of the low-income uninsured adults are eligible but not enrolled in Medicaid.

[29] Donna Cohen Ross and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2004).

[30] Todd Gilmer and Richard Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013", *Health Affairs* web exclusive, April 5, 2005.

APPENDIX A
MEDICAID ENROLLMENT IN FISCAL YEAR 2002

	Aged	Blind & Disabled	Child[a]	Adult	Total
U.S. Total	**4,760,000**	**8,060,000**	**25,490,000**	**13,250,000**	**51,550,000**
Alabama	99,000	191,000	418,000	137,000	845,000
Alaska	7,000	12,000	76,000	27,000	121,000
Arizona	44,000	110,000	514,000	386,000	1,054,000
Arkansas	51,000	109,000	311,000	138,000	608,000
California	664,000	990,000	3,621,000	4,062,000	9,336,000
Colorado	48,000	66,000	237,000	88,000	439,000
Connecticut	62,000	61,000	263,000	103,000	488,000
Delaware	11,000	18,000	66,000	53,000	147,000
Dist Columbia	14,000	44,000	95,000	52,000	205,000
Florida	256,000	522,000	1,375,000	539,000	2,692,000
Georgia	109,000	233,000	865,000	254,000	1,460,000
Hawaii	17,000	24,000	92,000	63,000	196,000
Idaho	13,000	27,000	127,000	30,000	196,000
Illinois	279,000	300,000	1,101,000	396,000	2,076,000
Indiana	78,000	117,000	534,000	153,000	882,000
Iowa	42,000	61,000	186,000	71,000	359,000
Kansas	31,000	53,000	174,000	48,000	305,000
Kentucky	72,000	208,000	379,000	110,000	770,000
Louisiana	105,000	177,000	598,000	110,000	990,000
Maine	72,000	119,000	100,000	55,000	346,000
Maryland	55,000	122,000	433,000	142,000	752,000
Massachusetts	116,000	243,000	483,000	362,000	1,204,000
Michigan	100,000	297,000	845,000	286,000	1,528,000
Minnesota	70,000	94,000	343,000	174,000	681,000
Mississippi	74,000	161,000	388,000	85,000	708,000
Missouri	99,000	150,000	591,000	258,000	1,099,000
Montana	10,000	18,000	56,000	22,000	106,000
Nebraska	24,000	30,000	161,000	52,000	266,000
Nevada	20,000	33,000	104,000	47,000	203,000
New Hampshire	13,000	15,000	72,000	17,000	116,000
New Jersey	112,000	179,000	485,000	207,000	983,000
New Mexico	23,000	55,000	294,000	90,000	463,000
New York	398,000	688,000	1,812,000	1,241,000	4,140,000
North Carolina	178,000	236,000	716,000	259,000	1,389,000
North Dakota	10,000	10,000	34,000	18,000	72,000
Ohio	145,000	280,000	959,000	372,000	1,754,000
Oklahoma	64,000	81,000	439,000	94,000	678,000
Oregon	44,000	68,000	263,000	262,000	637,000
Pennsylvania	212,000	386,000	829,000	284,000	1,711,000
Rhode Island	20,000	38,000	94,000	52,000	205,000
South Carolina	78,000	123,000	472,000	223,000	896,000
South Dakota	10,000	16,000	69,000	18,000	114,000
Tennessee	90,000	340,000	738,000	532,000	1,700,000
Texas	383,000	380,000	1,905,000	535,000	3,202,000
Utah	12,000	28,000	137,000	56,000	233,000
Vermont	20,000	19,000	69,000	49,000	157,000
Virginia	98,000	139,000	393,000	97,000	728,000
Washington	79,000	146,000	596,000	283,000	1,105,000
West Virginia	30,000	90,000	183,000	60,000	362,000
Wisconsin	96,000	139,000	353,000	189,000	777,000
Wyoming	5,000	9,000	42,000	14,000	70,000

Source: Based on data reported to HHS in the Medicaid Statistical Information System, as of Feb. 17, 2005. Counts are based on the unduplicated number of people enrolled at any time during the year. More recent data may be available from individual states. Such state data may not correspond with these national data because state counts are generally based on the number enrolled in a given month. Because of entries and exits of enrollees over the course of a year, the number enrolled in a month is inherently lower than the unduplicated number enrolled at any time during a year. These counts include people getting full and partial Medicaid benefits. The national total does not include the territories.

[a] These data include children in states whose SCHIP programs are implemented through Medicaid expansions. They do not include children in states that have separate SCHIP programs.