Georgetown University Health Policy Institute
Center for Children and Families

Children's Health Coverage: *States Moving Forward*

Implications for SCHIP Reauthorization

May 2007

Introduction

In recognition that families are increasingly finding it difficult to secure affordable health coverage for their children and of the strong public support for covering children, states across the nation are stepping forward to take action. The movement was sparked in large part by Illinois' decision in November 2005 to offer affordable coverage to its uninsured children and Massachusetts' passage in spring 2006 of a universal coverage system, but it now has spread far beyond these early leaders.

"Healthy children learn better, grow better and have a better chance of succeeding in life. We will continue to deliver on our promise to cover all kids because it is a moral duty and an economic necessity that we have a healthy next generation."

– Washington Governor Christine Gregoire[1]

Efforts to cover children are now apparent in every region in the country, engaging Republican and Democratic leaders alike. These initiatives build on the progress achieved over the past decade through the State Children's Health Insurance Program (SCHIP) and its larger companion program, Medicaid, often by combining initiatives to cover more of the uninsured children already eligible for the programs with eligibility expansions. In many states, children's advocacy and faith-based organizations have led major grassroots campaigns that are contributing to the momentum on children's coverage.

The renewed movement in states to cover uninsured children has important implications for the current debate in Congress over the future of SCHIP, which is up for renewal this year. Established in 1997 with bi-partisan support, SCHIP is a popular program with a strong track record. It provides states that invest their own state funds with capped federal matching funds to cover children by expanding Medicaid, establishing a separate child health program for families who earn too much to qualify for Medicaid, or combining the two

KEY FINDINGS

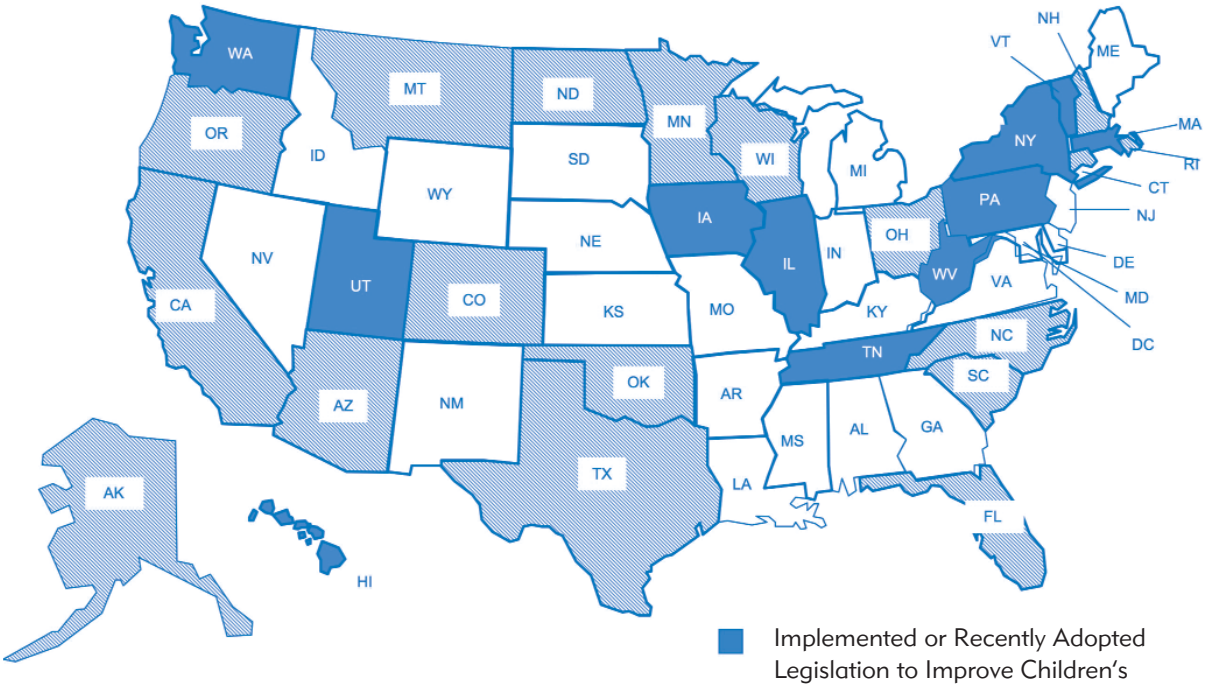
Between January 2006 and mid-April 2007:

- Twenty-nine states and the District of Columbia adopted legislation or were giving serious consideration to proposals aimed at covering more children through Medicaid and SCHIP (Figure 1).
- The vast majority of these state initiatives included plans to make it easier for low-income uninsured children already eligible for SCHIP or Medicaid to enroll in and keep coverage.
- Fifteen of these 29 states, and the District of Columbia, planned or proposed to increase their SCHIP income eligibility levels – the majority above 200 percent of the federal poverty level – so that more families can afford health care coverage for their children.
- The political will to cover more children emerged within a diverse group of states, including those in all regions of the country, in both urban and rural areas, and in states with leadership on both sides of the political aisle.

approaches. It was the adoption of SCHIP a decade ago that spurred the last successful, multi-year, nationwide effort to narrow the uninsurance gap for children. With many states again focused on moving forward, SCHIP reauthorization is occurring at a propitious time. A strong and timely reauthorization of SCHIP will support and strengthen the growing movement toward covering children. Conversely, without a strong reauthorization, state momentum for moving forward could be halted or even reversed.

In this report, the Center for Children and Families presents a portrait of state efforts across the country to cover uninsured children since Illinois made its decision in late 2005 to adopt legislation to cover all children. It discusses the implications of these efforts for the congressional debate over SCHIP reauthorization and identifies the key steps that could be taken during that debate to support a growing tide of state efforts to provide health coverage to America's uninsured children.

FIGURE 1: 29 States and DC Have Adopted or Are Considering Improvements in Children's Coverage



Source: Review by the Center for Children and Families on state initiatives adopted or under serious consideration between January 2006 and April 15, 2007.

Methodology for this Report

For this report the Center for Children and Families (CCF) conducted a nationwide review of state efforts to provide health care coverage to uninsured children. It focused on legislation adopted between January 2006 and mid-April 2007, as well as on proposals put forth by governors or legislators that were under serious consideration as of mid April 2007. Although not all of the proposals described in this report will be adopted by state legislatures this year (many legislatures are still in active session), the activity is indicative of the level of interest around the country in covering more children.

In conducting its review, CCF began with an examination of children's health legislation, as compiled by the National Conference of State Legislatures, and governors' State of the State addresses.[2] This information was supplemented by a review of state budget documents, legislative updates, media reports, and analyses by local organizations. Whenever possible, information was confirmed through direct communication with state stakeholders.

"When SCHIP became available, I was able to enroll my children in the Colorado Child Health Plus Plan and get my children health coverage. And like most kids, they needed it. While they were on SCHIP both my children sprained their ankles, my son broke his arm, and my daughter had a bad burn. Both received good care that kept them from any permanent harm and allowed them to go back to school and allowed me to go back to work."

– Susan Molina, Colorado parent and volunteer in the faith-based PICO network[3]

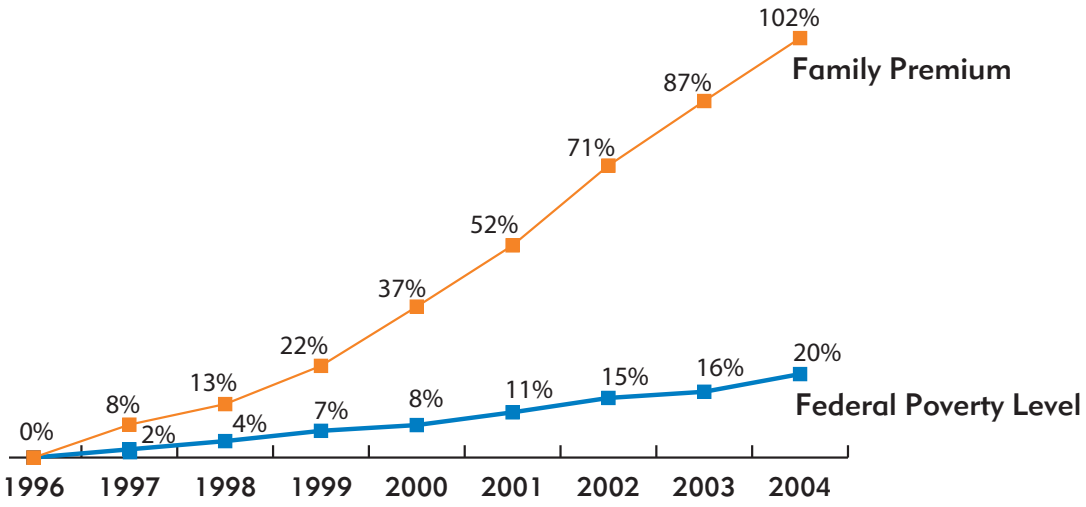
The review was not meant to be exhaustive, but, instead, was intended to provide an overview of proposals that have been adopted and those under active consideration as of mid-April 2007. As such, it does not include all local or state legislative proposals, and it does not cover non-legislative efforts that are underway to increase children's coverage. It also does not address actions aimed at non-coverage initiatives in children's health care, such as child health quality initiatives and immunization campaigns.

FAMILIES FINDING IT HARDER TO SECURE AFFORDABLE, EMPLOYER-BASED COVERAGE

The vast majority of children in the United States are covered by private health insurance, usually through a parent's employer.[4] For a growing number of families, however, it is becoming increasingly difficult to secure affordable insurance through their jobs. Even when coverage is offered, rising health care costs have led many families to face sharp increases in the amount that they must pay to enroll in and use employer-based coverage.[5]

A comparison of changes in the cost of private insurance premiums with changes in the federal poverty level since SCHIP was enacted shows the widening affordability gap and helps explain why states are considering public program expansions. Each year the federal poverty level is adjusted upward to reflect consumer price increases, but the premiums that families pay for private health insurance have been growing at a much steeper rate (Figure 2).

FIGURE 2: Growth in Private Premiums vs. Adjustments in Federal Poverty Level, 1996-2004



Note: This data represents the cumulative growth in private family premiums and the cumulative growth in the federal poverty level since 1996.

Source: Kaiser Family Foundation, *Effect of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level* (February 2007).

States' Child Health Initiatives

Americans stongly believe that all children should have coverage.[6] Coverage promotes access to care that children need as they grow and develop. Without proper physical and mental health care, children miss school because of untreated illnesses and may not attain their full potential. Additionally, they may end up in emergency rooms receiving more costly but often less timely and less appropriate care.[7]

> "Our goal is to help parents of uninsured children and teenagers learn about the HUSKY program and sign their kids up for the health coverage they need. We now have more than 221,600 children covered by HUSKY, but thousands who are eligible are not enrolled. They are going without health coverage, which means they are probably going without regular health care."
>
> *– Connecticut Governor M. Jodi Rell*[8]

Reflecting this widely recognized value, states are moving forward. This report shows that, as of mid-April 2007, 29 states and the District of Columbia adopted legislation or were seriously considering proposals aimed at improving children's coverage (Table 1, pages 6 and 7). This level of activity is extraordinary relative to recent years, but it builds upon successful efforts undertaken over the past ten years to lower the number of uninsured children through SCHIP and Medicaid.

The states that are moving forward represent a diverse mix. Some of the states have a number of large urban areas (e.g., Pennsylvania and New York), while others are mostly rural (e.g., Iowa, Montana and West Virginia). Children's coverage expansion efforts have also become policy priorities for both Democratic and Republican state policymakers. Governor Schwarzenegger of California, for example, has included major expansions in publicly subsidized coverage for children in his universal coverage proposal, as former Governor Romney did in his Massachusetts plan. In addition, many governors and state legislative leaders are reaching across party lines to work to adopt child coverage initiatives. For example, in Ohio, Democratic Governor Ted Strickland and Republican legislative leaders are working on legislative proposals that would make coverage affordable for Ohio's uninsured children.

The primary strategies that state leaders are utilizing to increase children's health coverage include:

1. Finding, enrolling and keeping SCHIP- and Medicaid-eligible children covered. With seven out of ten uninsured children already eligible for SCHIP or Medicaid,[9] states are redoubling their efforts, on top of significant efforts made last year, to enroll and keep eligible children in coverage programs.[10] Nearly all of the states in Table 1 have implemented or plan to undertake outreach and enrollment simplification initiatives. A number of states are specifically looking to reduce paperwork barriers to retention by extending the length of time before families must renew their children's coverage or automating renewal procedures.

For example, New Hampshire is proposing to reach 10,000 additional children through outreach activities and by simplifying application and enrollment processes. Similarly, Colorado is considering a number of enrollment and retention strategies, along with an eligibility expansion, to help reach its goal of covering all children by 2010.

TABLE 1. Examples of Adopted or Proposed State Child Health Initiatives

Alaska	Alaska is considering legislation to update its Medicaid/SCHIP eligibility level for children up to 175 percent of the 2007 federal poverty level.[11] Currently, the eligibility level is frozen at 175 percent of the 2003 federal poverty level (currently equivalent to 154 percent of the 2007 federal poverty level).
Arizona	Arizona Governor Janet Napolitano (D) has proposed adding state funding for outreach to enroll more eligible children in SCHIP. Her proposal is expected to be part of budget negotiations with the Arizona Legislature in coming weeks. The Governor has also proposed changes to state law to facilitate outreach and enrollment of eligible children through the schools.[12]
California	In addition to Governor Arnold Schwarzenegger's (R) well-publicized universal health care proposal, separate proposals by the California Senate President and Assembly Speaker seek to expand children's eligibility for SCHIP up to 300 percent of the federal poverty level and offer coverage to all immigrant children.[13] In 2006, California also adopted legislation to reach an estimated additional 94,000 children by simplifying Medicaid/SCHIP enrollment and retention processes and implementing "Express Lane" eligibility through WIC.[14]
Colorado	The Colorado Legislature is considering a proposal that seeks to cover more uninsured children by 2010 through a SCHIP eligibility expansion up to 300 percent of the federal poverty level and by implementing presumptive eligibility and 12-month continuous eligibility for children.[15]
Connecticut	In Connecticut, which currently has eligibility up to 300 percent of the federal poverty level, Governor M. Jodi Rell (R) announced plans to invest $1.1 million in grants to schools and community agencies to enroll more children in Connecticut's HUSKY program.[16]
District of Columbia	The District of Columbia has allocated $3.9 million to expand Medicaid/SCHIP coverage for children up to 300 percent of the federal poverty level and is currently awaiting federal approval.[17]
Florida	The Florida Legislature is considering a number of bills to simplify the enrollment process and fund outreach initiatives, including one bill that would seek federal approval to expand SCHIP eligibility up to 225 percent of the federal poverty level.[18]
Hawaii	In October 2006, Hawaii increased eligibility in Medicaid/SCHIP up to 300 percent of the federal poverty level.[19]
Illinois	Illinois offers coverage to all children in the state by combining Medicaid and SCHIP into the "All Kids" program, expanding eligibility levels, and allowing families with incomes above eligibility levels to buy into All Kids coverage.[20]
Iowa	Iowa Governor Chet Culver (D) signed a bill on March 15, 2007 to increase the tobacco tax by $1 and stated his intention to allocate some of the funds toward covering more uninsured children.[21]
Massachusetts	Last year, as part of a broader universal coverage initiative under then Governor Mitt Romney (R), Massachusetts improved children's coverage by expanding eligibility up to 300 percent of the federal poverty level in its MassHealth program (Medicaid/SCHIP) and covering children ineligible for MassHealth through its Children's Medical Security Plan.[22]
Minnesota	Minnesota Governor Tim Pawlenty's (R) Healthy Connections plan would use private and public insurance to reach uninsured children, while the Legislature is considering a number of bills to expand SCHIP eligibility up to or above 300 percent of the federal poverty level, as well as implement presumptive eligibility.[23]
Montana	The Montana Senate is considering a bill to increase SCHIP eligibility from 150 to 175 percent of the federal poverty level.[24]
New Hampshire	In New Hampshire, which already has SCHIP eligibility up to 300 percent of the federal poverty level, Governor John Lynch (D) has proposed adding funding to enroll an additional 10,000 children who are eligible for coverage.[25]
New York	On April 1, 2007, New York enacted a budget, which includes a proposal by Governor Eliot Spitzer (D) to streamline its Medicaid/SCHIP renewal process, invest in outreach efforts, and expand SCHIP eligibility up to 400 percent of the federal poverty level.[26]

January 2006 - Mid-April 2007

North Carolina	In North Carolina, Governor Mike Easley's (D) proposed budget creates a new sliding-scale premium health plan for children with family incomes between 200 and 300 percent of the federal poverty level. A legislative plan would also extend the Governor's proposal by allowing families above 300 percent of the federal poverty level to buy into the new health plan at full premium cost.[27]
North Dakota	The North Dakota Legislature is considering a bill to expand Medicaid/SCHIP eligibility from 140 percent to 150 percent of the federal poverty level.[28]
Ohio	Initiated by proposals introduced by Republican leadership and Governor Ted Strickland (D), the Ohio Legislature is considering a coverage expansion for uninsured children. The primary vehicle, the Governor's biennial budget bill, would expand Medicaid/SCHIP eligibility for children up to 300 percent of the federal poverty level and allow families with higher incomes to buy into coverage for their children on a sliding fee scale, with state subsidies ending at 500 percent of the federal poverty level.[29]
Oklahoma	The Oklahoma State House is debating a bill, supported by Governor Brad Henry (D) and passed by the Senate, to expand Medicaid/SCHIP eligibility for children from 185 percent to 300 percent of the federal poverty level and strengthen the state's premium assistance program.[30]
Oregon	The Oregon Legislature is considering a proposal by Governor Ted Kulongoski (D) to expand coverage for children in the Oregon Health Plan to 200 percent of the federal poverty level, simplify the administrative processes for enrollment and renewal, and create a new insurance product for children in families with incomes between 200 percent and 300 percent of the federal poverty level that do not have access to employer-sponsored coverage.[31]
Pennsylvania	On February 20, 2007, Pennsylvania was granted federal approval to increase children's coverage in SCHIP to 300 percent of the federal poverty level, with the option for families above that income level to buy into SCHIP if they have difficulty accessing or affording private coverage.[32]
Rhode Island	The Rhode Island General Assembly is considering legislation to expand Medicaid eligibility up to 300 percent of the federal poverty level (with a buy-in for higher-income families) and cover legal immigrant children. Another bill has been introduced to cover all immigrant children.[33]
South Carolina	The South Carolina Legislature is considering a budget proviso to expand SCHIP eligibility for children in families with incomes up to 200 percent of the federal poverty level.[34]
Tennessee	The new separate SCHIP program in Tennessee, Cover Kids, recently began enrolling children in families with incomes up to 250 percent of the federal poverty level and allowing children in families with higher incomes to buy in.[35]
Texas	In early April 2007, the Texas House passed a bill to streamline the SCHIP enrollment and renewal processes, eliminate the waiting period, adopt 12-month continuous eligibility, and allow families to deduct some income for childcare expenses.[36]
Utah	Utah recently passed a budget supported by Governor Jon Huntsman, Jr. (R) that included $4 million in state funds to leverage more federal dollars for children's coverage and re-open enrollment in its SCHIP program.[37]
Vermont	When Vermont passed its universal Catamount Health program last year under Governor Jim Douglas (R), it funded new outreach efforts for its Medicaid/SCHIP program, Dr. Dynasaur, which has eligibility set at 300 percent of the federal poverty level, and reduced the amount of premiums that families are required to pay.[38]
Washington	On March 13, 2007, Washington Governor Chris Gregoire (D) signed legislation to cover all Washington children by expanding coverage for SCHIP up to 300 percent of the federal poverty level, allowing families above 300 percent of the federal poverty level to buy into coverage, covering all immigrant children, investing in outreach and simplification, and improving the quality and accessibility of care.[39]
West Virginia	In March 2006, West Virginia Governor Joe Manchin III (D) signed legislation to expand SCHIP eligibility up to 300 percent of the federal poverty level, and on January 1, 2007, the state began a phased-in expansion by enrolling children in SCHIP with family incomes up to 220 percent of the federal poverty level.[40]
Wisconsin	Wisconsin Governor Jim Doyle (D) has proposed his BadgerCarePlus initiative to cover Wisconsin children by enrolling already eligible but uninsured children, lowering the cost of premiums for some families, expanding eligibility from 185 percent to 300 percent of the federal poverty level, and allowing families with higher family incomes to buy into coverage for their children.[41]

2. Increasing SCHIP and Medicaid eligibility. Increasingly, moderate-income families are not offered coverage through their jobs or they struggle to afford employer-based health insurance. To address the hardships this causes for children and their families, a number of states are looking to increase the income level at which children can qualify for SCHIP, typically requiring families to pay a premium for that coverage. Experience also shows that eligibility expansions and the resulting outreach helps boost participation rates among already-eligible children at lower income levels.[42]

200 Percent of the Federal Poverty Level, 2007

Family Size	Annual Income	Monthly Income
3	$34,340	$2,862
4	$41,300	$3,442

Between January 2006 and mid-April 2007, 15 states and the District of Columbia were planning or proposing to expand their SCHIP income eligibility levels — most above 200 percent of the federal poverty level (Table 2). Some states, such as California, Oklahoma, and Washington are planning or considering proposals to expand SCHIP coverage up to 300 percent of the federal poverty level.[43]

Eighteen states already have eligibility levels above 200 percent of the federal poverty level. If every proposal currently under consideration came to fruition, almost half of all states (23 states and the District of Columbia) would extend subsidized SCHIP coverage to children above 200 percent of the federal poverty level.[44]

TABLE 2. State Proposals to Expand SCHIP Eligibility, as of April 15, 2007

	Current SCHIP Eligibility Level	SCHIP Eligibility Level Under Expansion Proposal
Alaska[a]	154%	175%
California	250%	300%
Colorado	200%	300%
District Of Columbia	200%	300%
Florida	200%	225%
Minnesota[b]	275%	300%
Montana	150%	175%
New York[c]	250%	400%
North Dakota	140%	150%
Ohio	200%	300%
Oklahoma	185%	300%
Oregon	185%	200%
Rhode Island	250%	300%
South Carolina	150%	200%
Washington[d]	250%	300%
Wisconsin	185%	300%

a Alaska's current eligibility level is frozen at 175% of the 2003 FPL, which is equivalent to 154% of the 2007 FPL.

b Minnesota currently covers infants up to 280% FPL.

c New York recently approved a budget reflecting the expanded eligibility levels.

d Washington has already signed legislation expanding eligibility.

3. Integrating private and public insurance financing. Policymakers in several states are pursuing strategies to expand coverage by integrating public and private financing of health coverage for children. One strategy employed by Pennsylvania and Tennessee, allows families to "buy into" public coverage. Under this strategy, families with uninsured children over the state's income limit use their own funds to purchase public coverage, which is generally a lower-cost, higher-value product than otherwise is available on the individual market.[45] Another strategy includes creating or expanding premium assistance programs, which use public funds to help families purchase employer-sponsored coverage when it is cost-effective to do so.

Implications for SCHIP Reauthorization

The review of state activity indicates that policymakers across the country are looking to make significant strides toward increasing the number of children with health care coverage. These activities have clear implications for SCHIP reauthorization. By taking the following steps as part of SCHIP reauthorization, Congress can support and strengthen state efforts to cover uninsured children.

> "Ultimately it's the kid, without this program, who doesn't get to go to the doctor when they have an earache. It's the kids who suffer."
>
> *– Montana State Senator Dan Weinberg, arguing in support of a SCHIP expansion*[46]

- **Establish a strong and reliable SCHIP financing structure.** States moving forward to cover children are investing their own funds but they also need the federal government to be a strong and reliable financial partner in these efforts. It is well documented that current federal SCHIP funding levels (set ten years ago) fall short of what is needed by states to just maintain their existing programs over the next five years.[47] A substantial commitment of new funds is needed to allow states to sustain their existing programs and make new strides in reaching uninsured children already eligible for coverage, as well as to support the efforts of a growing number of states to expand eligibility. Without such an investment, the potential gains in children's coverage proposed by state-level policymakers will be difficult if not impossible to achieve, and some coverage or enrollment initiatives may even be rolled back.

- **Establish financial incentives and support for states that succeed in enrolling and retaining eligible children.** With close to seven in ten uninsured children already eligible for SCHIP or Medicaid,[48] one of the most important steps the country could take in covering America's children is to reinforce and strengthen state efforts to reach these already eligible children. A number of tools are available to states for this purpose, but some states are reluctant to use them due to concerns about the coverage costs they would incur as a result of successful enrollment initiatives. Of particular concern to states is that such initiatives often bring in as many children who are eligible for Medicaid as are eligible for SCHIP. This boosts coverage gains, but since Medicaid offers states a lower federal matching rate than SCHIP,[49] this "woodwork effect" can discourage states from undertaking enrollment initiatives.[50] SCHIP reauthorization could help to address this issue — some members of Congress have put forth proposals to provide states with added financial support in Medicaid to help them enroll eligible but uninsured children in SCHIP and Medicaid.[51]

- **Provide states with new options for reaching already-eligible children.** As illustrated by this review, many states are looking to enroll uninsured children who already are eligible for SCHIP or Medicaid. An "Express Lane" eligibility option, which would allow states to use financial information from other programs (e.g., school lunch or WIC) to enroll eligible children in health programs, could provide states with an important new tool to reach these children.[52] In addition, a number of stakeholders are calling for repeal or significant modification of a new mandate on states to document the citizenship status of citizens applying for Medicaid. SCHIP directors, for example, cite the negative effect the citizenship documen-

tation mandate has had on children's enrollment in coverage, the additional paperwork it unnecessarily has created for families and states alike, and the challenges it poses to operating a simplified, mail-in application process for SCHIP and Medicaid.[53]

- **Allow new eligibility and coverage options.** In general, states have broad flexibility to decide which children to cover under SCHIP, but a change in law is needed to permit states to cover some excluded groups, including children who are legal immigrants who have been in the country for less than five years.[54] In addition, state coverage initiatives seeking to integrate public and private financing could benefit from new tools to help states administer cost-effective premium assistance programs. For example, it has been recommended that states be allowed to require employers to share information about their health plans with states administering premium assistance programs.[55]

> "Having good health insurance through the Children's Health Insurance Program means that necessary medicines and anything we may need medically are always available to me and my siblings. There are no words to describe how safe that makes me feel. I wish everyone had the ability to get the medicine they needed to make their lives easier."
>
> *– Job Timothy Bedford, 13 year old Maryland enrollee*[56]

- **Preserve state flexibility to set income eligibility.** The federal government caps the amount of SCHIP funding available to states, but accords them broad flexibility to decide how to use these funds. In particular, the law allows states to establish income levels for coverage that they consider appropriate given the cost of living and the cost of health care coverage within their boundaries. Eighteen states already have opted to establish an SCHIP income threshold above 200 percent of the federal poverty level. As noted above, if all of the expansion proposals under consideration are adopted, almost half of all states and the District of Columbia will have SCHIP income thresholds set above 200 percent of the poverty level.[57] Given that income eligibility expansions are a key tool in states' arsenal for reaching more uninsured children, particularly in light of rising health insurance costs, it will be important to retain state flexibility to decide which children they will cover with available funds.

In sum, a strong and timely reauthorization of SCHIP will support and strengthen the growing movement toward covering children. Conversely without a strong reauthorization, state momentum for moving forward could be halted or even reversed.

Conclusion

Lawmakers across the country, representing a diverse set of states and ideologies, are investing in efforts to make health coverage available to more children in their states by building on the foundation of SCHIP and Medicaid. Over half of all states have either adopted or are considering new strategies to cover children, including those that would boost enrollment and retention among already eligible but uninsured children, increase eligibility levels in SCHIP, and integrate public and private financing. The outcome of these initiatives, however, depends not just on state action and state political will, but also on federal action and federal political will in the context of SCHIP reauthorization. With children's coverage a clear national priority, SCHIP reauthorization presents federal lawmakers the opportunity to renew and strengthen the federal commitment to moving forward.

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28 H.B. 1463, 60th Legislative Assembly (North Dakota, 2007).

29 For more information, see Governor Strickland's budget proposal, see http://www.legislature.state.oh.us/BillText127/127_HB_119_I_N.html (pages 1121-1122).

30 S.B. 424, 51st Legislature (Oklahoma, 2007).

31 H.B. 2201, 74th Legislative Assembly (Oregon, 2007).

32 For more information, see Pennsylvania's SCHIP State Plan Amendment #7 on the CMS website; and for more information about the Cover All Kids Program, see http://www.chipcoverspakids.com.

33 S.B. 902/H.B. 6210 & S.B. 415/H.B. 5412, General Assembly, 2007 Session (Rhode Island, 2007).

34 H.B. 3152, 117th General Assembly (South Carolina, 2007).

35 See the Tennessee current SCHIP state plan at http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/TNCurrentStatePlan.pdf; and for more information on Cover Kids, see http://www.covertn.gov/cover_kids.html.

36 H.B. 109, 80th Legislature (Texas, 2007).

37 For more information on Governor Huntsman's budget proposal, see http://www.governor.utah.gov/gopb/budgetfy08.html; also see Voices for Utah Children analysis of budget outcomes at http://www.utahchildren.org/documents/2007FamilyandChildBudgetTracker-FINAL.pdf.

38 For more information on Catamount Health: The 2006 Health Care Affordability Act, see http://www.leg.state.vt.us/HealthCare/2006LegAction.htm; and also *Vermont's Health Reform Laws* fact sheet by Families USA (December 2006), available at http://www.familiesusa.org/assets/pdfs/vt-catamount-health.pdf.

39 S.B. 5093, 60th Legislature (Washington, 2007); and Washington Office of the Governor (March 13, 2007). *Governor Gregoire Signs Legislation to Give More Children Access to Health Care.* Press Release. Retrieved March 28, 2007 at http://www.governor.wa.gov/news/news-view.asp?pressRelease=513&newsType=1.

40 H.B. 4021, 77th Legislature (West Virginia, 2006); For more information about the West Virginia expansion, see http://www.wvchip.org/text/chip_notes.html.

41 For more information on Governor Doyle's BadgerCarePlus, see http://dhfs.wisconsin.gov/badgercareplus/.

42 Experience has shown that outreach initiatives associated with expansions tend to bring in many children who were already eligible. For example, Santa Clara County in California saw a 28% increase in Medi-Cal and Healthy Families applications when they increased income eligibility to 300% for all children; 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, Issue Brief No. 1 (April 2005). Similarly, 75% of the enrollment following implementation of the All Kids program in Illinois was from children who were previously eligible but not enrolled in Medicaid and SCHIP; see D. Cohen Ross, L. Cox, & C. Marks, *Resuming the Path to Health Coverage for Children and Parents*, Kaiser Commission on Medicaid and the Uninsured (January 2007).

43 The SCHIP law permits states to establish income eligibility thresholds at 200 percent of the federal poverty level or 50 percentage points above their existing Medicaid eligibility levels. In addition, the law accords states broad flexibility to set the rules for determining how income is counted. As a result, states can provide eligibility to children with family incomes above 200 percent of the federal poverty level. For more information, see the forthcoming publication from the Center for Children and Families entitled *SCHIP Reauthorization: Can the Nation Move Forward Without Going Backward?*.

44 As of April 1, 2007 eighteen states have SCHIP income eligibility levels above 200 percent of the federal poverty line (CA, CT, GA, HI, MD, MA, MN, MO, NH, NJ, NM, NY, PA, RI, TN, VT, WA, WV). If every expansion proposal listed in Table 2 were adopted, an additional five states (CO, FL, OH, OK, WI) and the District of Columbia would have SCHIP eligibility levels above 200 percent of the federal poverty level.

45 J. Hadley & J. Holahan, *Is Health Care Spending Higher Under Medicaid or Private Insurance?*, Inquiry, 40 (Winter 2003/2004).

46 M. Dennison, "Senate votes to expand CHIP's reach", *Billings Gazette* (April 13, 2007).

47 C. Peterson, *SCHIP Financing: Funding Projections and State Redistribution Issues*, Congressional Research Service (January 30, 2007) and E. Park & M. Broaddus, Fourteen States Face SCHIP Shortfalls This Year Totaling Over $700 Million, Center on Budget and Policy Priorities (February 22, 2007).

48 op. cit. (9).

49 The federal government provides states an enhanced matching rate for SCHIP expenditures. The enhanced matching rate essentially reduces state costs by 30 percent relative to Medicaid. For example, a state with a 50 percent Medicaid matching rate has a 65 percent SCHIP matching rate.

50 See "SCHIP, Medicaid Outreached Blocked by Some States", *Inside CMS*, vol. 10, No. 7 (April 5, 2007).

51 For example, a SCHIP reauthorization bill introduced by Senators Rockefeller (D-WV) and Snowe (R-ME) proposes an adjustment to the match rate for Medicaid in states that succeed in enrolling eligible children. A summary of the bill is available at http://www.senate.gov/~ rockefeller/news/2007/pr033007a.html.

52 The Children's Partnership and First Focus, *The Children's Express Lane to Improve Health Coverage and Program Integrity Act* (April 2007), available online at http://www.expresslaneinfo.org/Content/NavigationMenu4/PolicyAdvocacy/FederalPolicy/Legislation/BingamanLugar2007/Lugar.BingamanFactSheetTCPFirstFocusHillFinal.pdf.

53 National Academy for State Health Policy, *Reauthorizing SCHIP: Principles, Issues, and Ideas from State Directors* (April 2007).

54 National Governors Association, *Policy Position – HHS-09. The State Children's Health Insurance Program* (April 9, 2007).

55 C. Shirk & J. Ryan, *Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?*, National Health Policy Forum, Issue Brief No. 812 (July 17, 2006).

56 op. cit. (44).

57 Testimony, U.S. Senate Finance Committee (February 1, 2007).

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