Rhode Island KIDS COUNT

Issue Brief

HEALTH INSURANCE FOR CHILDREN AND FAMILIES

Access to regular medical care and preventive services is critical to the physical, educational and social well-being of children and to the overall health of the community. Children benefit when parents have health insurance that addresses their own health needs. Lack of health insurance makes it difficult for children and adults to obtain necessary preventive care as well as primary and specialty care.

WHY HEALTH INSURANCE MATTERS

The benefits of health insurance accrue not only to the covered individuals but to the state as a whole. Employers frequently offer benefits to attract and retain employees, recognizing that health insurance coverage is critical to a productive workforce.[1] Publicly-funded health insurance provides a general economic stimulus due to the influx of federal dollars into the health care industry and the state economy.[2,3] Health care providers benefit from health insurance as a reliable form of payment.[4]

Children with health insurance coverage are more likely to receive needed medical care and to have a usual source of health care than uninsured children.[5,6] Insured children are more likely to:

- Receive medical treatment for common childhood illnesses.
- Receive recommended childhood immunizations.
- Receive preventive medical care.
- Obtain medications prescribed to treat acute and chronic health problems, such as injuries, asthma, and ear infections.[7]

Health insurance coverage for parents promotes health, improves access to health care and protects families against unexpected health care costs. Uninsured adults are less likely to receive health services, even for serious conditions. People without health insurance are less likely to receive preventive services and appropriate routine care for chronic conditions.[8] Covering parents increases the likelihood that children will receive preventive care, reduces unmet health needs, and improves health care access for both parents and children.[9]

MARCH 2003

POSITIVE HEALTH OUTCOMES

RIte Care has resulted in greater access to health care and improvements in overall health outcomes.

Improved access to prenatal care. Adequate prenatal care for women enrolled in Medicaid improved from 56% in 1993 to 73% in 2000.[12]

Increased intervals between births. In 2000, 78% of women enrolled in Medicaid waited at least 18 months between births. Before RIte Care implementation, only 60% of women waited at least 18 months between births.[13]

Reduction in smoking during pregnancy. The percentage of women who smoked during pregnancy, an important factor in preventing low birthweight infants, decreased from 32% in 1993 to 24% in 2000.[14]

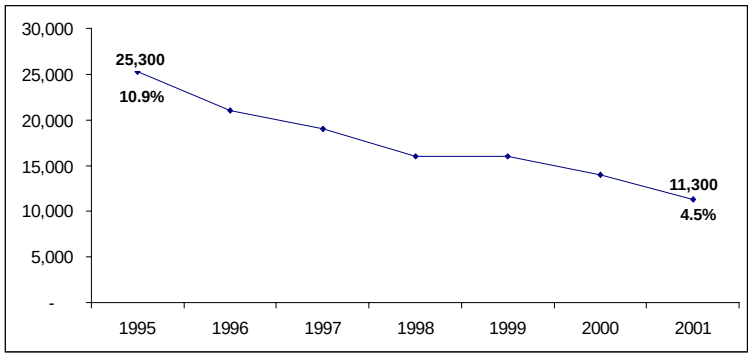
Improved access to primary care. Children enrolled in RIte Care have higher rates of recommended well-child visits than children with commercial insurance.[15]

Up-to-date preventive health screenings. Children enrolled in RIte Care are more likely to have up-to-date *immunizations* and to be *screened for lead poisoning and anemia* than children enrolled in Medicaid nationally. Rates are comparable to those for children enrolled in commercial health plans.[16]

RHODE ISLAND RANKS BEST IN THE NATION

Rhode Island has made enormous progress in expanding access to health insurance and improving the health of children and families. Among all 50 states, Rhode Island has the lowest rate of uninsured people (7.2%), the lowest rate of uninsured women of childbearing age (8.2%), and the lowest rate of uninsured children (4.5%).[10,11]

Uninsured Children, Rhode Island, 1995-2001



Source: U.S. Census Bureau, Current Population Survey, three-year averages.

Between 1995 and 2001, the percentage of Rhode Island children without health insurance was reduced by more than half, from 10.9% in 1995 to 4.5% of all children in 2001. The number of uninsured children decreased from 25,300 to 11,300.

RITE CARE/RITE SHARE

RIte Care and RIte Share are Rhode Island's Medicaid-funded health insurance programs for children and families. RIte Care/RIte Share provide comprehensive quality health care to low-income children up to age 19 and parents of eligible children up to 185% of the federal poverty line (FPL). Eligibility is based on family size and income.

Once enrolled in RIte Care, families receive services through one of three participating health plans: Neighborhood Health Plan of Rhode Island, United Healthcare of New England, or Blue CHIP Coordinated Health Partners. Each plan is under contract with RIte Care to provide comprehensive services to all enrollees. Dental care is provided on a fee-for-service basis.

Eligible families are enrolled in RIte Share if a parent works for an employer who offers a qualified health plan. The family is enrolled in the employer's plan and the state pays the employee's share of the premium. RIte Care and RIte Share participants are entitled to the same scope of coverage. Services not available through the employer's plan are covered by Medical Assistance. All participants are entitled to services to help them access health care, including interpreter services and transportation services.

SPECIAL POPULATIONS

The success of RIte Care's managed care delivery system has encouraged the state to enroll eligible children currently covered through Medicaid fee-for-service into RIte Care. Enrollment in RIte Care will improve access to services, care coordination and overall quality of care, as well as controlling costs. Most children in foster care (substitute care through the Department of Children Youth and Families) were switched from Medicaid fee-for-service to RIte Care in 2000. Children with special health care needs will soon be enrolled.

CHILDREN IN FOSTER CARE

In November 2000, children in substitute care began to be transitioned into RIte Care through Neighborhood Health Plan of Rhode Island (NHPRI). As of December 31, 2002, there were 1,981 children enrolled.[17] As a result of the partnership between DCYF, DHS and NHPRI, the behavioral health network available to children in substitute care has been strengthened significantly. A data exchange capability between DCYF and NHPRI tracks any change in a child's foster care placement and/or primary care provider in order to ensure continuity of care.[18] More children entering substitute care are receiving a primary care visit within the first 60 days of placement and use of outpatient behavior health services has increased.[19]

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

In February 2003, the Department of Human Services received approval from the Center for Medicare and Medicaid Services to transition the three remaining groups of children with special health care needs from Medicaid fee-for-service to managed care. These include children with disabilities who are eligible for Medicaid because of their eligibility for SSI (Supplemental Security Income) or coverage through the Katie Beckett provision, and families who receive an adoption subsidy. Children with special health care needs who are enrolled in their parents' commercial insurance will remained covered by the commercial plan. Medical Assistance will provide wrap-around services not available through the commercial plan.

In FY 2002, children with special health care needs represented 7% of the total Medical Assistance caseload and 12% of the expenditures.[20] Total Medicaid spending for this population rose to $154 million, with an average monthly expenditure of $1,139 per child.[21] By moving these children into Medicaid managed care, they will benefit from a system of coordinated care with increased access to health services. The Department of Human Services has involved parents, providers, health plans and advocates in crafting and implementing the new delivery system to ensure that these children and their families receive the comprehensive services they need.

RITE CARE HISTORY

1994 General Assembly passes RIte Care and implementation begins. Covers children up to age 6; pregnant women up to 250% FPL; families enrolled in AFDC.

1996 Coverage expands to children up to age 8 with household incomes up to 250% FPL.

1997 Coverage expands to children up to age 18 with household incomes up to 250% FPL.

U.S. Congress passes federal legislation to create the State Children's Health Insurance Program (SCHIP).

1998 DHS implements the simplified mail-in application to replace face-to-face interviews previously required to apply.

Coverage expands to parents of eligible children in families with incomes to up to 185% FPL.

1999 Coverage expands to all children up to age 19 in households with incomes up to 250% FPL.

Covering Kids Rhode Island begins, sponsored by the Robert Wood Johnson Foundation.

Covering Kids helps launch the DHS Outreach Project and expand the Family Resource Counselor network.

2000 Health Reform RI 2000 signed into law - instituting RIte Care premiums and health insurance reform.

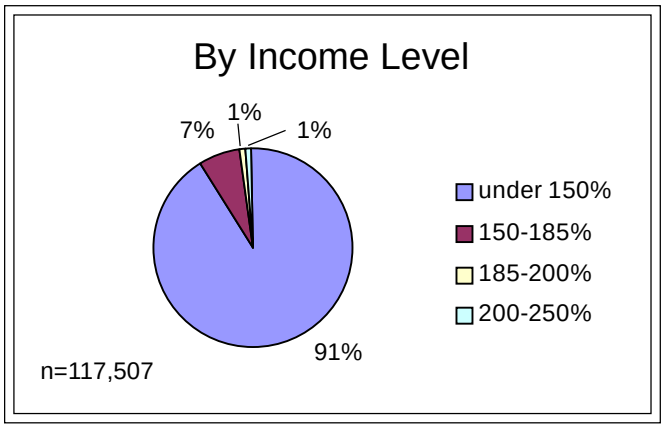
DHS Outreach Project ends.

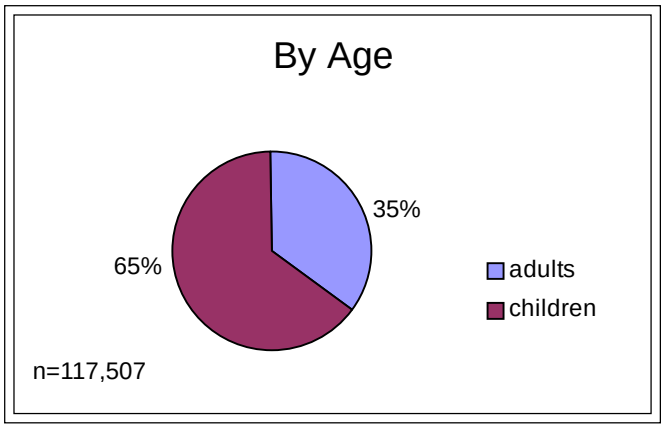
Children in foster care transferred from Medicaid fee-for-service to RIte Care.

2001 RIte Share enrollment begins and DHS begins to charge premiums to RIte Care members.

2002 General Assembly approves Governor's budget plan to transfer Children with Special Health Care Needs into RIte Care.

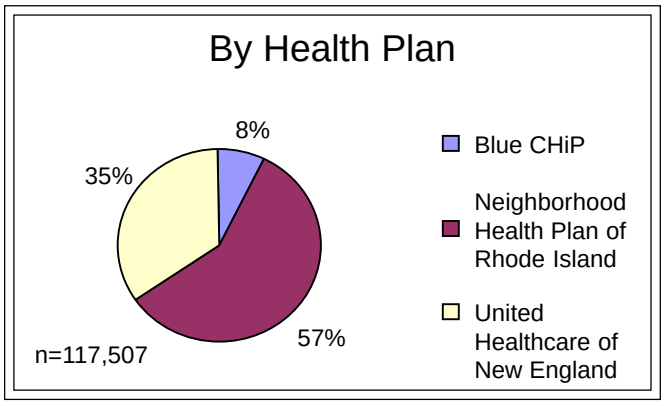
RITE CARE ENROLLMENT, DECEMBER 2002

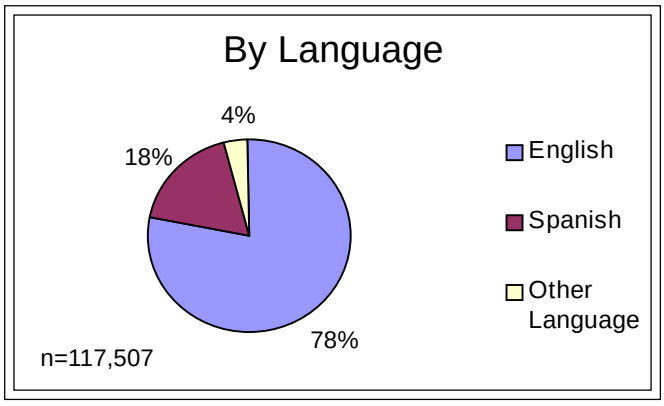




- As of December 2002, there were 117,507 people enrolled in RIte Care.
- Of all RIte Care participants, 65% were children (including 1,981 children in substitute care) and 35% were adults.
- Most (91%) RIte Care recipients live in households with income below 150% FPL ($22,530 for a family of three).
- Thirty percent of all adults receiving RIte Care are enrolled in the Family Independence Program (FIP).

Source: RI Department of Human Services, Center for Child and Family Health, December 31, 2002.





- Of all RIte Care participants, 57% (67,412) are enrolled in Neighborhood Health Plan of Rhode Island; 35% (40,998) are enrolled in United Healthcare of New England; and 8% (9,097) are enrolled in BlueCHiP.
- More than three-quarters (78%) of people enrolled in RIte Care speak English. The next most common language is Spanish at 18%. Eleven additional languages are spoken by RIte Care participants.

Source: RI Department of Human Services, Center for Child and Family Health, December 31, 2002.

COVERING KIDS AND FAMILIES
A NATIONAL HEALTH INSURANCE ACCESS INITIATIVE

PARTNERS

Rhode Island KIDS COUNT
Neighborhood Health Plan
of Rhode Island
The Rhode Island Foundation
Progreso Latino
St. Joseph Hospital for
Specialty Care
RI Health Center Association
Ocean State Action Fund
The Poverty Institute at
RI College School of Social Work
RI Department of Human Services
RI Department of Health
RI Department of Elementary
and Secondary Education
Health and Education Leadership
for Providence

Lead Agency
Rhode Island KIDS COUNT
Amy Lapierre,
Project Director
401-351-9400

LOCAL COALITION LEADERS

Providence
St. Joseph Hospital for Specialty Care
Jennifer Bowdoin,
Providence Coordinator
401-456-4480

Pawtucket
Cunningham/Slater
COZ Family Center
Sonia Rodrigues-Carr,
Pawtucket Coordinator
401-728-2512

Central Falls
Progreso Latino
Matilda Sansone,
Central Falls Coordinator
401-728-5920

GOALS AND STRATEGIES

Covering Kids and Families Rhode Island is a partnership of public and private organizations dedicated to ensuring that all children have access to health care. The initiative works statewide and in three local communities to ensure that all children and adults eligible for RIte Care or RIte Share are enrolled and retain their coverage. Local Covering Kids and Families projects are in Providence, Pawtucket and Central Falls.

The goals of Covering Kids and Families Rhode Island are to:

- Reduce the number of uninsured children and parents in Rhode Island.
- Enroll eligible children and adults in RIte Care/RIte Share.
- Retain eligible children and adults to ensure continuous health coverage.
- Simplify enrollment and renewal processes.
- Coordinate existing health coverage programs.

Key strategies of Covering Kids and Families statewide and in local communities include:

- Strengthening the Family Resource Counselor program in hospitals, community health centers and organizations serving immigrant communities.
- Reaching out to uninsured parents through unemployment offices, temporary agencies, adult literacy classes and other programs.
- Simplifying enrollment and renewal processes, including working with the Department of Human Services and the health plans to improve retention rates and to simplify renewal forms and notices.

Covering Kids and Families is sponsored by the Robert Wood Johnson Foundation with additional funding support from The Rhode Island Foundation, The Annie E. Casey Foundation, Neighborhood Health Plan of Rhode Island, and Ocean State Charities Trust.

MEDICAID AS AN ECONOMIC STIMULUS FOR RHODE ISLAND

Medicaid provides health care services to low-income people in every state. Medicaid also plays an important role in stimulating the state's business activity and the economy. For every state dollar spent on Medicaid, federal dollars are pulled into the state's economy. According to a recent study by Families USA, the movement of these federal dollars into Rhode Island has spurred $1.32 billion in business activity, created 14,280 jobs and contributed to $467 million in salaries and wages.[22]

Besides its general economic stimulus effect, Medicaid - including RIte Care - serves as an economic development engine for Rhode Island in a number of ways, including:

- A reduction in the public burden of paying for free care.
- A reduction in emergency room overcrowding.
- Reducing personal bankruptcies.
- Stimulating spending on the part of participating families.

Medicaid not only provides needed health care services to the low-income elderly, disabled adults, children and families, but it also serves as a tool in the state's economic development. Reductions in Medicaid expenses also trigger reductions in state revenue. For example, a budgetary cut of $10 million from Medicaid would mean the loss of more than $24 million in business activity, the loss of almost 250 jobs and $8.6 million in lost salaries and wages.[23]

MEDICAID, RHODE ISLAND 2002

Medicaid is a federally-sponsored health care program for individuals and families with limited income. The program was established by the federal government in 1965 as Title XIX of the U.S. Social Security Act. Medicaid is both the primary payer and purchaser of health care for many individuals and families in need. In fiscal year 2002, Medicaid spent $1.45 billion in state and federal funds to provide health care services to an average of 170,440 people each month.

The State Medicaid Budget by Cost Per Capita Per Month Fiscal Year 2002

Elderly	$1,659
Adults with Disabilities	$1,611
Children with Special Needs	$1,139
RIte Care	$184

Medicaid is the chief source of funding for long-term care for elderly individuals with limited means; health care services for low-income adults with disabilities; RIte Care health coverage for low-income families and their children, including pregnant women and infants; and health care coverage for children in substitute care (foster care) through the Department of Children, Youth and Families.

Comprehensive coverage through RIte Care costs $184 per person per month. Coverage for disabled adults costs $1,611 per person per month and costs for the elderly are $1,659 per person per month. Coverage for children with special health needs is $1,139 per person per month.

Source: Rhode Island Medicaid Program Annual Report, Fiscal Year 2002

RITE CARE BUDGET MYTHS

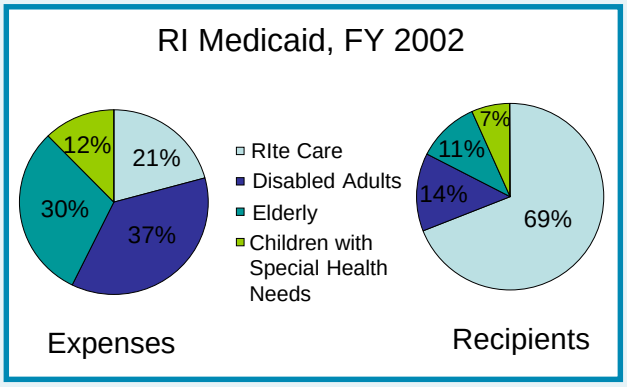
Despite the critical role that RIte Care plays in keeping Rhode Island children and families healthy, there is perception that the program is too expensive and puts the state budget at risk. However, these perceptions are often based on misunderstandings about the program and the people it serves.

Net Change in RIte Care Enrollment 1999-2002	
FY 1999	15%
FY 2000	20%
FY 2001	7%
FY 2002	5%

Source: RI Medicaid Program Annual Report, FY 2002

Myth: RIte Care enrollment has soared at an uncontrollable rate.
Reality: RIte Care enrollment increased in FY 1999 and 2000, but leveled off in 2001 and 2002.

In FY 1999 and FY 2000, RIte Care enrollment grew 15% and 20% respectively. These increases were due to a combination of factors including an effective Covering Kids and DHS Outreach Initiative, the addition of newly eligible parents, implementation of the new mail-in RIte Care application, and a major health insurer (Harvard/Pilgrim) leaving the state. Since that time, however, net enrollment growth has decreased significantly. Net enrollment in RIte Care rose just 7% in 2001 and 5% in 2002.[24]



Source: Rhode Island Medicaid Program Annual Report, FY 2002

Myth: RIte Care is the largest part of the Medicaid budget.
Reality: RIte Care covers more than two-thirds (117,000 people) of the state's Medicaid recipients with one-fifth ($262 million) of the Medicaid budget.

For state Fiscal Year 2002, RIte Care recipients comprised 69% of the state's total Medicaid recipients, yet comprised only 21% of the state's Medicaid budget. Adults with disabilities and the elderly account for 25% of the Medicaid population and 67% of total expenditures. The state Medicaid budget increased by $130 million from FY 2001 to FY 2002. More than two-thirds of the Medicaid cost increases are due to services for adults with disabilities and the elderly.[25] Cost drivers for adults with disabilities include inpatient utilization and chronic illness. Cost drivers for the elderly include prescription drugs and nursing home costs.[26]

HEALTH REFORM RHODE ISLAND 2000

From 1995 through 1998, RIte Care's enrollment remained fairly stable, ranging from 70,000 to 75,000. In 1999, enrollment growth expanded significantly, growing to 104,000 by June 2000. Also in late 1999, Rhode Island's commercial insurance market began to deteriorate, as Harvard Pilgrim Health Care left the state and premiums offered by the remaining commercial carriers increased dramatically. These cost increases had an adverse effect on many small firms and low-wage workers. In response to this growth and the instability in the small group health insurance market, the Governor and the Legislature moved quickly to enact a legislative package under the title Health Reform Rhode Island 2000. Components of the law include:

Health Reform RI 2000. This Act established the RIte Share program, a combined Medicaid/SCHIP premium assistance program intended to assist low-income families with the cost of employer-sponsored coverage. The Act also authorized the Department of Human Services to implement cost-sharing for Medicaid and SCHIP expansion populations.

Small Employer Market Reform. To bring Rhode Island into compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, the reform required compressing rate bands in order to stabilize premiums in the small group market, and by requiring that health insurers issue a basic health plan. The Department of Business Regulation has authority for this component of the legislation.

Source: Rhode Island Medicaid Program Annual Report, FY 2002.

RITE SHARE

RIte Share is a public-private partnership that helps low-income and middle-income families obtain health insurance coverage through their employer. RIte Share pays for the eligible employee's share of the monthly premium and provides wrap-around coverage (services comparable to those available through RIte Care) through the fee-for-service Medicaid program. In implementing RIte Share, the Department of Human Services creatively addressed several administrative barriers that hindered implementation of similar programs in other states. These include qualifying health plans for RIte Share on an employer-by-employer basis instead of family-by-family and broad standards for qualifying health plans (so that the majority of health plans offered in Rhode Island are included).

RIte Share Enrollment	
December 2001	111
March 2002	409
June 2002	1,596
September 2002	2,304
December 2002	2,905
February 2003	3,460

Source: RI Department of Human Services, RIte Share Program, February 2003.

RIte Share has experienced slow but steady growth since its implementation in April 2001. As of February 2003, there are 1,092 families (3,460 children and parents) enrolled in their employers' insurance through RIte Share. A total of 736 employers participate or offer approved plans.[27] The average cost of RIte Share is $338 per family per month savings are (compared to $450 per month for RIte Care). Savings are estimated to be $132 per month or $1,584 per year for a family enrolled in RIte Share compared to the cost to enroll that family in RIte Care. In FY 2002, state savings from RIte Share were $75,000 (half of the $180,000 total).[28] For FY 2003, state savings are estimated to be $800,000 out of a total of $1.8 million in savings.[29] The remaining savings are returned to the federal government.

COST SHARING: RITE CARE PREMIUMS

Beginning in January 2002, families with income above 150% FPL were required to pay a monthly premium of 3% of income ($43 - $58/month). In August 2002, the monthly premium increased to 4% of income ($61 - $92/month). Failure to pay the premium for two months results in a penalty of four months ineligibility for RIte Care (pregnant women and children under age 1 are not subject to the penalty). Approximately 10% of the families enrolled in RIte Care are required to pay the premium.

In April 2002, the first month in which sanctions were imposed for failure to pay premiums, 579 families lost their RIte Care coverage. During the next five months, an average of 168 families per month lost their coverage. With the implementation of higher premiums in August 2002, the average number of closures increased to 181 families per month.[30]

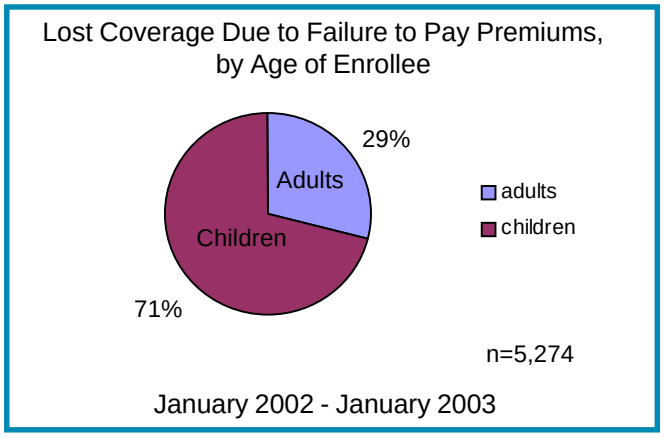
Since the implementation of premium payments, a total of 2,325 families lost their RIte Care/RIte Share coverage for failing to pay premiums.[31]

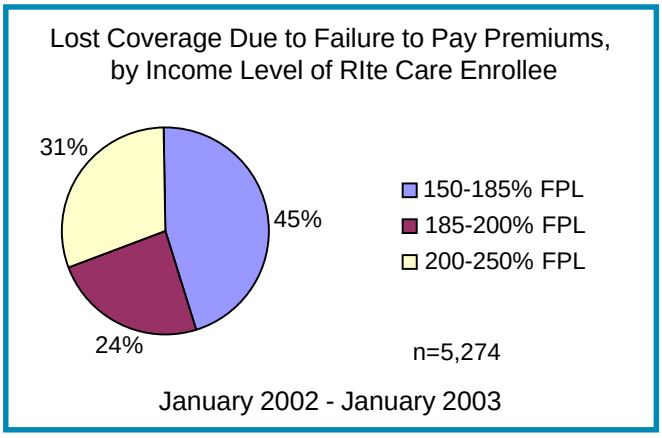
The Department of Human Services collected $1.2 million in premiums between January and June 2002. However, because of the blend of federal and state cost-sharing for different populations, approximately 64% of collections are remitted to the federal government and the state's share of the revenue was $450,000.[32] For each monthly premium collected from low-income families ($61 per month) the state keeps $22. For FY 2003, DHS anticipates collecting $3.2 million in premiums, of which the state will keep $1.2 million.[33] However, these savings come at the cost of an increased number of uninsured children and parents.

RITE CARE PREMIUMS, JANUARY 31, 2002

2002 Federal Poverty Level (FLP)	Family of Three Monthly Income	Monthly Premium	Total Number of Families Required to Pay Premiums	Total Number of People in Families Required to Pay Premiums
150-185%	$1,878-2,315	$61	2,543	8,026
185-200%	$2,316-2,502	$77	469	1,560
200-250%	$2,503-3,129	$92	829	861

Source: Rhode Island Department of Human Services, Center for Child and Family Health, February 2003.





Source: Rhode Island Department of Human Services, Center for Child and Family Health, February 2003.

Between January 1, 2002 and January 31, 2003, there were 5,274 people sanctioned for failure to pay premiums; of these, almost three-quarters (71%) of the people who lost coverage were children. Forty-five percent of the 5,274 people sanctioned for failure to pay premiums were in the lowest income group.

HEALTH INSURANCE FOR CHILDREN AND FAMILIES: THE INTERPLAY BETWEEN PUBLIC AND PRIVATE INSURANCE

There has been a steady erosion of employer-sponsored insurance across the country over the past two decades. In 1980, 74% of employers contributed fully to the cost of health insurance. By 1993 only 21% of employers contributed fully to the cost of health insurance.[34] As the private insurance market declines, the public insurance market has served as the safety net for low-income families who cannot access health insurance through their employers. Medicaid and the State Children's Health Insurance Program (SCHIP) have provided coverage to some families with children who became uninsured due to loss of employer-sponsored insurance.[35]

CHANGES IN EMPLOYER-SPONSORED INSURANCE COVERAGE

- **Rise in Unemployment Rates**
  Since 2001, unemployment rates have risen from a national average of 4.8% in 2000 to 5.9% in 2002. The Congressional Budget Office estimates that unemployment rates will remain at six percent through the first half of 2003.[36] The Rhode Island unemployment rate peaked at 5.4% for the year ending December 2002. Rhode Island last reached the 5.4% level in 1997.[37]

  Since the majority of workers and their dependents receive health insurance coverage through their employers, unemployment often results in the loss of health care coverage. As the number of unemployed families increases, so does the number of uninsured.[38] Over the past decade, expansions in public insurance programs like Medicaid have cushioned the impact of growing unemployment on health insurance coverage.[39]

- **Growth in Premium Costs for Employers**
  Premiums for employer-provided health insurance grew by 11% in 2001, the largest increase in almost a decade.[40] In response to the increasing cost of insurance premiums, fewer employers are offering health coverage. Small businesses are especially vulnerable to the inflation in premiums prices and are the first to stop offering health insurance coverage.[41]

- **Increase in Employee Contributions for Health Insurance**
  More businesses are passing health insurance costs on to the employee. As a result, workers are paying a larger percentage of premiums costs, making it unaffordable for many families. Many families are also facing higher deductibles and co-payments.[42]

THE FINANCIAL RISKS OF THE UNINSURED

Medical debt is a burden for both medical providers as well as for individuals who need to seek medical care but have inadequate health insurance coverage. One study that examined bankruptcies by low-income people found that medical debt was a factor in 80% of bankruptcies and accounted for 42% of unsecured debt.[43] By providing comprehensive medical coverage for otherwise uninsured families, RIte Care contributes substantially to the economic stability of low-income Rhode Island families.

RECOMMENDATIONS

Rhode Island has made wise investments in RIte Care over the past ten years. RIte Care helps children and families lead healthier lives. The following recommendations are important if Rhode Island is to preserve the gains in improved health outcomes and further improve access to health care for all Rhode Islanders.

MAINTAIN RITE CARE

- **Maintain RIte Care at current eligibility levels.** It is cost effective for Rhode Island to maintain investments in RIte Care for low-income children and parents. Current RIte Care eligibility guidelines provide access to health care coverage that is critical if Rhode Island is to preserve the positive improvements in health outcomes.

- **Maintain RIte Care benefits and services.** Services including transportation and interpreter services are essential for children and families to access quality health care.

MAKE HEALTH INSURANCE AFFORDABLE

- **Make RIte Care premiums affordable.** Reducing premiums to 2% of income will make RIte Care more affordable to low-income families required to pay the premium.

- **Make health insurance affordable for all Rhode Islanders.** The success of the RIte Share program depends on the participation of employers offering commercial health care coverage. Rising commercial rates are forcing many businesses to either stop offering family health coverage or to pass on unaffordable premiums to their employees.

SIMPLIFY RITE CARE ENROLLMENT AND IMPROVE RETENTION

- **Fully fund the Family Resource Counselor (FRC) Program.** Family Resource Counselors help the state meet its federal obligation to have outstationed eligibility workers at disproportionate-share hospitals and federally qualified health centers. Family Resource Counselors assist families in completing RIte Care applications and renewals. They also screen families for eligibility in other programs and refer families to needed services.

- **Improve retention of health care coverage.** Many families experience gaps in health care coverage due to the administrative or programmatic barriers they face when they renew their application for RIte Care each year. This disrupts access to care for chronic health problems as well as preventive health care.

IMPROVE ACCESS TO HEALTH CARE

- **Improve access to dental care for low-income children and families.** Consider a RIte Care model for dental services. Currently, dental care through the Medicaid fee-for-service model is difficult to access, there are not enough dental prevention and treatment services available and the Medical Assistance payments to dentists are inadequate. As a result, many children and families go without needed dental care.

- **Consider a managed care model for other special populations.** Managed care is proving to be an effective model for providing high quality comprehensive services to populations with complex needs, such as children in foster care. Explore managed care models for other special populations, such as adults with disabilities.

- **Improve retention of pediatric medical, dental and behavioral specialists.** Increase the Medical Assistance rates paid to providers of specialty care for children. Assess reimbursement policies to ensure that children have access to the range of preventive and specialty care to meet their health needs.

ACKNOWLEDGMENTS

For assistance with this issue brief we thank: Linda Katz, Poverty Institute at Rhode Island College School of Social Work; Marti Rosenberg, Kathryn Hopkins, Ocean State Action; John Young, Tricia Leddy, Lissa DiMauro, Melinda Thomas, Nora Leibowitz, Deb Florio, Murray Blitzer, Diana Beaton, RI Department of Human Services; Chris Koller, Brenda Whittle, Neighborhood Health Plan of Rhode Island; William Hollinshead, RI Department of Health; and Kerrie Jones Clark, Deb Silvia, RI Health Center Association.

REFERENCES

[1,4,5,8] Institute of Medicine. *Coverage Matters: Insurance and Health Care* (2001). Washington, DC: National Academy Press.

[2,22,23,24,25] *Medicaid: Good Medicine for State Economies* (2003). Washington, DC: Families USA Foundation.

[3,43] Miller, Michael. *RIte Care: Right for Rhode Island. A Briefing Paper on RIte Care's Positive Economic Impact* (2002). Boston, MA: Community Catalyst for Ocean State Action.

[6] *The March of Dimes Data Book for Policy Makers: Maternal Infant, and Child Well- Being in the United States* (2001). Washington, DC: March of Dimes, Office of Government Affairs.

[7] *Children's Health – Why Health Insurance Matters* (2002). Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

[9,35] *Medicaid Matters for America's Families* (2002). Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

[10] U.S. Census Bureau, Current Population Survey, three-year averages. Compiled by The Annie E. Casey Foundation and Rhode Island KIDS COUNT.

[11] U.S. Census Bureau, Current Population Survey, 2000-2002 average. Compiled by the March of Dimes.

[12,13,14,18,20,21] *Rhode Island Medicaid Program Annual Report, Fiscal Year 2002* (2003). Cranston, RI: Rhode Island Department of Human Services.

[15,16] *Program Results* (2003) and *Program Results* (2001). Cranston, RI: Rhode Island Department of Human Services.

[17,24,30,31] Rhode Island Department of Human Services, Center for Child and Family Health (2003).

[19,26] Neighborhood Health Plan of Rhode Island, February 2003.

[27] Rhode Island Department of Human Services, RIte Share Program (2003).

[28,32] Rhode Island Department of Human Services, Fiscal Year 2002, Actual Expenditures.

[29,33] Rhode Island Department of Human Services, November Estimates to the Caseload Estimating Conference, Testimony (2002).

[34] Paul Frostin. Employee Benefit Research Group, as quoted in *The Providence Journal*, August 30, 1996.

[36,38,41,42] *The Number of Americans without Health Insurance Rose in 2001 and Appears to be Continuing to Rise in 2002* (2002). Washington, DC: Center on Budget and Policy Priorities.

[37] "State's Unemployment Rate Rises to a Peak of 5.4%" *Providence Business News* (February 2003).

[39,40] Rising Unemployment and the Uninsured (2002). Washington, D.C.: The Henry J. Kaiser Family Foundation.

Rhode Island KIDS COUNT is a children's policy organization that provides information on child well-being, stimulates dialogue on children's issues, and promotes accountability and action. Funding for Rhode Island KIDS COUNT is provided by The Rhode Island Foundation, The Annie E. Casey Foundation, Prince Charitable Trusts, The Robert Wood Johnson Foundation, the David and Lucile Packard Foundation, the Ford Foundation, the Ewing Marion Kauffman Foundation, CVS/pharmacy, Hasbro Charitable Trust and other corporate, foundation and individual sponsors.

Rhode Island* KIDS COUNT *Staff

Elizabeth Burke Bryant,
Executive Director
Catherine Boisvert Walsh,
Deputy Director
Dorene Bloomer, Finance Director
Wilsa Galarza,
Administrative Assistant
Olinda Matos,
Communications Coordinator
Laura Beavers, Research Analyst
Veronika Kot, Policy Analyst
Theresa Hancock, Policy Associate
Royce Conner, Policy Associate
Raymonde Charles, Program Assistant
Amy Lapierre, Project Director
Covering Kids & Families
Sonia Rodrigues-Carr,
Pawtucket Coordinator,
Covering Kids & Families
Jason L. Anthony, Publications Assistant

***Rhode Island* KIDS COUNT**

One Union Station
Providence, RI 02903
401-351-9400
401-351-1758 (fax)
email: rikids@rikidscount.org
www.rikidscount.org

CVS/pharmacy®

Production of the Rhode Island Kids Count Issue Brief Series is made possible through the generous support of CVS/pharmacy.