A Progress Report On State Health Access Reform

States are filling the void in federal reform activity, although only a minority have enacted meaningful reforms to date.

by John E. McDonough, Michael Miller, and Christine Barber

ABSTRACT: Enactment of ambitious health reform laws in Massachusetts and Vermont in 2006 helped instigate a wave of state legislative activities to expand coverage to uninsured people. We identify thirty-nine states that have enacted laws in at least one access category since 2006. At least thirteen states have begun processes to enact comprehensive reforms to cover at least half of their uninsured residents. Key activities involve coverage expansions for uninsured children and for uninsured adults; regulatory changes in small-group and individual insurance markets; and individual and employer mandates. The future extent and durability of this wave are uncertain. [*Health Affairs* 27, no. 2 (2008): w105–w115 (published online 29 January 2008; 10.1377/hlthaff.27.2.w105)]

Enactment of ambitious health reform laws in Massachusetts and Vermont in the spring of 2006 helped instigate a new wave of state legislative activities to expand coverage to uninsured people and to achieve other health system reforms.[1] In the past two years, lawmakers in at least thirty-nine states and the District of Columbia have enacted laws to address shortcomings in access, quality, and costs. This is the most far-reaching and expansive wave of state health coverage reforms since an earlier surge between 1988 and 1993.[2]

State health reform activities are worth watching not only for interest in their products and processes; they can serve as clues and cues to action in other states and in the federal government. Over the past twenty years, waves of state health reform helped policymakers generate policy ideas and summon the political will to encourage important federal health reform activities. For example, the 1988–1993 state health access reform wave demonstrated public support and generated policy ideas to inform the ill-fated federal health reform drive in 1993 and 1994. State activities between 1990 and 1996 to reform poorly functioning small-group and individual health insurance markets served as a source of ideas and motivation leading to passage of the federal Health Insurance Portability and Accountability Act (HIPAA) in 1996. Efforts in the mid-1990s in two dozen states to ex-

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DOI 10.1377/hlthaff.27.2.w105 ©2008 *Project HOPE–The People-to-People Health Foundation, Inc.*

pand coverage of uninsured children inspired congressional action to create the State Children's Health Insurance Program (SCHIP) as part of the 1997 Balanced Budget Act (BBA). State initiatives in the late 1990s to provide Medicare beneficiaries with access to affordable prescription drugs helped sustain support for that issue, culminating in passage of the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA) in 2003.

As candidates for the 2008 presidential nomination frame health reform platforms proposing a new and reinvigorated round of federal health reform, states are again playing a critical role by defining and testing new ideas. This report provides a snapshot and discussion of state health access reform laws—enacted statutes—and other key activities between early 2006 and late December 2007.

Study Data And Methods

■ **Focus of analysis.** In this paper we catalogue the latest round of state legislative health access enactments and draw lessons from them. We focus our analysis on five categories of state health access reform activities: (1) expansion of publicly subsidized coverage for uninsured children; (2) expansion of publicly subsidized coverage for uninsured adults; (3) changes to small-group and individual insurance markets; (4) new coverage mandates on individuals or employers, or both; and (5) ongoing efforts to enact "comprehensive reforms"—defined as efforts to expand coverage to at least half of the uninsured population in a state.

For categories one through four, we restrict findings to access laws enacted in 2006 or 2007; for category five, we include enacted comprehensive reforms and proposals pending in states where the reform process was initiated or supported by the governor, the senate president, the House/Assembly speaker, or some combination. Because category five includes pending proposals, it is the most subjective and subject to change. For example, as of this writing in late December 2007, California's governor and Assembly have reached an agreement that, if approved by the State Senate and ratified by voters on the November 2008 ballot, will result in the enactment of major reform.

■ **Data sources.** Data were collected from multiple sources, including national reports on state health reform activities; examination of state legislative Web sites with information on 2006 and 2007 enactments; and a survey of state policy leaders who participate in the Reforming States Group, an international health policy network staffed by the Milbank Memorial Fund. Information was collected between July and December 2007.[3]

Not included in this survey is information on state legislative enactments related to improving quality and controlling costs. Many states have been active in this arena—most prominently, Vermont, which made chronic disease management a central feature of its 2006 health reform law. Although a survey encompassing quality and cost control enactments, as well as access enactments, would no doubt prove informative, it is beyond the scope of the present work.

Study Results

Exhibit 1 displays results from those states, including the District of Columbia, that enacted reforms or comprehensive reform initiatives, or both, in 2006 and

EXHIBIT 1
State Health Coverage Enactments And Comprehensive Coverage Campaigns In 2006 And 2007

	Children's coverage expansion	Insurance market reform	Adult coverage expansion	Individual and/ or employer mandate	Comprehensive reform
Alaska	●				
Arizona			●		
California					●
Colorado	●	●			●
Connecticut		●	●		●
Delaware		●	●		
DC	●				
Hawaii	●	●			
Idaho		●			
Illinois	●				●
Indiana	●		●		
Iowa	●		●		
Kansas			●		
Louisiana	●				
Maine		●			●
Maryland		●	●		●
Massachusetts	●	●	●	●	●[a]
Minnesota	●	●			●
Missouri	●		●		
Montana	●	●			
Nevada			●		
New Hampshire		●			
New Jersey			●		
New Mexico	●				●
New York	●	●	●		●
North Carolina	●	●			
North Dakota	●				
Ohio	●		●		
Oklahoma	●		●		
Oregon	●				●
Pennsylvania	●				●
Rhode Island		●		●	
South Carolina	●				
Tennessee	●		●		
Texas	●		●		
Vermont			●	●	●[a]
Washington	●	●			●
West Virginia	●				
Wisconsin	●				●
Wyoming			●		
Total	26	15	18	3	15

SOURCE: Authors' analysis of findings from national reports (see Note 4 in text), state legislative Web sites, and survey of state policymaker participants in the Reforming States Group.
NOTE: States that are not shown had no reforms in the categories surveyed during the survey period.
[a] Reform accomplished as of 31 December 2007.

2007. The most common reforms enacted involve expansion of children's coverage programs—evident in twenty-six states. The next most frequent reform category involves expansion of programs targeting uninsured adults, in eighteen states. Third most frequent is insurance market reforms to improve the functioning of these markets and to expand access to private health insurance coverage—evident in fifteen states. Only three states have enacted any form of individual or employer mandates. Finally, fifteen states either have enacted comprehensive reforms or are seriously seeking to legislate such reforms.

■ **Elements of state reform.** *Children's coverage expansions.* The most robust category of access expansion enacted by legislatures and governors over the past two years has involved coverage for children, principally expansions involving SCHIP. In all, we identified twenty-six states that have enacted new coverage expansions for children. This reflects the continuing political attractiveness of children's access expansions and the lower cost to states to cover children compared with coverage costs for other populations. Children's coverage expansions cost states less because of lower average costs to provide insurance for children and higher federal reimbursements available to states through SCHIP.

New York State enacted the broadest—and most controversial—eligibility expansion, raising the income ceiling for uninsured children to 400 percent of the federal poverty level.[4] Following the path of Illinois, several states, including Colorado, Hawaii, Minnesota, Pennsylvania, and Washington, established statutory goals to cover all uninsured children within a specified number of years. In addition, Ohio enacted a Medicaid "buy-in program" for children with catastrophic health conditions in families with incomes above 300 percent of poverty who are unable to obtain creditable coverage because of preexisting conditions. In the congressional controversy over SCHIP reauthorization, several proposed expansions—most prominently New York's—have been halted, at least temporarily, by Bush administration decisions to deny new state expansion plans for children in families with incomes greater than 250 percent of poverty.[5]

Adult coverage expansions. For coverage expansions affecting uninsured adults, we found laws passed in eighteen states that increase the number of adults eligible for Medicaid or other public programs. This includes states that increased the income eligibility standard for adults—in some cases, for any uninsured adults; in other cases, solely for parents or pregnant women. Although coverage for pregnant women is frequently catalogued with children's coverage expansions, we included expansions for pregnant women in this category. Some states expanded eligibility within their existing high-risk pools to provide coverage options for people who are uninsurable in the private market because of preexisting conditions. We did not include restorations of specific benefits (such as dental care or prosthetics).

A number of states expanded eligibility for "buy-in" programs to allow working adults to pay for health coverage, either partially subsidized or at full cost. This category includes Connecticut, where eligibility rose from 150 percent to 185 per-

cent of poverty for parents of HUSKY (Connecticut's SCHIP program) children, and Delaware, which increased eligibility to 120 percent of poverty. Indiana, using funding from a forty-four-cent tobacco tax, created a new, limited coverage program for adults up to 200 percent of poverty that includes mandatory participation in managed care plans, health savings accounts, and preventive care programs. Iowa will use revenue from a one-dollar-per-pack cigarette tax to finance coverage for both children and parents.

Starting in 2009, Kansas will subsidize insurance for adults earning less than 50 percent of poverty and plans to subsidize coverage for all uninsured people up to 100 percent of poverty by 2012. Missouri, in a major reconfiguration of its Medicaid program, restored coverage for some workers with disabilities and for lower-income parents who had lost coverage in 2005. In a novel and unprecedented move, New York enacted an expansion of its Family Health Plus program to enable any employer to buy unsubsidized coverage through the program. North Carolina created an Insurance Risk Pool for eligible adults unable to buy private coverage. In Oklahoma, eligibility for the Insure Oklahoma program was expanded to include businesses with 250 or fewer workers (raised from 50) and to workers with incomes below 250 percent of poverty (from 185 percent). Maryland lawmakers voted to expand Medicaid coverage for parents up to 116 of poverty and intend to expand coverage for childless adults over several years; they also established a $30 million subsidy program for lower-wage workers in small businesses.

Finally, Massachusetts and Vermont, as part of comprehensive reform laws, created new, non-Medicaid, sliding-scale, subsidized insurance programs for adults earning up to 300 percent of poverty, called Commonwealth Care in Massachusetts and Green Mountain Health in Vermont.

Insurance market reform. In reviewing fifteen state enactments in insurance market reform, we focus on changes intended to improve access to coverage. This category contains an array of changes, including extending the age children may remain on their parents' health policies, creating a health insurance purchasing mechanism, and changing the premium rating system for private insurance. Each of these reforms holds the potential to improve access to insurance coverage.

In the most popular reform, many states have directed state-licensed insurance carriers to allow children to remain on their parents' insurance plans—up to age twenty-four in Delaware; age twenty-five in Idaho, Maine, Massachusetts, Montana, New Hampshire, New York, Rhode Island and Washington State; and up to age twenty-six in Connecticut and Maryland.

Colorado passed legislation prohibiting two insurance underwriting factors: preexisting conditions and health claims experiences. Massachusetts merged its small-group and nongroup health insurance pools into one larger pool to spread risk more evenly and to lower individual insurance premiums. Massachusetts also created a Health Insurance Connector, a quasi-public market mechanism to allow consumers and small employers to compare and purchase health insurance more

efficiently and transparently. Washington State created the Health Insurance Partnership, a Connector-like mechanism for certain employees of small businesses. Hawaii passed legislation reinstating rate regulation for managed care plans by prohibiting insurance rates that are excessive, inadequate, or unfairly discriminatory; the law allows the insurance commissioner to impose monetary penalties on plans that violate these regulations.

Individual and employer mandates. Although mandates on employers or individuals, or both, have been proposed in legislation in at least ten states, only three have enacted such measures. Only Massachusetts has enacted a mandate on individuals to purchase health insurance. Beginning 31 December 2007, Massachusetts began imposing tax penalties on those not purchasing coverage when it is deemed "affordable" to them by the state. If California's recently announced agreement between the governor and legislature is enacted, it will join Massachusetts in having both employer and individual requirements. California's proposed individual mandate would differ from Massachusetts' by employing "automatic enrollment," with the state sending bills to those not purchasing coverage voluntarily.

Three states have imposed new requirements on employers. Massachusetts imposes a $295 annual per worker assessment on employers with more than ten full-time-equivalent workers who do not make a "fair and reasonable" contribution to workers' premiums. Vermont set a $365 annual assessment on employers not providing coverage—by 2009, on employers with more than four employees. Massachusetts and Rhode Island now require employers with more than a set number of workers (ten in Massachusetts, fifty in Rhode Island) to establish Section 125 plans to enable workers to obtain health insurance on a pretax basis, even when employers make no premium contributions on their behalf. To enforce this requirement, Massachusetts will penalize employers (with eleven or more workers) who do not set up a Section 125 mechanism and whose workers obtain hospital benefits financed through the state's Health Safety Net Trust Fund (formerly its Uncompensated Care Pool). California's reform law envisions the most expansive employer requirement: a mandatory "play-or-pay" assessment of up to 6.5 percent of payroll, permitting employers to deduct from their liability all health insurance contributions. (We discuss the Employee Retirement and Income Security Act, or ERISA, implications of these requirements in our conclusion.)

■ **Comprehensive reform—works in progress.** In the wake of the Massachusetts and Vermont enactments, governors and key legislative leaders in at least thirteen other states have proposed comprehensive reform laws, with most proposal elements drawing from these two accomplished enactments (Exhibit 2). Most comprehensive proposals include elements from all categories identified in this survey, including expansions for children and working adults, insurance market reforms, and mandates of one form or another.

As of 31 December 2007, no state other than Massachusetts and Vermont had enacted a comprehensive reform agenda, although, as noted, California has taken

EXHIBIT 2
Status Of Comprehensive State Coverage Campaigns In Thirteen States As Of December 2007

State	Status of reform process
California	As of this writing, the Assembly and governor have reached agreement on comprehensive reform; if approved by the Senate, this measure will go to the ballot in 2008
Colorado	Governor's Blue Ribbon Commission on Reform has presented comprehensive plans to Legislature for possible action in 2008
Connecticut	Enacted a number of reforms in 2007; trying for more comprehensive reform in 2008 and 2009
Illinois	Governor proposed comprehensive expansions in 2007, unable to reach agreement with Legislature; administration began enrolling people in expanded coverage in December without consent of Legislature
Maine	Enacted reform designed to cover all in 2003; governor now proposing additional reforms to reach this goal, including individual mandate
Maryland	"Play or pay" on large employers struck down in 2007; state expanded Medicaid coverage for parents, with future plans to cover childless adults subject to available funding
Minnesota	Enacted coverage expansions in 2007; two current task forces set to advise governor and Legislature on comprehensive health reform
New Mexico	State commission modeled comprehensive plans; governor announced his reform agenda based on modeling
New York	Enacted major coverage expansions in 2007; governor expressed commitment to universal coverage and convened group to submit a proposal to Legislature in 2008
Oregon	Commission examining health care reform options currently; governor proposed expansion for children in 2007, but funding initiative failed on ballot in November 2007
Pennsylvania	Governor proposed comprehensive plan in 2007, unable to push coverage expansion through Legislature; governor has reintroduced reform for 2008
Washington	Enacted various health reforms in 2007; governor proposing additional reforms in 2008
Wisconsin	Governor's proposal for some expansions enacted this year; Senate passed plan in 2007 for universal coverage and could not reach compromise with Assembly; may be proposed in 2008

SOURCES: National reports and interviews with state policymaker participants in the Reforming States Group.

a major legislative step toward that goal. Parts of Pennsylvania governor Ed Rendell's comprehensive health reform plan, proposed in early 2007, have been enacted, including elements addressing chronic care management, scope of practice, and health care–acquired infections; access to insurance coverage and insurance reforms are under legislative review.[6] Illinois governor Rod Blagojevich's universal coverage agenda has similarly been held back from enactment because of an inability to reach consensus on financing, although the governor has sought to implement large portions of his plan through executive action.[7]

Several states have convened commissions to craft and assess expansion proposals. In Colorado, Kansas, New Mexico, New York, and other states, commis-

sions are working to evaluate reform ideas. In other states, including Connecticut, Wisconsin, Maine, Maryland, and Minnesota, political leaders' interest in comprehensive reform is guiding the way for proposals for significant expansions.

The lack of success to date for other states' comprehensive reform efforts should not be surprising. Massachusetts' 2006 law was the state's third effort at major reform, following prior enactments in 1998 and 1996; each enactment involved processes spanning at least three years.[8] Vermont's 2006 statute was more than two years in the making. The Illinois plan has been in play for several years, and the California effort can be traced back to enactment of a "play-or-pay" employer mandate that was defeated on that state's ballot in 2004.[9] Enacting comprehensive reforms takes longer, substantively and politically, than winning approval for more targeted and incremental reforms.

Beyond this, Massachusetts and Vermont began their processes with a proportion of uninsured residents much lower than the national average. Massachusetts achieved its breakthrough with sizable safety-net funding already in hand, requiring less new financing than would be required in most other states. Should California's efforts succeed, given that state's huge proportion and number of uninsured residents as well as its comparatively low level of federal financing, it would be especially noteworthy.

Discussion And Observations

■ **The asterisks: two steps back, one step forward.** Although state-level enactments have led to major expansions in coverage, it would be erroneous to assume that they have necessarily resulted in a lower proportion of uninsured residents in every case. In some states—notably, Tennessee, Missouri, and Texas—expansions occurred in the wake of earlier, more severe eligibility cutbacks to Medicaid and other health care access programs—leaving lower-income populations with more limited coverage than was available prior to cuts.

For example, in 2005, Tennessee cut 170,000 people from TennCare, the state's Medicaid program, and imposed benefit limits on 400,000 remaining enrollees. Tennessee's new program, CoverTN, offers new coverage to some of those left uninsured by the 2005 reductions, albeit with benefit limitations. Current expansions do not advance coverage levels beyond those in existence prior to cutbacks.

■ **A new wave of state-based health reform is under way.** This survey of state health care access enactments in 2006 and 2007 provides evidence that a new wave of state health reform is under way. The last time numerous states simultaneously engaged in broad-based coverage expansion efforts was between 1988 and 1993. That reform wave provided ideas and political will to motivate the unsuccessful Clinton health reform initiative. Interest by current presidential candidates in national health reform suggests that this current wave of state activity may have a similar impact if a new national health reform process begins in 2009. Reform ideas from Massachusetts, Vermont, and California can be found in the health plans announced

earlier this year by Democratic presidential candidates, including Senators Hillary Clinton and Barack Obama and former Senator John Edwards.[10]

■ **States are experimenting with new ideas and approaches.** There is something new under the sun evident in laws enacted to date. We identify six new ideas in reforms enacted thus far.

Individual mandates. Although only Massachusetts has enacted this requirement, individual mandates have caught the interest of other states and presidential candidates. Switzerland and the Netherlands are the only other governments to have established an individual health insurance mandate. Because it is so new, judgments on a mandate's success and practicality in the U.S. context are premature.

New employer responsibilities. Hawaii broke the ice on state-mandated employer responsibility in 1974, but it took thirty-two years for Massachusetts and Vermont to follow by implementing comparatively small annual assessments on employers that do not provide health insurance to their workers. California's agreed-to mandate would be much higher—up to 6.5 percent of payroll for larger nonoffering employers. (Massachusetts, Oregon, Washington, and Minnesota passed more expansive employer mandates in the 1988 to 1993 reform wave, none of which was successfully implemented.) Massachusetts also broke new ground by requiring that employers make Section 125 cafeteria plans available to uncovered workers who are ineligible for employer plans, a move already adopted in Rhode Island.

Insurance connectors/exchanges. Massachusetts created a new quasi-governmental entity to connect individuals and small employers in a more functional health insurance environment. This idea, first advanced by the Heritage Foundation, has its roots in purchasing pools debated as part of 1990s-style health reform.[11] A similar structure has since also been created in Washington State.

Small-group and individual market merger. This is graduate-level insurance market reform, and it may only work in states that have already reorganized both their small-employer and individual insurance markets. Most states have instituted reforms such as guaranteed issue and renewal, elimination of medical underwriting, and modified community rating in the former and not the latter market. The merger appears to have had a significant impact in lowering the cost of individual coverage in Massachusetts, although it is too early for conclusive findings.

Allowing all employers to buy into state coverage pools. New York State will soon permit any employer of any size to purchase coverage through its Family Health Plus program at full cost, creating an alternative and potentially significant source of employer-based coverage.

Combining coverage expansions with quality and cost initiatives. Some state officials are linking new coverage expansions with quality and cost control initiatives. Maine, whose Dirigo Health Plan preceded the wave of reforms discussed here, was an early pioneer in this category. Increasingly, states are looking to expand access, control rising costs, and implement quality improvement initiatives simultaneously. Although detailed exploration of this new trend is beyond the scope of

this paper, it is novel to this reform wave and thus noteworthy.

■ **Comprehensive state health reform takes time and patience.** The failure of any other state to follow Massachusetts and Vermont by enacting comprehensive reforms could be viewed as evidence that there is less to this wave than meets the eye. Still, it is undeniable that more high-level state political leaders have embraced and advanced broad-reaching health care access reforms in the past two years than at any other time in the past fifteen. The Massachusetts and Vermont experiences demonstrate that working through reform options and summoning political will to enact major changes normally takes years, not months.

■ **Federal financing remains critical to successful state reform efforts.** Nearly all major state coverage expansions rely heavily on federal financing, whether through traditional Medicaid, Medicaid waivers, or SCHIP. The Massachusetts example is most compelling: were it not for the threatened loss of $750 million in federal waiver dollars in fiscal years 2007 and 2008, it is unlikely that major health reform would have been enacted. The question is not whether reform should be accomplished at the state or federal level. Both levels are essential partners.

■ **Don't forget ERISA.** Massachusetts and Vermont's health reform statutes—as of late December 2007—have thus far escaped any legal challenges on the grounds that their employer requirements violate ERISA. ERISA preempts states from regulating employer-provided health benefit plans. (ERISA preemption defenders in 2007 successfully overturned so-called Wal-Mart play-or-pay taxes in Maryland and Suffolk County, New York, on ERISA grounds.) Lack of action may be because both states' employer requirements are considered far less onerous than other play-or-pay proposals and because leading state-based business groups in both states support their respective reform laws. Still, rumors of potential ERISA lawsuits abound. It is premature to declare that either Massachusetts or Vermont has figured out how to thread the ERISA preemption needle. And California's more substantial employer assessment would certainly face a tougher bout of ERISA scrutiny.

The future of state health reform is uncertain. We attribute the current wave of state reforms to a confluence of four factors: rising numbers of uninsured people, combined with a better understanding of the problem of uninsurance; fiscal opportunity—all expansions described herein were enacted in positive economic periods for state governments; recent changes in political leadership bringing more momentum to health reform; and Massachusetts and Vermont demonstrating new policy options, and other states wanting to be considered health coverage innovators.

Although state health care access activity has increased noticeably, the future of this reform wave remains unclear. There is much state interest in tackling problems plaguing the U.S. health care system. Still, states face difficulty solving the financing dilemma: how to pay for reforms in a long-term, sustainable way. This challenge can be eased or made more difficult by the federal government. States

can light the sparks of reform. It takes partnership with the federal government to keep the flames alive.

The authors acknowledge funding from the Milbank Memorial Fund and the Robert Wood Johnson Foundation. They thank Cheryl Fish-Parcham, Donna Folkemer, Shelly Gehshan, Enrique Martinez-Vidal, and members of the Reforming States Group.

NOTES

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4. New York's expansion was denied a federal waiver. As of this writing, the issue of using SCHIP funding to cover children in families higher up the income scale remains unresolved.
5. See letter from Dennis Smith, Director of the Center for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, to State Health Officials (SHO #07-001), (17 August 2007), http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf (accessed 2 January 2008).
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