



Moving Backward: New Federally Imposed Limits On States' Ability to Cover Children

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On August 17, 2007, the Centers for Medicare and Medicaid Services (CMS) issued a new State Children's Health Insurance Program (SCHIP) directive that has the effect of barring states from covering children with family incomes above 250 percent of the federal poverty level (FPL), the equivalent of \$42,925 a year for a family of three.¹ As Secretary of Health and Human Services (HHS) Leavitt confirmed in a letter to Senator Grassley just a few weeks before CMS' new directive, federal SCHIP law grants states the authority to decide the income eligibility level they will apply in their state's SCHIP program.² The new directive eliminates this longstanding authority by establishing a federal income cap through the back door. Specifically, it imposes new conditions on states that want to offer affordable SCHIP coverage to children over 250 percent of the FPL – conditions that states will almost certainly not be able to meet. These conditions will effectively make it impossible for states to cover uninsured children.

This new, unilateral attempt to reverse SCHIP policy without any change in statute or even regulation comes just as Congress is debating these issues in the context of SCHIP reauthorization. Neither the House nor the Senate reauthorization bill imposes an income cap on SCHIP coverage. Instead, both bills leave existing state flexibility intact, although the Senate bill reduces the federal matching

rate for SCHIP coverage of children with incomes above 300 percent of the FPL. In addition, the CMS directive comes at a time when a diverse array of states has enacted legislation to expand their SCHIP programs to cover more uninsured children. The new CMS policy would not only stop these states from moving forward with their plans (for example, Louisiana has already announced it may be forced to scale back its coverage plans in light of the new directive³), but also will force a roll back in eligibility in states that have covered uninsured children in this income range through SCHIP for years.

Impact on States and Children

Significant numbers of children in states throughout the country are at risk of losing their SCHIP coverage or the opportunity to obtain SCHIP coverage as a result of the new directive, adding to the growing number of uninsured children. Just ten days after the release of this directive, the U.S. Census Bureau announced that the number of uninsured children rose by more than 600,000 in 2006 to 8.7 million, the highest number since the turn of the century.⁴

- **As many as 23 states from all regions of the country would be clearly and directly affected by the new rules** (Table 1). These 23 states include 11 states that already have income eligibility thresholds above 250 percent of the FPL and eight states that have adopted, but not yet im-



plemented, such eligibility thresholds. Four other states have income eligibility thresholds at or slightly below 250 percent of the FPL but apply deductions when computing eligibility (for example, deducting income used to pay for child care expenses). As a result, these four states also will see some children lose coverage as a result of the new directive.

- **Hundreds of thousands of children with family incomes above the new threshold,⁵ as well as children with lower incomes could lose coverage.** Children in lower income families may lose coverage because when states expand their programs, it is common for many of the children who gain coverage to be lower income children who were already eligible but unenrolled.⁶
- **Ultimately, all states are potentially harmed by the new rules.** Any state that might decide in the future to exercise the option to cover uninsured children in their state above the \$42,925 income level (for a family of three) will now be prevented from doing so by this directive.

The New Policy

Under the new directive, states cannot cover children with family incomes above 250 percent of the FPL unless they meet enrollment participation rates for lower income children that no state has yet met; make certain assurances regarding the availability of employer-based coverage over which they have little or no control; impose harsh new uninsured waiting periods for children as a mechanism to prevent “crowd-out”; and charge families costs that might make SCHIP coverage unaffordable for their children.

Specifically, the directive requires states to:

- **Show that they have enrolled at least 95 percent of the children in the state who are eligible for SCHIP or Medicaid and that have family incomes below 200 percent of the FPL;**
- **Assure that the number of children in the “target population” insured through private employers has not decreased by more than two percentage points over the prior five years;**
- **Establish 12-month (or longer) waiting periods, meaning that a child who previously had coverage through private insurance would have to be uninsured for at least one year before enrolling in SCHIP; and**
- **Impose cost sharing that either is no less than one percentage point of family income below charges under “competing private plans,” or that is set at the maximum allowed under federal SCHIP law (five percent of family income).**

Implications

The new directive reverses longstanding policy without any change in the federal SCHIP statute or regulations. By effectively barring states from covering children in families with income above 250 percent of the FPL, the federal directive eliminates states’ discretion to determine the appropriate income eligibility level for children in their state and ignores significant variations in the cost of living across states. It also fails to account for cost trends that are making private health insurance unaffordable for a growing number of families.

As permitted by the flexibility established in the original SCHIP law, states as diverse as Louisiana, New York, Oklahoma and Washington are responding to these trends by rais-



**Table 1: States Affected by the CMS Directive
(Eligibility levels adopted as of August 1, 2007)**

| State | Eligibility Level |
|------------------------------------------------------------------------|-------------------|
| States with Income Eligibility Levels Above 250% FPL | |
| Connecticut | 300% |
| District of Columbia+ | 300% |
| Hawaii+ | 300% |
| Indiana* | 300% |
| Louisiana* | 300% |
| Maryland+ | 300% |
| Massachusetts | 300% |
| Minnesota | 275% |
| Missouri+ | 300% |
| New Hampshire | 300% |
| New Jersey | 350% |
| New York* | 400% |
| North Carolina* | 300% |
| Ohio*+ | 300% |
| Oklahoma* | 300% |
| Pennsylvania | 300% |
| Vermont | 300% |
| Washington* | 300% |
| West Virginia* | 300% |
| SUBTOTAL | 19 |
| Other States with Income Eligibility Levels At or Near 250% FPL | |
| California | 250% |
| Georgia | 235% |
| New Mexico+ | 235% |
| Rhode Island+ | 250% |
| SUBTOTAL | 4 |
| TOTAL | 23 |

Notes: States marked with an asterisk (*) have recently adopted their expansions but have not yet implemented to the levels shown. States marked with a plus sign (+) are Medicaid expansion states; the directive appears to apply to these states, although some questions have arisen about its applicability to Medicaid expansion states. States in the second group will have some children affected, because they apply deductions (e.g., for child care expenses) when computing income eligibility.

Source: Based on a survey by the Center on Budget and Policy Priorities, for the Kaiser Commission on Medicaid and the Uninsured, as updated by CCF.



ing the income eligibility levels in their SCHIP programs to cover more children.⁷ The coverage offered to these newly eligible families is affordable but not free; families pay premiums for SCHIP coverage on a sliding scale basis. SCHIP was specifically designed to bridge the affordability gap by covering children whose families incomes are above Medicaid levels but still too low to afford the cost of other coverage. A one-size-fits-all income cap at 250 percent of the FPL would leave a significant number of children without an affordable coverage option, and that number can be expected to grow over time.

The extent to which the affordability gap has worsened since SCHIP was first enacted and the problem with imposing a fixed income ceiling tied to a percentage of the federal poverty level is illustrated by comparing the growth in families' costs for employer-based family coverage with changes in the federal poverty level. The poverty level is adjusted each year to account for changes in the cost of living; in nominal terms it has grown by 24 percent between 1996 (the year before SCHIP was enacted) and 2005. During this same period of time, however, the average cost to families of premiums for employer-based family coverage has grown by more than 100 percent (Figure 1).

The specific rules in the directive that, together, serve to effectively eliminate the flexibility to determine the appropriate income eligibility level for their state are discussed below.

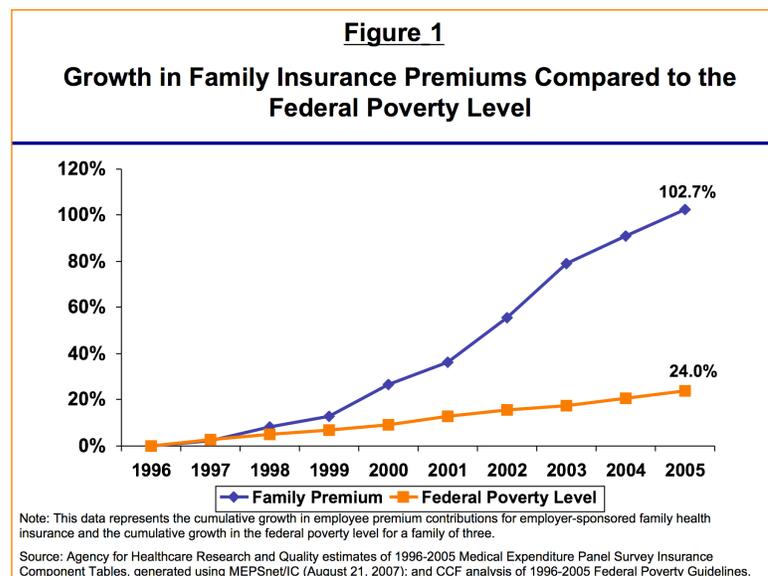
New Rules on Enrollment of Low-Income Children

The CMS directive conditions

approval of SCHIP coverage for children with incomes over 250 percent of the FPL upon a showing that the state has been able to enroll 95 percent of all eligible low-income children (i.e., those with incomes below 200 percent of the FPL) in SCHIP or Medicaid. This provision is similar to an amendment offered and defeated in the context of the SCHIP Senate debate; it is not clear what CMS' current legal authority is for imposing such a rule.

Improving participation rates is an important policy objective, but the 95 percent level is likely unattainable, at least in the short term.

- Participation rates in both Medicaid and SCHIP among low-income children has been rising in recent years, but as of 2004-2005, the highest participation rate achieved was 92 percent in the state of Vermont. The average nationwide was 74 percent (Figure 2).⁸
- The directive offers no basis for the 95 percent level selected by CMS. This rate is well above participation rates in virtually all public programs other than Medicare, which has nearly universal eligibility and virtually automatic enrollment. CMS'



participation rate among Medicare beneficiaries eligible for the low-income subsidy program for the Part D drug benefit was, as of January 2007, about 43 percent.⁹

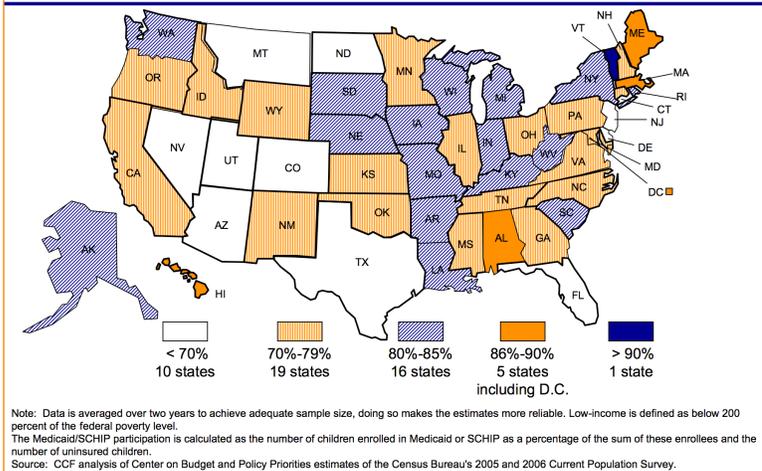
- The new directive is likely to hurt the very group of children it purports to be targeting for coverage – lower income uninsured children who are eligible for SCHIP or Medicaid but not enrolled. State experience shows that coverage expansions are very effective in reaching these previously eligible but uninsured children. Broader and simpler coverage rules eliminate much of the confusion that can keep eligible children from enrolling in SCHIP or Medicaid.

How Can Medicaid and SCHIP Participation Rates be Improved?

Mandating states to meet unrealistic new standards as a condition of covering children with more modest incomes is not likely to help states achieve higher participation rates in Medicaid and SCHIP, but stronger financing and new policy tools could make a large difference.

According to the Congressional Budget Office (CBO), the largest coverage gains for children achieved under both the House and the Senate SCHIP reauthorization bills would be among low-income children already eligible for Medicaid and SCHIP but not enrolled – these are almost entirely children with incomes below 200 percent of the FPL. The bills achieve these results by providing states with new financial resources, incentives, and policy tools aimed at encouraging enrollment among this group of children. CBO projects that more than 92 percent of the five million newly insured children covered by the House bill and 87.5 percent of the four million children covered by the Senate bill in 2012 would be children who are currently eligible for Medicaid and SCHIP but uninsured.¹⁰

Figure 2
Medicaid/SCHIP Participation Rates Among Low-Income Children Under 19, 2004-2005



New “Crowd Out” Rules

As Congress has been debating SCHIP reauthorization, the Bush Administration and some conservative think tanks have argued for cutting back on the income eligibility of the children who can be covered through SCHIP on the basis that public coverage “crowds out” or substitutes for private coverage.¹¹ Inevitably, any attempt to cover the uninsured, whether through public programs, the new Medicare drug benefit, or tax credits, will have a crowd out effect.

At the time SCHIP was passed Congress anticipated some crowd out. The original SCHIP law requires all states to describe in their state plans the procedures they will use to prevent crowd out and makes a variety of policy options available to states to reduce substitution. The experience of the last ten years has shown that some substitution of coverage has occurred, but less than states and Congress anticipated.¹² Overall SCHIP and Medicaid have been remarkably successful in providing coverage to millions of children who otherwise would have been uninsured. Dr. Jonathan Gruber, a leading expert on crowd out often cited by those who argue



against expanding SCHIP, has noted that “public insurance expansions are by far the most cost-effective means of expanding insurance coverage in the U.S. today.”¹³

The new directive includes two measures aimed at preventing crowd out: new private insurance decline standards, and mandatory 12-month waiting periods.

The Private Insurance Decline Standard

The directive prohibits states from covering children above 250 percent of the FPL through SCHIP if employer-based coverage of children among the target population has declined in their state by more than two percentage points over the past five years. By doing so, it imposes the wrong solution on a real problem over which states have little control.

- Employer-based coverage is weakening for all groups of people, including children nationally. Children’s coverage through employer-sponsored insurance dropped from 64.4 percent in 2001 to 59.7 percent in 2006.¹⁴ This decline is attributable to many different factors, almost none of which states can control. In fact, federal law (ERISA) limits states’ authority to require employers to offer or to not drop coverage.
- The availability of public coverage has had some effect on private insurance, but even assuming the high end of the range of crowd out estimates, SCHIP coverage expansions remain a relatively minor influence on the broader and complex private insurance market dynamics.¹⁵
- The new one-size-fits all rule will have arbitrary and disparate effects across the country. For example, states with plant closings, and states with higher job growth in the service sector or among

small businesses that are less likely to offer health insurance would have less of an opportunity to expand coverage for children through SCHIP than other states with more robust and stable employer-based markets.

Ironically, the solution imposed by the directive to the coverage problems faced by families as a result of the declining employer-based coverage – shutting down SCHIP coverage that a state has determined children need – will invariably lead to more uninsured children.

Mandating 12-month waiting periods

The new directive also requires all states that cover or plan to cover children with family incomes above 250 percent of the FPL to adopt 12-month waiting periods, overriding existing federal SCHIP rules that give states discretion in this area.¹⁶ States themselves have an interest in deterring crowd out to avoid spending limited state funds covering a child that could be insured through an employer plan.

Waiting periods have been one tool many states have used to limit substitution. As of July 2006, of the 36 states with separate SCHIP programs, 28 had waiting periods to discourage families from enrolling their children in public coverage when they have viable private insurance alternatives.¹⁷ Waiting periods, however, can have harsh results for children. By definition, waiting periods require eligible uninsured children who previously had private coverage to remain uninsured for some number of months. Research has firmly established that uninsured children receive less preventive care and are less likely to see a doctor or have a usual source of care compared to insured children.¹⁸



- Currently, only two states (Alaska and Illinois) have a 12-month waiting period.¹⁹ All other state-imposed waiting periods are six months or less.
- According to clarifications provided by Dennis Smith from CMS to state SCHIP directors, exceptions to the new 12-month waiting period will not be permitted. All states with waiting periods allow some exceptions. For example, a waiting period might not be imposed when the cost of the prior employer-based plan was unaffordable (generally measured as a percent of the family's income) or when the private coverage the family once had is no longer available for reasons beyond their control (e.g., employer bankruptcy). Pennsylvania's newly approved plan, for example, exempts children under age two from its six-month waiting period to be sure that very young children receive regular check ups and that any developmental issues are addressed in a timely and appropriate manner.²⁰
- States monitor crowd out as well as the impact of waiting periods on children and have adjusted their policies accordingly. By July 2006, compared to the original implementation of SCHIP, fourteen states had eliminated their waiting period or reduced the length of time during which a child must remain uninsured, and three states adopted a new waiting period or expanded the length of their waiting period.²¹

The new directive removes states' ability to adjust and shape their waiting period policies in light of the evidence of crowd out problems and the impact in children's access to health care.

New Mandated Cost Sharing Policies

The directive also mandates new SCHIP cost sharing rules. Families with modest incomes whose children are covered by SCHIP do not receive free coverage; they pay a portion of the cost through premiums, enrollment fees and/or copayments. While states expect families at these income levels to share costs, they also have generally been mindful not to set charges at levels that would make SCHIP coverage unaffordable. A primary reason why children with offers of private insurance are still uninsured is that the private insurance is not affordable to the family. SCHIP is specifically designed to address this affordability issue.

The new directive would take away states' discretion to determine the level of costs they will impose on families within the guidelines that have been set by federal law. States would be required to impose costs at five percent of family income (the maximum now permitted under federal law) unless they could show that the costs were no less than one percentage point below the total cost sharing charges of "competing" private plans (this would include premiums, deductibles, copayments and coinsurance amounts).

- States will likely have difficulty obtaining information about the costs of "competing" plans or calculating "total costs" for plans that typically rely heavily on deductibles and copayments. If so, the practical result of the requirement may be to push states to charge the full five percent of income in their SCHIP programs. (Presumably, the costs would have to be imposed through premiums or enrollment fees; this would be the only way a state could assure that the costs imposed actually equaled five percent of family income as required by the directive since other



costs, such as copayments, ultimately depend on a child's utilization of services.)

- For a family of three with income just above 250 percent of the FPL, a premium set at five percent of income would be \$2,146 a year. A model developed by researchers at the Urban Institute suggests that only about 17 percent of families would enroll their children in coverage if premiums were this high.²²
- This level of costs (five percent of income) is well above current SCHIP premiums in most states.²³ To meet the five percent requirement through premiums for a family of three with two children with income at 275 percent of the federal poverty line, New Hampshire and Illinois would need to more than double their current premiums, and Pennsylvania, which just recently received CMS approval to cover children up to 300 percent of the FPL, would have to increase monthly premiums by \$77 per family, from \$120 to \$197.²⁴

As several states have seen over the course of the years, premiums that are too high will deter families with eligible children from enrolling in coverage. Maryland, for example, recalibrated its premium levels when it found that the original levels were too high for the target group of families to afford.²⁵ The new directive removes this discretion from states, potentially requiring them to charge fees that will make SCHIP coverage unaffordable to the families it was designed to serve.

The CMS Directive Raises Significant Process Questions.

The process chosen by the Administration to impose these new far-reaching policies raises a number of questions. The directive

was issued during the Congressional recess, just after the House of Representatives and the Senate adopted bills to reauthorize SCHIP. Both bills continue to let states set the income levels in their SCHIP programs, although the Senate bill reduces the match rate for children with incomes over 300 percent of the FPL. Some amendments offered and defeated in the context of the congressional debate included provisions similar to those included in the directive.

The new policy was not preceded by any change in statute or even a new regulation. It was issued in the form a letter to state health officials. According to the CMS website, "The State Medicaid Director (SMD) and State Health Official (SHO) letters are used to provide States with guidance and clarification on current information pertaining to Medicaid policy, Medicaid data issues and State Children's Health Insurance Program (SCHIP) policy. The intent of these letters is not to establish policy, but to ensure consistency and better serve the States."²⁶ As the directive itself notes, this letter does establish new policy, without the benefit of any prior notice to stakeholders or a comment period that typically precedes new federal policies established by regulation.

Conclusion

CMS's new policy puts children's coverage at risk while raising a number of policy, legal and process questions. The new federal directive usurps authority that has long rested with the states and interferes significantly with states' interest in continuing to make progress in reducing the number of children who lack health insurance. The imposition of a new federally imposed income ceiling in SCHIP comes at a time when states have been expanding their programs and when Congress is debating this very issue in the context of



SCHIP reauthorization. Since the new policy is inconsistent with the approach taken by both the Senate and the House, it is likely that it will be revisited as Congressional action on SCHIP moves forward.

Endnotes

¹ 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), (August 17, 2007), available at <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf> (accessed August 27, 2007).

² Letter from Secretary Leavitt to Senator Grassley (July 31, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg081607a.pdf> (accessed on August 27, 2007).

³ See “New Rules for SCHIP Enrollment Likely To Prevent Implementation of Louisiana Proposal To Expand LaCHIP,” *Kaiser Daily Health Policy Report* (August 27, 2007), available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=47133 (accessed August 27, 2007).

⁴ C. DeNavas-Walt, B. Proctor, & J. Smith, “Income, Poverty, and Health Insurance Coverage in the United States: 2006,” U.S. Census Bureau (August 2007), available at <http://www.census.gov/prod/2007pubs/p60-233.pdf> (accessed August 28, 2007).

⁵ States do not generally report enrollment data by income level and reliable data on the numbers of uninsured children in relatively small income bands are not available on a national level by state. The Congressional Research Service estimated that about nine percent of the 6.7 million children “ever enrolled” in SCHIP in 2006 had incomes above 200 percent of the FPL, see C. Peterson & E. Herz, “Estimates of SCHIP Child Enrollees Up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees,” Congressional Research Service (March 13, 2007). This number includes many children with incomes below 250 percent of the FPL, and it also does not consider the 13 states that have implemented or adopted coverage expansions above 200 percent of the FPL since 2006.

⁶ For example, see C. Trenholm, “Expanding Coverage for Children: The Santa Clara County Children’s Health Initiative,” *Evaluation of the Santa Clara County Children’s Health Initiative, Brief #1* (April 2005). Based on these experiences, New York estimates that 50,000 newly eligible children and 250,000 previously eligible children would be enrolled as a result of their newly enacted coverage expansion, based on communication with Judith Arnold, New York State SCHIP Director (July 2007).

⁷ Center for Children and Families, “Children’s Health Coverage: States Moving Forward, Update,” (July 2007), available at <http://ccf.georgetown.edu/states.html> (accessed August 28, 2007).

⁸ These rates are based on Current Population Survey data reported by the U.S. Census Bureau. They calculate the percent of children with Medicaid or SCHIP coverage among the group of children with incomes below 200 percent of the FPL who do not have private insurance. These rates do not consider eligibility for coverage. Most notably, the CPS data includes children who are not eligible for Medicaid or SCHIP based on immigration status, a fact that will affect some states more than others.

⁹ Kaiser Commission on Medicaid and the Uninsured, “SCHIP Reauthorization: Key Questions in the Debate; A Description of the New Administrative Guidance and the House and Senate Proposal,” (August 2007). This calculation excludes dual eligibles who are automatically enrolled in the low-income subsidy, as well as a small number of beneficiaries with employer coverage.

¹⁰ This includes 800,000 children currently on SCHIP who would become uninsured without additional funding after 2007 plus for the House bill the 3.8 million children and for the Senate bill the 2.7 million children who are currently eligible but are not enrolled in Medicaid or SCHIP and would gain coverage under these bills; Center for Children and Families analysis of “Preliminary CBO Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under H.R. 3162, the Children’s Health Insurance And Medicare Protection Act,” Congressional Budget Office (August 1, 2007), available at <http://www.cbo.gov/ftpdocs/85xx/doc8519/HR3162.pdf> (accessed August 27, 2007), and “CBO’s Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under H.R. 976, the Children’s Health Insurance Program Reauthorization Act of 2007,” Congressional Budget Office (August 24, 2007).

¹¹ For example, see N. Owcharenko, “The Administration’s SCHIP Regulations: A Sound Prescription,” *The Heritage Foundation* (August 27, 2007), available at <http://www.heritage.org/Research/HealthCare/wm1591.cfm> (accessed August 28, 2007); and A. Grossman & G. D’Angelo, “SCHIP and ‘Crowd-Out’: How Public Program Expansion Reduces Private Coverage,” *The Heritage Foundation* (June 21, 2007), available at <http://www.heritage.org/Research/HealthCare/wm1518.cfm> (accessed August 27, 2007).



¹² Crowd out estimates vary widely, some based on econometric studies with varying assumptions and some based on actual state experience; Congressional Budget Office, "The State Children's Health Insurance Program," (May 2007), available at <http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf> (accessed August 27, 2007). In general, states have not found crowd out to be as much of an issue as anticipated. According to research for the congressionally-mandated evaluation of SCHIP, of the 16 states presenting data on crowd out, eight reported no evidence of children dropping private coverage to enroll in SCHIP, five states reported substitution rates of less than 10 percent, and only three states reported rates between 10 and 20 percent; M. Rosenbach, et al., "Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations" [Chapter VIII], Mathematica Policy Research, Inc., (March 2003). Another multi-state evaluation of SCHIP found that seven percent of children enrolled in SCHIP might have been able to stay enrolled in private coverage; A. Sommers, S. Zuckerman, L. Dubay, & G. Kenney, "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States," *Health Affairs*, 26:529-537 (2007).

¹³ Letter from Dr. Gruber, MIT, to Representative Dingell, Chairman of the House Energy and Commerce Committee (February 28, 2007), available at http://energycommerce.house.gov/Press_110/110-ltr.022807.Gruber_ltr_to_Dingell.pdf (accessed August 27, 2007).

¹⁴ Center on Budget and Policy Priorities, "More Americans, Including More Children, Now Lack Health Insurance," (August 28, 2007), available at <http://www.cbpp.org/8-28-07health.htm> (accessed August 28, 2007). These are U.S. Census Bureau data for all children. It is not clear what population CMS is referring to in the guidance by its reference to the "target population" or what data CMS would expect or allow state to use.

¹⁵ An Urban Institute report estimates that SCHIP may have contributed to a two percent decline in private coverage among all children; L. Dubay & G. Kenney, "The Impact of SCHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families," Urban Institute, Working Paper (2007).

¹⁶ In addition to the two new crowd out requirements described here, the directive requires states to submit to CMS monthly crowd out monitoring reports "with data" (it is not clear what data is required) and to monitor and verify information regarding coverage available through noncustodial parents.

¹⁷ D. Cohen Ross, L. Cox, & C. Marks, "Resuming the Path the Health Coverage for Children and Parents," Kaiser Commission on Medicaid and the Uninsured (January 2007), available at <http://www.kff.org/medicaid/7608a.cfm> (accessed August 27, 2007).

¹⁸ For example, see J. Hadley, "Sicker and Poorer – The Consequences of being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review*, 60: 3S-75S (June 2003).

¹⁹ Illinois' waiting period is not a SCHIP coverage waiting period since it applies to coverage of children between 200 and 300 percent of the FPL which is state-funded only.

²⁰ See Pennsylvania's Current SCHIP State Plan, seventh amendment, approved on February 20, 2007, at <http://www.cms.hhs.gov/LowCostHealthInsFamChild/SCHIPASPI/list.asp#TopOfPage> (accessed August 27, 2007).

²¹ *Op cit.* (17).

²² L. Ku & T. Coughlin, "Sliding Scale Premium Health Insurance Programs," *Inquiry*, 36: 471-480 (Winter 1999/2000).

²³ *Op cit.* (17).

²⁴ Center for Children and Families analysis of premiums in New Hampshire's Healthy Kids Program (<http://www.nhhealthykids.com/pdfs/Income%20Guidelines2007.pdf>), Illinois' All Kids program (<http://www.allkids.com/income.html>), and Pennsylvania's CHIP program (http://www.chipcoverspakids.com/upload/admin/File/CAK_Premiums_2007.pdf); and *op. cit.* (19).

²⁵ Maryland Department of Health and Mental Hygiene, "Maryland Children's Health Program: Assessment of the Impact of Premiums, Final Report," (April 2004), available at <http://www.statecoverage.net/statereports/md36.pdf> (accessed August 27, 2007).

²⁶ See the "State Medicaid Director Letters" section of the Centers for Medicare and Medicaid Services website at http://www.cms.hhs.gov/SMDL/01_overview.asp#TopOfPage (accessed August 27, 2007).

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