MEDICAID'S IMPACT ON ACCESS TO AND UTILIZATION OF HEALTH CARE SERVICES AMONG RACIAL AND ETHNIC MINORITY CHILDREN

ALLYSON G. HALL, PHD

In 1965, President Lyndon B. Johnson signed into law what is perhaps the most important health care legislation in the 20th century for low-income children and adults. Over the last three decades, Medicaid has become a significant source of health care financing for poor children and has improved access for those low-income children lucky enough to be enrolled. Despite subsequent expansions in eligibility in the 1980s and 1990s, Medicaid has never provided health coverage for all poor and near-poor children.

Historically, Medicaid has been an essential source of health insurance for minorities. In 1978, Medicaid assured financial access to medical care for one in five blacks under the age of 65.[1] By 1996, 22% of blacks, 19% of Hispanics, and 6% of whites were Medicaid recipients.[2] The enrollment of racial and ethnic low-income minorities in Medicaid is partially responsible for reducing disparities in health status and in improving access to care for these groups over the last three and a half decades.

Improvements in life expectancy among minority groups are particularly noteworthy. Life expectancy for white females increased by 5.5 years between 1960 and 1995. In comparison, for the same period, life expectancy for black females increased by 8 years.[3]

Infant mortality rates for blacks have fallen since the Medicaid program was introduced. Between 1950 and 1960, white infant deaths decreased by almost 15%.

Dr. Hall is Program Officer, Commonwealth Fund, One East 75th Street, New York, NY 10021. (E-mail: agh@cmwf.org)

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Black infant deaths for the same period increased by 1%.[1] However, following the enactment of Medicaid, between 1960 and 1990 the white infant mortality rate decreased by 72%, and black infant mortality rates fell by 66%.[3] Despite declines in infant mortality for minority and white populations, black/white differences still persist. In 1995, infant mortality for whites was 6.3 per 1,000 live births. The rate among blacks was 15.1 per 1,000 live births.[3]

Utilization of health care services by minorities has increased since the mid-1960s. Prior to 1965, despite poorer health status, low-income blacks and other minorities visited physicians an average of 3.1 times a year compared to 4.7 times for whites. By 1976, average physician visits among both poor minorities and whites had increased. Whites had an average of 5.7 visits per year, while blacks and other minorities averaged 5 visits.[1] Gaps still persist according to race and ethnicity, however, in the number of physician contacts for children under age 5. In 1994, white children averaged 7 visits compared with 5 visits for black children.[3]

Despite advances, differences in health status and access still remain. Minority children are still at increased risk for acute and chronic illness, primarily because they live in adverse conditions linked to poverty. Hispanic and black children, for example, are more likely to be underimmunized. In 1995, 68% of Hispanic infants and 70% of black infants between 19 and 35 months received the recommended combined series of vaccinations. However, 77% of white infants were immunized.[3]

Black children represent a disproportionate share of pediatric acquired immunodeficiency syndrome (AIDS) cases. In 1995, of the total number of children diagnosed with AIDS at age 13, 60% were black, 20% were Hispanic, 19% were white, and the remainder were Native American or Pacific Islander.[3] Asthma continues to be a serious chronic condition affecting children living in inner cities. Being poor and black are significant risk factors for asthma-related mortality.[4]

Table I shows sizable differences in death rates across racial and ethnic groups for children under age 5. Black males and females have the highest death rates, followed by Hispanic males and females.

Although Medicaid has made sizable contributions in improving minority health, disparities in health across racial and ethnic groups still remain. This paper examines the impact Medicaid has on access to health care services among low-income minority children. The report begins with a discussion of the program's coverage and benefits. Then, a summary of research demonstrating how Medicaid has improved access and coverage for children—particularly minority children—is presented. Data from *The Kaiser/Commonwealth Five State Low Income*

TABLE 1 Death Rates for Children Aged 1 to 4, by Race and Ethnic Origin, 1995 (Deaths per 100,000)*

	Males	Females
White	39	31
Black	82	68
Asian	30	25
Hispanic	43	35

*From National Center for Health Statistics.[3]

Survey 1995–96 provide a current snapshot of Medicaid's impact on low-income minority children. The paper concludes with challenges facing the Medicaid program and its ability to improve the availability of care for children of different racial and ethnic groups.

COVERAGE AND BENEFITS

Medicaid's form and structure is largely unchanged since the program's inception in 1965. Federal and state resources fund the program. States administer the program under broad federal guidelines. For the first 25 years, eligibility was linked directly to qualification for welfare payments under either the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income* programs. States also could cover children up to age 18 in families meeting state income standards. Finally, medically needy families who spent down their assets due to medical bills were also eligible for Medicaid.

Subsequent legislation expanded Medicaid's eligibility criteria to include pregnant women and children who would otherwise not qualify for Medicaid. In addition to families that meet the old AFDC criteria and Supplemental Security Income beneficiaries, pregnant women and children less than 6 years of age whose family incomes are at or below 133% of the federal poverty level can enroll. Also eligible are children under 19 years of age born after September 30, 1983, who are in families with incomes at or below 100% of poverty.[5]

As intended, these expansions increased the percentage of children on Medicaid. In 1987, 15% of all children under age 18 were on Medicaid. By 1997, 23%

*Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, AFDC was replaced with Temporary Assistance for Needy Families. Temporary Assistance for Needy Families has more restrictive eligibility criteria than AFDC. However, persons who previously qualified for AFDC (and therefore Medicaid) are still eligible for Medicaid under current law.

TABLE II Number of Children (Millions) on Medicaid and Percentage Increase Between 1989 and 1993*

	1989	1993	Percentage Increase
White	3.13	5.48	75
Black	3.40	4.42	79
Hispanic	1.80	3.22	30

*From United States General Accounting Office.[7]

of children had Medicaid coverage.[6] As Table II shows, Medicaid expansions had a greater impact for white and Hispanic children than for black children.[7] Part of the reason for the increase in the number of Hispanic children covered was due to the fact that more two-parent families became eligible for Medicaid. Hispanic families tend to be composed of two-parent households.

Medicaid coverage is most prevalent among children younger than 5 years, minorities, and children from single-parent households.[8] In 1995, 18% of white children, 45% of black children, and 37% of Hispanic children were Medicaid beneficiaries. [6]

Medicaid benefits are comprehensive and superior to many private health insurance plans. Benefits include inpatient and hospital services, prenatal care, physician care, and diagnostic services. Children on Medicaid are required to receive an extensive array of early periodic screening, diagnosis, and treatment services. Many states also opted to provide a prescription drug benefit and dental care.

MEDICAID'S IMPACT ON ACCESS TO CARE FOR RACIAL AND ETHNIC MINORITY CHILDREN: REVIEW OF THE LITERATURE

There is little doubt that the presence of health insurance greatly enhances an individual's ability to seek and utilize health care services. Analyses dating as far back as 1969 showed that public assistance* recipients had higher rates of health services utilization than other low-income respondents did.[9]

A review of the literature conducted by the US General Accounting Office in 1997 concluded that

*In this study, public assistance was used as a crude proxy for receipt of Medicaid benefits.

- Uninsured children are less likely to have an established relationship with a primary care doctor and to have received primary and preventive care.
- Uninsured children receive less care when injured or ill.
- Uninsured children are hospitalized more frequently due to a lack of primary care.
- Uninsured children receive unequal care when hospitalized.
- Uninsured children with chronic conditions receive less care.
- Parents of uninsured children are more likely to delay getting care for their children.[10]

Specific examinations of the effect of Medicaid on access for low-income children demonstrate that public insurance has reduced the gap between the uninsured and privately insured. An analysis of the 1981 Child Health Supplement to the National Health Interview Survey found that uninsured low-income children in poor health had 21% fewer ambulatory services visits compared to similar children with Medicaid coverage.[11]

Poor children with Medicaid are more likely to have a timely visit to a physician for routine care, to have a usual source of routine care,[12] to have more ambulatory care visits,[11] and to receive timely preventive services[13] compared to their counterparts without Medicaid. Economically disadvantaged adolescents with Medicaid experience higher physician utilization rates compared to poor adolescents without Medicaid and to nonpoor teenagers. Among adolescents with compromised health, there is no difference in physician utilization between nonpoor adolescents and poor adolescents with Medicaid.[14]

Although there is substantial evidence that children on Medicaid have higher rates of utilization compared to uninsured children, a few studies indicate that privately insured children, on average, have the highest number of physician visits.[15] Children on Medicaid are less likely to receive their care in physicians' offices and instead receive care from clinics, outpatient departments, and emergency rooms. Continuity of care among Medicaid children also is jeopardized because they tend to see different providers for routine and sick care.[16]

With respect to Medicaid's specific effect on minorities, there is little evidence because considerations of race often are limited to a variable in a multivariate model rather than the primary research focus. Nevertheless, there are a few studies that look at Medicaid's impact on racial minorities.

Four years after Medicaid was enacted, national data showed that whites covered by Medicaid were more likely to be hospitalized and to see a private physician compared with their black counterparts.[9]

A few studies conclude that Medicaid is effective at reducing access barriers for minority children. After controlling for a variety of factors, including having Medicaid coverage, minority children were found to have similar rates of physician or ambulatory care contacts as white children.[17] Medicaid also was found to be the strongest predictor of entry into the health care system for Hispanic and black children.[18] A study conducted by the National Bureau of Economic Research concluded that expanding Medicaid eligibility was associated with reduction in racial disparities in the number of physician visits and child mortality.[19]

Some analyses found that minority children and adolescents with public insurance are less likely to have a regular source of care, to have a lower number of physician visits, to have lower immunization rates, and to have higher rates of emergency room utilization compared with white children.[17,20]

Analysis using data from the National Health Interview Survey demonstrated that children with public or private insurance appeared equally likely to have an identified regular source of care regardless of their race or ethnicity (Table III).[21] Overall, uninsured children are less likely to have a regular source of care. However, among the uninsured, minority children, particularly Hispanic children, are less likely than whites to have a regular source of care.

MEDICAID'S IMPACT ON ACCESS TO CARE FOR RACIAL AND ETHNIC MINORITY CHILDREN: RESULTS FROM THE *KAISER/COMMONWEALTH FIVE STATE LOW INCOME SURVEY*

Data from the *Kaiser/Commonwealth Five State Low Income Survey* are used to assess Medicaid's current impact on access to health care among low-income minority children. The survey, conducted by Louis Harris and Associates, Inc., involved interviews of more than 10,000 adults with family incomes at or below 250% of poverty. In addition to their own health care experiences, respondents were asked about their children's health insurance coverage and use of health care

TABLE III Percentage of Children (Age 0–17) in Poor Families with a Regular Source of Care*

	Public Insurance	Private Insurance	Uninsured	Total
White, non-Hispanic	95	96	82	92
Black, non-Hispanic	93	94	79	91
Hispanic	92	92	66	82

*From Simpson, Bloom, Cohen, and Parsons.[21]

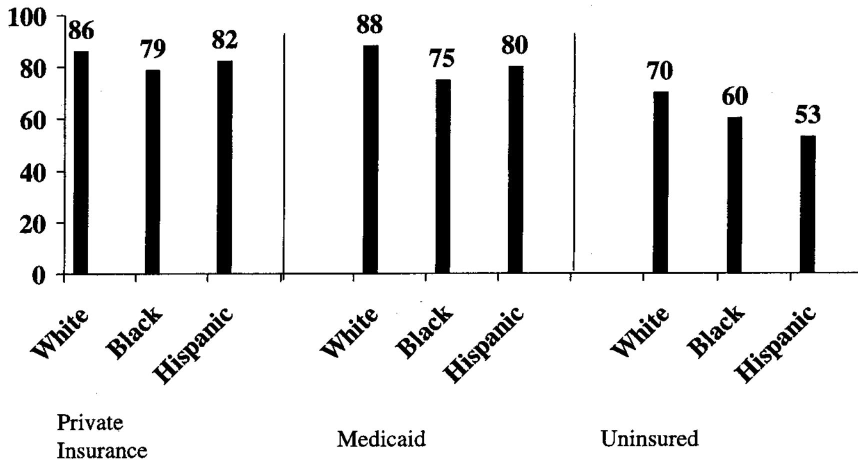

FIG. 1 Percentage of low-income children with a particular doctor, by insurance status and race/ethnicity of the parent. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

services.* The states included in the survey (Florida, Minnesota, Oregon, Tennessee, and Texas) were selected because they had adopted innovative approaches to insuring low-income families.† The survey was fielded in late 1995 and early 1996.

The vast majority of privately insured and publicly insured children have an identified doctor or health professional they see when they are sick and in need of medical attention (Fig. 1). Minority parents across all insurance categories are less likely to report that their child has an identified provider. Among privately insured children, blacks are slightly less likely to have a particular doctor than whites. However, differences in the likelihood of having a particular doctor are more pronounced between children with Medicaid and the uninsured. This trend is particularly disturbing among the uninsured; only half of low-income Hispanic children have an identified provider compared with 70% of white low-income children.

Although most of the children in the survey have a particular doctor or health care professional, fewer than half of low-income children report that they see this particular doctor at a private physician's office (Fig. 2). Low-income children with private health insurance, especially black and Hispanic children, are more

*Child race assignment was based on the reported race of the parent.

†See C. Schoen and E. Puleo, Low-income working families at risk: uninsured and underserved, *J Urban Health: Bull NY Acad Med,* 1998;75:30–49 or C. Schoen, B. Lyons, D. Rowland, K. Davis, and E. Puelo. Insurance matters for low income adults: results from a five state survey, *Health Affairs,* 1997;16:163–171.

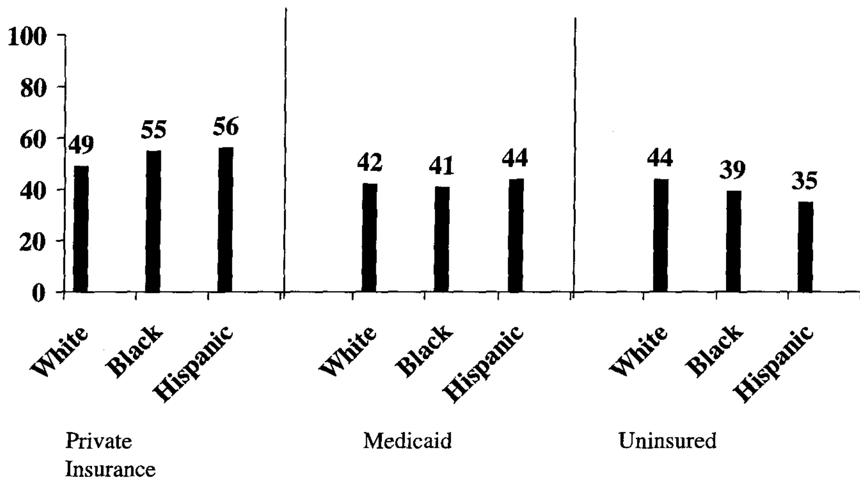

FIG. 2 Percentage of low-income children whose regular site of care is a physician's office, by insurance status and race/ethnicity of the parent. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

likely to receive care in a private physician's office compared to those on Medicaid and uninsured children. In general, this sample of low-income children is less likely to identify a physician's office as their regular source of care compared with the average population. Analyses of the 1993 National Health Interview Survey estimate that approximately 85% of all children identify a physician's office as their regular site of care.[21,22]

For all insurance groups, parents of black and Hispanic children reported a greater reliance on sites of care other than physician's offices and clinics compared to white parents (Fig. 3). For example, 21% of uninsured Hispanic children reported that hospital outpatient departments and emergency rooms are their regular sites of care compared with 8% of uninsured white children. These other sites of care are not ideal because they are less likely to provide continuous care, an important element in effective health care delivery.

Figure 4 shows that health insurance improves access for low-income children. Insured children are less likely to experience not getting or difficulty in obtaining routine care, emergency care and vision and hearing and dental services.

There is variation in parents reporting that their children received care in the last 12 months from a doctor or health professional by race/ethnicity and insurance (Fig. 5). Low-income children who are on Medicaid are more likely to have had a doctor's visit compared to privately insured and uninsured children. Within each insurance category, minorities are less likely to have visited a doctor or health professional. Hispanic children are at the greatest risk of not having a

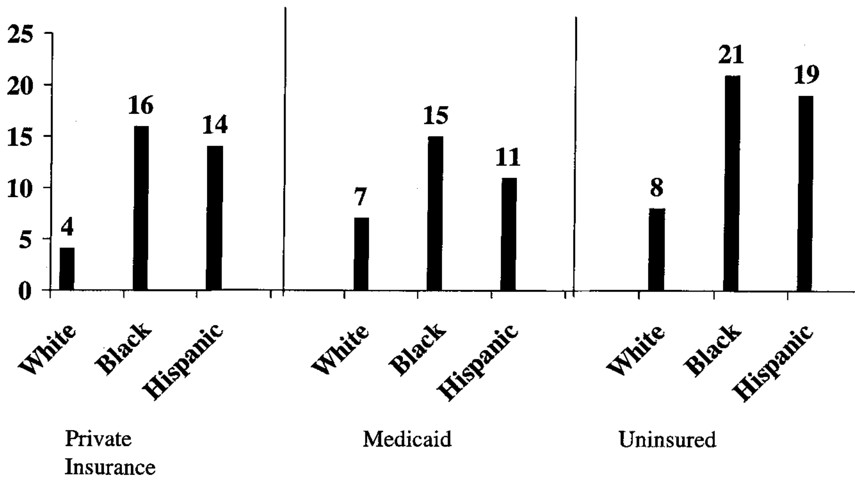

FIG. 3 Percentage of low-income children whose regular sites of care are hospital outpatient departments and emergency rooms, by insurance status and race ethnicity of the parent. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

visit. Less than half of uninsured Hispanic children received care from a doctor—a 24% difference from that received by white uninsured children. Similarly, among the privately insured children, only 65% of Hispanic children saw a doctor or health professional versus 79% of white children.

Figures 5 and 6 have similar distributions, reflecting the fact that most of the care children receive is routine. Children on Medicaid report the highest rates of receipt of routine care in the past year. A possible explanation for this could be Medicaid's emphasis on early diagnostic screening and treatment. Nevertheless, minority children are less likely to receive routine care, including checkups

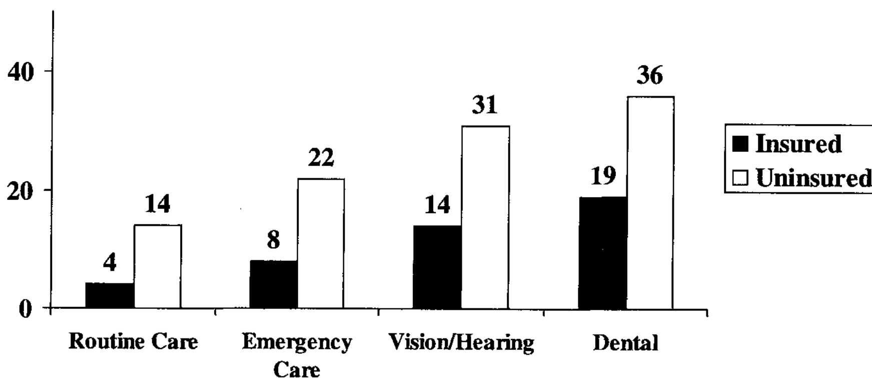

FIG. 4 Percentage of low-income children not getting or needing care in the last 12 months. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

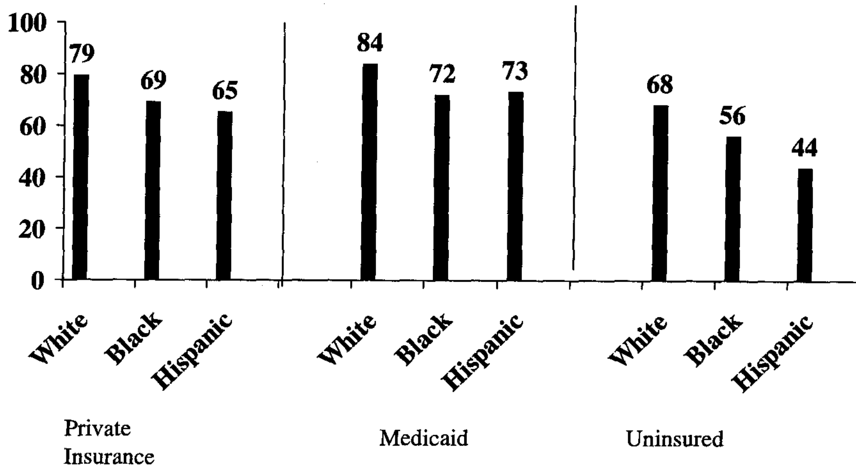

FIG. 5 Percentage of low-income children who received health care from a doctor or health professional in the last 12 months, by insurance status and race/ethnicity of the parent. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

and immunizations, compared to their white counterparts, even when health insurance is considered.

Less than half of children in the sample received any specialty care in the past year (Fig. 7). This is may be a reflection of the low demand for specialty care among children. However, there are disparities in access to specialty care across racial and ethnic groups. Minorities, particularly Hispanic children, have

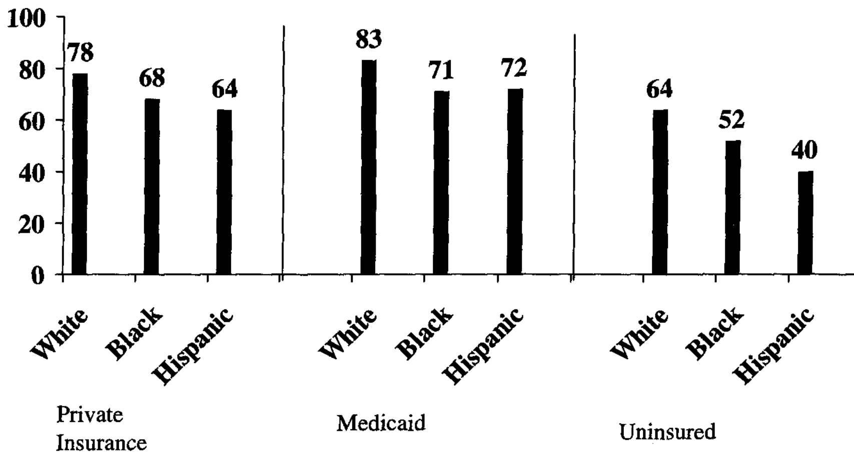

FIG. 6 Percentage of low-income children who received routine care in the last 12 months, by insurance status and race/ethnicity of the parent. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

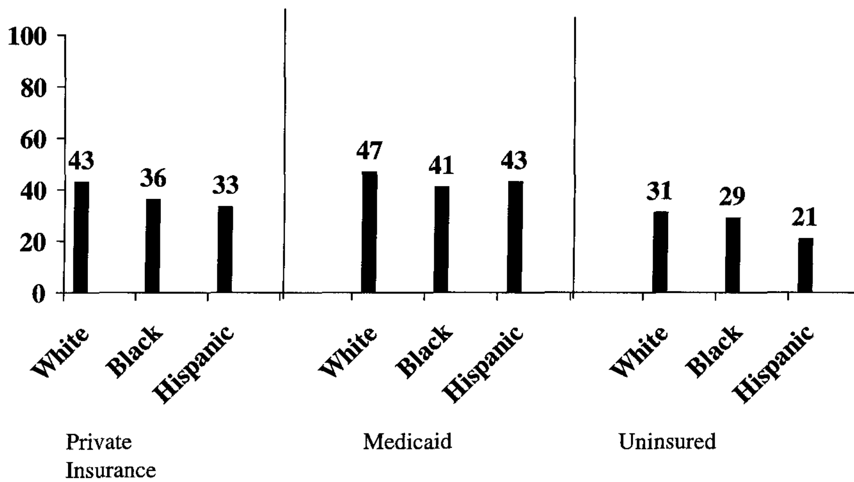

FIG. 7 Percentage of low-income children who received any specialty care in the last 12 months, by insurance status and race/ethnicity of the parent. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

lower rates of specialty utilization. Children on Medicaid, however, access specialty care at slightly higher rates compared to children who are privately insured.

Findings from the *Kaiser/Commonwealth Five State Low Income Survey* indicate that, although the presence of health insurance improves access to health care for low-income persons, it does not equalize health care utilization across racial and ethnic groups. Other factors clearly play a role in determining whether children receive health services. One possible explanation could be that the level of parents' education influences their ability to obtain health care services for their children. However, as Fig. 8 shows, among children whose parents have at least a high school education, minority children are still less likely to visit a doctor or health professional in the past year compared with white children across all insurance categories.

Another possible explanation for the utilization differentials could be that minority parents face additional nonfinancial barriers to care, such as geographic inaccessibility and the inadequacy of clinic and office hours. Another factor may be the lack of understanding by providers and health plans about why and how people from different backgrounds seek and utilize health care services. Certain minority groups may have reduced rates of utilization because, based on past experiences, their expectations of the health care system are low. Minorities also may have different perceptions of their need for health care services. Thus, even if health insurance is available, some groups may use health care services at later stages in an illness than others.

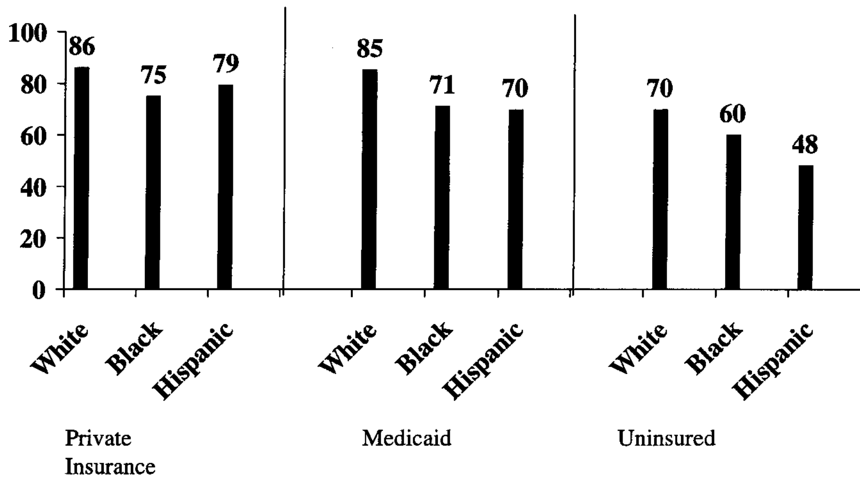

FIG. 8 Percentage of low-income children who received health care from a doctor or health professional in the last 12 months, by insurance status and race/ethnicity of the parent. Parent has at least a high school diploma. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

Time limits on the survey precluded questions regarding the health status of the children. Nevertheless, minority children have higher mortality and morbidity rates than white children and are less likely to report being in excellent or good health.[6] Higher, or at least similar, rates of health care utilization for minority children compared to white children should be expected.

WHAT'S NEXT? CHALLENGES FACING THE MEDICAID PROGRAM AND THE US HEALTH CARE SYSTEM

Although Medicaid is successful in improving access to health care for poor children, challenges still remain. First, a sizable number of children, despite being eligible for Medicaid, are not enrolled. In 1997, 5.1 million of all Medicaid-eligible children were uninsured.[23] These children are more likely to be Hispanic, US-born children of foreign parents or to be foreign born (Table IV).[24] Many of these parents do not enroll their children in Medicaid because (1) they are unaware of the program and its eligibility criteria, (2) they believe that their families are healthy and not in need of health insurance, and (3) they fear enrolling in Medicaid may jeopardize their immigrant status. In response, many states are beginning to adopt a variety of approaches aimed at increasing enrollment among eligible children. The challenge for Medicaid programs is to ensure that outreach and enrollment activities are targeted at specific groups, such as eligible immigrant and Hispanic communities.

TABLE IV Percentage of Medicaid Eligible Children Who Were Uninsured in 1996*

Race/Ethnicity	Percentage Uninsured
White	21
Black	19
Hispanic	29
Other	26
Birth status of child and parent	
US-born child with US-born parents	18
US-born child with foreign-born parents	30
Foreign-born child with foreign-born parents	55
Total	23

*From US General Accounting Office.[23]

Second, despite the recent Medicaid expansions, a large number of children remain or become uninsured. The Child Health Insurance Program was estimated to provide health care coverage for 4 million of the 11.3 million uninsured children under age 19 in 1996.[24] This program, together with planned Medicaid expansions, has the potential to cover 9.1 million uninsured children under age 19. Most of the remaining 1.7 million children who will remain without health insurance are from families whose incomes are greater than 200% of poverty.[24] However, the number of uninsured low-income children could increase as employment-based health care coverage continues to decline. Minority children may be particularly susceptible to this decline because their parents tend to work in jobs and industries that do not provide health care coverage.

The Personal Responsibility and Work Opportunities Act of 1996 also can increase the numbers of the uninsured, particularly among recent legal immigrants. Under the new law, states are given the option of maintaining Medicaid eligibility to qualified aliens legally admitted to the US prior to August 8, 1996. Qualified aliens entering after this date must wait 5 years from the date of their arrival before states can opt to make them Medicaid eligible. So far, states appear to be providing coverage to aliens admitted prior to August 8, 1996.[25] Of concern are the recent immigrants, who often work in low-wage jobs that generally do not provide health insurance coverage. It is unclear whether states will use their own funds to provide health insurance coverage for children in these newly immigrated families.

Third, the reduction of financial barriers alone will not ensure equitable utiliza-

tion of health care services across racial and ethnic groups. The US health care system must begin to address other factors related to health care access. The growth in managed care requires that Medicaid move from merely serving as a financing mechanism to becoming at least partially responsible for the delivery of health care services. In addition, there is a growing realization that, as the population of the US becomes increasingly diverse racially and ethnically, the cultural sensitivity of providers and health plans is an important element in ensuring appropriate health care utilization. As an example, health plans' enrollment processes and utilization controls may discourage health services use among those with limited education and different cultural backgrounds. It is imperative that Medicaid programs require health plans address social, behavioral, and cultural barriers to care.

Finally, in order to assess Medicaid's effectiveness at reaching different population groups, adequate data on race and ethnicity should be collected. Data that incorporate racial and ethnic measures will aid in understanding many of the nonfinancial barriers to health care. Measures of race and ethnicity should move beyond simply grouping people into broad categories based on mostly biologic or geographic (as in the case of Hispanics) dimensions. This aggregation may hide important differences within subpopulations. Instead, ethnicity variables should measure the heterogeneity of cultures within the traditional race categories. Also, since some racial and ethnic groups are not evenly distributed throughout the country, many of the large national surveys are unable to collect adequate samples of these groups. Data collection activities either must deliberately oversample subpopulations in the national surveys or must conduct regional surveys in areas where large numbers of specific minority groups reside.

CONCLUSION

Numerous studies throughout the last 30 years and the results presented here from the *Kaiser/Commonwealth Five State Low Income Survey* support Medicaid's role in improving access to care for poor minority children. Since minority children are affected disproportionately by the unavailability of health insurance, Medicaid's role as a financing source is particularly important to these groups. It is also clear that reducing financial barriers will not eliminate completely the inequalities in health care utilization and disparities in health status across different racial and ethnic groups. As discussed above, despite Medicaid's influence, minority children still exhibit poorer quality of health. Thus, strategies for the next century should focus on ensuring that all barriers to care are removed. This will involve not only the guarantee of universal health care coverage for

all children, but also the elimination of social, cultural, and behavioral barriers to optimum health and health care as well.

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