

Covering All Kids: States Setting the Pace

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OVERVIEW — *Providing health insurance coverage for the uninsured is a challenge that has remained unresolved for decades. In the absence of a national solution, states have initiated their own efforts to expand access to health insurance coverage, particularly for children. Half of the states have enacted or are in the process of debating expansions of their Medicaid and State Children’s Health Insurance Programs, in many cases without the guarantee of federal financial support. Indeed, nine states have decided to pursue what can be considered “universal” children’s coverage—providing access to some form of affordable health insurance coverage for all children in the state, regardless of family income. This issue brief provides a history and status of state children’s coverage initiatives and features several states that appear to be setting the pace by developing successful strategies for expansion and cultivating the political will and leadership needed to institute them. In highlighting some of the key lessons that can be learned from states’ experiences, this paper may inform the broader discussion about health reform and offer some insights into the federal-state dynamics that are at play.*

Covering All Kids: States Setting the Pace

The 2008 presidential race has rekindled the national discussion about how to cover the 45.7 million uninsured individuals living in the United States.¹ Providing universal coverage for children as a first step has emerged as a significant part of the national debate, but states have long since moved ahead. States now have a decade of experience with expanding coverage through the State Children's Health Insurance Program (SCHIP), with great success. In addition, several states have devised and implemented strategies to build upon the coverage they offer through SCHIP and Medicaid, often without the guarantee of federal funding. State legislatures are moving forward in developing universal coverage plans and timelines, and governors are making bold statements about their commitment to ensuring that every child in their state has access to health care coverage.

These state initiatives are in part a response to the perception that universal coverage for children is an achievable goal. The U.S. Census Bureau recently reported that 8.9 million children under age 19 were uninsured in 2007; 62 percent of these children are thought to be eligible for Medicaid or SCHIP but are not enrolled.² That leaves a smaller slice of the child population—roughly 3.4 million children—whose families do not have access to, cannot afford, or choose not to purchase private coverage. Several states have risen to the challenge of providing access to coverage for these uninsured children. Eight states have implemented universal coverage plans, and 18 more are making significant expansions in children's coverage.³

Despite the progress that has been made and the potential for continued forward motion in the states, questions persist about the long-term viability of these expansions, given the erosion of state budgets and uncertainty about what the future may hold in terms of federal policy and financial support. States vary widely in terms of political and economic circumstances that influence their willingness and ability to expand coverage without federal support, in no small part because of their inability to operate at a deficit.⁴ Many proponents argue that states are limited in their capacity to effect significant change beyond the local level (and should not be expected to shoulder the financial burden). Even the most ardent supporters of state autonomy and innovation point out that the federal government has a leadership responsibility in terms of providing a structure for overall reform. Alan Weil, executive director of the National Academy for State Health Policy, noted in his testimony before the House Committee on Ways and Means, "While state efforts make a real

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contribution, federal leadership is needed to make substantial, sustained progress in health reform efforts.”⁵

MEDICAID AND SCHIP: THE FOUNDATION

In the wake of the health care reform discussions of 1993 and influenced by a movement to block grant the Medicaid program in 1995, Congress enacted significant legislation that can now be viewed as the catalyst for expanding coverage for uninsured children in working families. Although a relatively small element of the Balanced Budget Act of 1997, SCHIP was the first major expansion of publicly subsidized coverage since the statutory change that phased in Medicaid coverage for all children living in poverty seven years earlier.⁶ Congress authorized and appropriated \$39 billion to SCHIP over ten years, targeting the funds toward providing health coverage to 5 million of the estimated 10 million low-income uninsured children in the United States at that time.

By most accounts, SCHIP has been a successful program that has met and in many ways exceeded expectations. States embraced the new options that SCHIP provided. As part of the compromise, SCHIP was deliberately designed to give states the option of creating a program that was independent of Medicaid and that more closely resembled commercial insurance coverage. These features enabled states to change many people’s perceptions about what public coverage programs could accomplish. More than 7 million children received health coverage through SCHIP in 2007, and evaluations of the program have consistently shown improvements in children’s access to health care services.⁷

For the first time in many states, outreach and marketing campaigns were used to promote the value of health insurance coverage for children. With support from foundation-funded initiatives like the Robert Wood Johnson Foundation’s Covering Kids project, states received both financial support and technical assistance for the development of social marketing and outreach campaigns as they launched their SCHIP programs in the late 1990s. States chose new and creative names for their SCHIP (and sometimes Medicaid) programs in order to make them more appealing to families, and over time nearly every state made changes to their eligibility and enrollment processes that made applying for coverage more user-friendly and less intimidating. States have widely reported that, particularly in the early years of the program, for every child enrolled in SCHIP, two children were identified as eligible for Medicaid. In fact, the outreach efforts were so successful that, during the recession of 2001 to 2003, states were forced to suspend marketing campaigns in order to keep enrollment levels within the constraints of the programs’ funding capacity.⁸

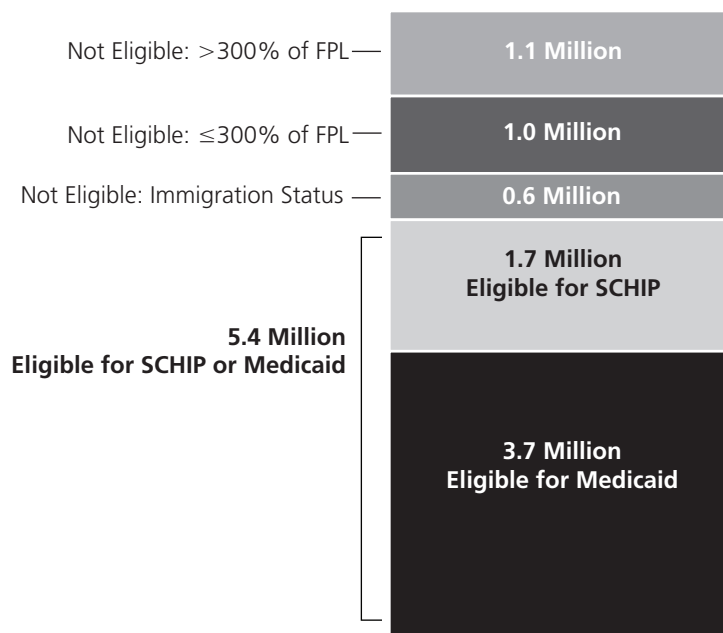
Reauthorization Roadblock

As the states’ SCHIP programs matured, more and more states began to reach and exceed their federal SCHIP funding allotments. Up to 28 states are

expected to experience shortfalls in SCHIP funding by the end of fiscal year (FY) 2009.⁹ While most of the cause for these shortfalls is enrollment, some of the financing discrepancies are due to the structure of the SCHIP allotment system. As a capped allotment, state-specific amounts are statutorily determined each year, based on a number of variables that states have long argued do not sufficiently reflect the actual numbers of uninsured children. As reauthorization of the program approached in 2007, policy and financing experts proposed changes to the SCHIP financing structure that would make SCHIP allotments more predictable and consistent from year to year, enabling states to better plan and make budgetary decisions. More importantly, the conference agreement, known as CHIPRA (the Children’s Health Insurance Program Reauthorization Act of 2007), would have provided an additional \$35 billion over five years in federal funding for SCHIP, which would have translated to coverage for an estimated 4 million additional uninsured children, nearly 90 percent of whom are eligible for SCHIP or Medicaid but are not enrolled.¹⁰ (See Figure 1 for distribution of uninsured children by eligibility for SCHIP and Medicaid.) However, the reauthorization legislation was ultimately vetoed by President Bush, and Congress extended the program at essentially flat funding levels through March 2009.¹¹

The debate and failure to reach resolution on SCHIP reauthorization brought to the forefront the states’ relationship with the federal government and raised questions about long-term federal financial support of coverage expansion efforts. The consensus reached in 1997 to increase the federal role in financing health coverage for uninsured low-income children has become strained. During the reauthorization debate, SCHIP expansion opponents cited their general objection to any new federal legislation that might shift a greater share of public program costs to the federal government, through coverage expansions or substitution of public coverage for private coverage (known as crowd-out). They also expressed concern about “expanding dependency to the middle class.”¹² The issue of crowd-out is one that dates back to the initial debates around the creation of SCHIP and continues to be a point of contention at both the state and the federal level. The Bush administration further articulated its opposition to unrestricted coverage expansions and concerns about

FIGURE 1
Distribution of Uninsured Children
in the United States
(by eligibility for Medicaid or SCHIP)



Note: Data have been adjusted for the Medicaid undercount (see endnote 2).

Source: Kaiser Family Foundation. Based on Urban Institute analysis of 2004 data from Bureau of the Census, Annual Social and Economic Supplement to the Current Population Survey; available at www.kff.org/charts/072307.htm.

crowd-out in a letter from the Centers for Medicare & Medicaid Services (CMS) to all state health officials on August 17, 2007.¹³ The August 17 “directive” announced new and specific limitations on states’ ability to expand Medicaid and SCHIP-funded coverage (see text box below). Many analysts have argued that this policy statement runs counter to states’ enthusiastic commitment to the goals of SCHIP and to the general public’s support of expanding access to health coverage for children.¹⁴

STATES SET THE PACE

Partly in anticipation of an eventual SCHIP reauthorization that will likely include significant new funding and perhaps partly in frustration from waiting for federal action, states have moved forward with their

The August 17 Directive: An Update

On August 17, 2007, CMS issued a directive imposing new restrictions on states’ ability to provide SCHIP coverage for children with gross family incomes above 250 percent of the federal poverty level (FPL). The directive specifies several new requirements that states must meet in order to receive federal matching funds for SCHIP coverage of children at higher family-income levels. CMS gave states one year to either comply with the requirements of the directive, if they intended to cover (or continue covering) children above 250 percent of the FPL, or face federal sanctions. No state has received CMS approval for an expansion above 250 percent of the FPL since the letter was released.

The August 17 directive affects two groups of states: (i) those that have adopted legislation to expand coverage to children with family incomes above 250 percent of the FPL but have not received federal approval to implement (and begin collecting federal matching funds) and (ii) states that currently cover children with gross incomes above 250 percent of the FPL and theoretically must comply with the directive’s requirements in order to continue to receive federal funding for newly enrolled children at this income level.

Eleven states fit into the first group. Five of these have received CMS approval only for coverage up to gross income levels of 250 percent of the FPL (despite these states’ proposals to set eligibility at higher levels). The rest of the states in this group have either had their proposals denied or have delayed their plans, pending further guidance from CMS. The implications of the directive for the 14 states in the second group are less clear. CMS indicated in a follow-up letter on May 7, 2008, that current enrollees with incomes above 250 percent of the FPL would not be affected, as long as they remained continuously enrolled. However, CMS did not give direct answers on the applicability of the other elements of the directive. As the August 18, 2008, effective date of the directive approached, the state of California sent a letter to CMS, indicating the state’s inability and unwillingness to comply with the policies outlined in the directive. CMS’s only response to this announcement was in the form of a press statement directed to California, indicating that the agency “would not be taking compliance action against the states at this time.” No additional formal guidance has been provided.

plans for pursuing universal coverage for children. State-based universal coverage for children can be defined in a variety of ways and, in many cases, includes coverage of noncitizen children as well as those that are undocumented. Universal coverage, for the purposes of this issue brief, is defined as making some form of health coverage available to all uninsured children in a state, regardless of family income.¹⁵ Further, while coverage of noncitizen and undocumented children is noted where appropriate, its absence was not a disqualifying factor for those states making concerted efforts to craft their programs to expand overall access to health insurance coverage. The Appendix provides an overview of states that have implemented universal coverage.

The state initiatives discussed in this paper use a combination of approaches designed to ultimately achieve universal access to health coverage for children. All include expansions of existing Medicaid and SCHIP programs, but what makes these initiatives interesting is that states are moving beyond these more stable sources of financing to test new and innovative approaches to serving families with different financial circumstances. As a result of these wide-ranging efforts, hundreds of thousands of children have gained access to more affordable, comprehensive health coverage. As of May 2008, eight states—Hawaii, Illinois, Maine, Massachusetts, Pennsylvania, Vermont, Washington, and Wisconsin—had enacted and implemented state universal coverage for children. New Jersey also recently passed universal coverage legislation.¹⁶ These expansions have been largely considered successful: Washington has enrolled an additional 32,000 children; Wisconsin has increased enrollment by more than 50,000; and Illinois' All Kids program boasts an additional 240,000 children enrolled in coverage, 177,000 of whom were previously eligible for but not enrolled in Medicaid or SCHIP. Seventeen additional states have enacted slightly less ambitious eligibility expansions for children but have also increased enrollment and made program improvements.¹⁷ While the jury is still out as to whether these states will be able to sustain these initiatives in the long term, absent a national health reform plan, lessons can already be learned from the strategies they have developed and the commitment they have shown.

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Key Strategies

As more and more states get serious about pursuing universal coverage for children, several common approaches have emerged. Virtually all of the coverage expansions build on the foundation of Medicaid and SCHIP. States have worked within the federal parameters of Medicaid/SCHIP eligibility to maximize federal financing and have used the existing programmatic options to the full extent possible under the law and as permitted by CMS. All of the universal coverage states have enacted

legislation to offer coverage to children with incomes up to 300 percent of the federal poverty level (FPL), which is \$52,800 for a family of three in 2008; however, some of these states have not received federal approval and are operating these expansions with state-only funds. Beyond Medicaid and SCHIP, states have designed coverage expansions for additional populations (such as higher-income children and noncitizen children) often through subsidy mechanisms, or “buy-in” programs, in which uninsured families have the opportunity to purchase coverage through the state without having to navigate the individual insurance market.

- **Buy-in programs** have become a common element in states that have enacted and implemented universal children’s coverage plans. A buy-in can be defined in a variety of ways, but effectively it means offering the opportunity to purchase often-unsubsidized coverage to more moderate-income families that do not qualify for Medicaid or SCHIP. Through buy-in programs, states allow families to purchase coverage through the public program (SCHIP or another state-subsidized plan) at the state-negotiated group rate (rather than at a rate they would pay in the individual market), making the coverage more affordable. States tend to offer subsidies on a sliding scale for families at lower income levels and require a full buy-in for families with incomes above 300 percent of the FPL. For example, Pennsylvania requires families with incomes above 250 percent of the FPL to contribute 35 percent of the premium cost, families with incomes above 275 percent of the FPL to contribute 40 percent, and families with incomes above 300 percent of the FPL to pay the full premium.¹⁸ To date, Connecticut, Hawaii, Illinois, Maine, Massachusetts, Ohio, Pennsylvania, Washington, Wisconsin, and Vermont have either implemented or enacted buy-in programs. And several other states are in discussions about implementing buy-ins as part of their universal coverage plans.
- Several states, including Illinois, Maine, Massachusetts, New Mexico, Wisconsin, and Vermont also offer **premium assistance** for employer-sponsored insurance coverage for families who have such coverage available to them. Through premium assistance programs, states subsidize the premium amount that the employee would otherwise have to pay, and the employer contributes the remainder of the cost of the employer group coverage.¹⁹ This is generally authorized through a SCHIP or Medicaid section 1115 waiver and includes both federal and state funding. Premium assistance has been offered in various forms in both Medicaid and SCHIP over the years and has proven to be a politically desirable strategy but poses coordination challenges on many levels.²⁰
- Coverage of **noncitizen children** has been a constant point of contention in discussions about the definition of universal coverage. As a result of statutory changes included in the welfare reform legislation, most legal immigrants are ineligible for federally funded health coverage through Medicaid and SCHIP for the first five years of residence in the United States.²¹ This has been an ongoing issue between the states and the

federal government and was part of the SCHIP reauthorization debate. States and many other stakeholder groups argued that reinstating eligibility for noncitizen children would ultimately reduce uncompensated care costs and improve overall child health and development. However, restoring coverage to certain legal immigrant children who are currently ineligible under the five-year bar on eligibility was not included in the final conference agreement. In the meantime, many states have decided to cover noncitizen children with state-only funds. Several states, including Hawaii, Illinois, Maine, Massachusetts, Pennsylvania, Washington, and Vermont cover certain groups of noncitizen children as part of their universal coverage plans.²² However, only Hawaii, Illinois, Massachusetts and Washington currently provide coverage for undocumented immigrant children.²³

Renewed outreach and enrollment initiatives have featured prominently in states' universal coverage efforts. States have launched media campaigns and partnered with schools, community-based organizations, and advocacy groups to increase awareness of public coverage. Many have continued the progress made through SCHIP by using simplified enrollment and retention strategies. Nearly all states now use a single application for both Medicaid and SCHIP and have shortened the application form. (See text box for further discussion.) Today, 16 states offer 12-month continuous eligibility for children in their Medicaid programs and 27 states offer it in their separate SCHIP programs.²⁴ An increasing number of states are making use of income and other personal information from existing data systems to assist in enrollment. States have also linked health care coverage programs with other assistance programs, like the Free and Reduced Price School Lunch Program, to identify children who are eligible but not enrolled. Finally, states are beginning to work within the tax system to conduct outreach to potentially eligible families. For example, beginning in the 2008 tax year, Maryland will include a question about health insurance coverage on the state tax forms; it will then send Medicaid and SCHIP applications to parents who indicate that they have an uninsured dependent child, if they appear to meet the income eligibility requirements for public coverage.²⁵

States are facing interesting new challenges as they design outreach, marketing, and programmatic strategies for reaching the

Simplification: A Double-Edged Sword

Ongoing research and monitoring of states' eligibility and enrollment processes over the past ten years have shed new light on the extent to which these administrative procedures can encourage or deter participation. Some of the aspects of welfare programs that were effective at deterring applicants from enrolling carried over into the Medicaid eligibility and enrollment process. These barriers included long wait times spent at county welfare offices where a face-to-face interview was required in order to be approved for benefits and burdensome paperwork requirements, such as 30-page applications, quarterly redeterminations of eligibility, and extensive documentation requirements. The chilling effect of these types of procedures became clear only when states experienced remarkable enrollment increases as they began to streamline their processes. This phenomenon also enabled states to attach dollar amounts to the processes for purposes of estimating potential cost-savings during difficult financial times. Today, states sometimes resurrect burdensome administrative procedures in order to contain costs. These types of programmatic changes are easier (and more politically palatable) to institute than an official rollback of eligibility, which can be difficult to restore when economic times improve.

population of uninsured children whose families likely earn too much to qualify for Medicaid or SCHIP (even at expanded eligibility levels) but either do not have access to employer coverage or cannot afford the coverage that might be available to them.²⁶ This segment of the population may not ever have been exposed to a government-sponsored program before (or, if they had heard of SCHIP, assumed they were not eligible). Pennsylvania has had success reaching out to a broader population through marketing campaigns throughout the state and the slogan, “We Cover All Kids.” The state has also posted a notice on its Web site, “CHIP Has Expanded. More Children can enroll. Don’t assume you earn too much to qualify.”²⁷

Foundations as Core Supporters

To bolster states’ efforts, several national foundations, including the David and Lucile Packard Foundation, the Robert Wood Johnson Foundation, and the W. K. Kellogg Foundation are supporting technical assistance and other activities to help states achieve universal coverage for children. Several state officials have acknowledged the importance of this foundation support, both locally and in a broader sense. Discrete projects now under way focus on providing guidance regarding outreach strategies targeted at children who are eligible for public programs but are not enrolled and supporting broader state-based advocacy efforts. For example, in 2008 the Packard Foundation launched the Finish Line Project, a \$15 million initiative that provides financial and technical support to advocacy organizations in states positioned to make significant advances in children’s coverage. These efforts are led by grass-roots organizations, child advocacy groups, or alliances or coalitions focused on expanding children’s coverage. The Center for Children and Families, based at Georgetown University’s Health Policy Institute provides research, policy, and communications support to each of the eight Finish Line grantees (Arkansas, California, Colorado, Iowa, Ohio, Rhode Island, Texas, and Washington). Another component of the Finish Line project will include a multistate evaluation to monitor the progress and impacts of the advocacy efforts and the implementation of new state-initiated children’s coverage expansions.²⁸

The National Academy for State Health Policy (NASHP) has, with ongoing funding from the Packard Foundation, provided support to states in implementing and improving SCHIP since the program was enacted. NASHP is also assisting state agencies working to achieve coverage for all children. Begun in 2006, this work now serves as a component of the broader Finish Line initiative, with NASHP providing technical assistance and state-to-state learning exchange opportunities. In addition, the organization serves as the national program office for a new Robert Wood Johnson Foundation initiative, the Maximizing Enrollment for Kids program that aims to increase enrollment and retention of eligible children into Medicaid and SCHIP programs and to establish and promote best practices among states in this area. The program is designed to help selected states improve their

enrollment policies, procedures, and systems by providing an in-depth assessment of the strengths and weaknesses of their current Medicaid and SCHIP enrollment and retention processes. NASHP will also be assisting states with implementation strategies to cover more children who are eligible but not enrolled and will be measuring the states' progress.²⁹

Profiles in Leadership

Several states can be considered at this point to have real experience in implementing universal coverage programs for children as well as adults. The most highly publicized efforts have been in Massachusetts, Maine, and Illinois, but Pennsylvania, Wisconsin, Hawaii, and Washington also have interesting stories to tell. To date, more than half of the states are seriously considering, if not formally pursuing, significant coverage expansions for children. A growing number of these states are on the road to universal coverage (see Appendix). The initiatives of three states—Pennsylvania, Washington, and Hawaii—are described below.

Pennsylvania—In 2004, the Pennsylvania Insurance Department released results of a survey that found that an estimated 133,000 children, or 4 percent of the state's child population, did not have health insurance.³⁰ And of these uninsured children, 108,000 were thought to be eligible for Medicaid or SCHIP (known as CHIP in Pennsylvania). In response, Gov. Ed Rendell announced the Cover All Kids initiative in January of 2006.³¹ The initiative began with a significant expansion of CHIP to provide coverage to children with family incomes up to 300 percent of the FPL.

Families have the option to buy in to the Pennsylvania CHIP plan on a sliding scale, if their income exceeds 200 percent of the FPL. Families with incomes above 300 percent of the FPL pay the full cost of coverage—an average of \$160 per child, per month. Families wishing to buy into CHIP must demonstrate that private coverage is unavailable or was denied due to a preexisting condition or that the cost of such coverage is unaffordable as determined by the state. There is a six-month waiting period for CHIP for families with incomes above 200 percent of the FPL, unless the child is under age two or lost insurance due to a parent's loss of employment.³²

Improving outreach and enrollment has been a critical part of the state's coverage initiative. Pennsylvania has had great success at streamlining enrollment and renewal processes through the use of innovative technology, in particular an online application called COMPASS (Commonwealth of Pennsylvania Access to Social Services).³³ It has also partnered with community-based organizations, health departments, and schools to market the program to targeted populations (for example, non-English-speaking children, minority groups, and inner-city and rural children). Since implementing Cover All Kids in March 2007, Pennsylvania has provided health coverage to 51,368 additional children, more than half of whom were already eligible for Medicaid or CHIP programs.³⁴

Washington — The state of Washington has had a history of ups and downs as a leader in pursuing coverage expansions for children. The state typically has one of the lowest rates of uninsurance, only 4.4 percent of children, and has been providing health coverage to children, regardless of their immigration status, since the passage of welfare reform in 1996. However, budgetary challenges beginning in late 2002 prevented the state from making further advances, and an estimated 50,000 children lost Medicaid and SCHIP coverage between 2002 and 2005.³⁵ When Gov. Chris Gregoire was elected in 2005, she ran on a renewed promise to cover all children in Washington by 2010.³⁶ In 2007, the state legislature enacted a plan to “cover all kids,” which phases in coverage for every child in Washington.³⁷ Today, children with family incomes up to 250 percent of the FPL are eligible for coverage, regardless of immigration status through a combination of Medicaid, SCHIP, and a state-funded program. The state will increase eligibility to 300 percent of the FPL through SCHIP and the new state-funded program in January 2009.³⁸ Under the planned expansion, families with incomes above 300 percent of the FPL will have the option of buying in to health coverage at full cost.³⁹

In addition, Washington is developing several measures to increase enrollment and retention in Apple Health for Kids, the new program name that will encompass coverage for children in one program.⁴⁰ If a change in family income results in a change in eligibility for any other coverage program, the family will be notified and automatically transferred to that program without a break in coverage. The state is required by statute to collaborate with local public health agencies, health care providers, parents, and selected state agencies to assist in outreach and helping to ensure access to medical homes.⁴¹

In the first year of implementation of the outreach efforts, organizations in almost every county in the state received grants to develop the infrastructure needed to enhance local outreach efforts. In addition, outreach organizations began receiving \$75 per successful application for helping families navigate the enrollment process if they were already enrolled in other state programs, such as Basic Food, the Early Child Care Subsidy Program, or child support. In the second year, outreach organizations will receive \$150 for each child that is successfully enrolled. While efforts to streamline the enrollment process are still under way, the state is working toward using enrollment information from other programs to generate lists of children to be potentially targeted for outreach.⁴²

Hawaii — In 2006, over 16,000 children, or 5 percent of the child population in Hawaii, lacked health insurance. And 9,000 of these children were thought to be eligible for Medicaid or SCHIP coverage.⁴³ In October 2006, the state received approval from CMS to increase SCHIP eligibility to 300 percent of the FPL. The state passed legislation in 2007 that eliminated premiums for enrollees in QUEST (Hawaii’s Medicaid managed care program) who had family incomes between 250 and 300 percent of the FPL (making the program entirely free) and established Keiki Care, a three-year

pilot program for children ineligible for Medicaid or SCHIP, regardless of income or immigration status. Keiki Care was launched in April 2008 and provides coverage to children from one month old up to age 19.

The Keiki Care program is funded through a public-private partnership between the state and the Hawaii Medical Service Association, which is the local Blue Cross/Blue Shield nonprofit insurance company. Enrollees in Keiki Care are not assessed premiums, though they are subject to cost sharing. Keiki Care offers a slightly more limited benefit package than the state's Medicaid or SCHIP program.⁴⁴ It imposes a six-month waiting period, and children must not have been eligible for any other public coverage program during this time. Children in Medicaid or SCHIP who lose coverage due to an increase in income are eligible for Keiki Care and are not subject to the six-month waiting period. The expansion is being financed with state-only funds. As of July 2008, 1,951 children were enrolled in Keiki Care.⁴⁵

Children's Health Initiatives: Lessons from California's Counties

With a large and ethnically diverse population, California has a long history of struggling to find the best ways to take care of its most vulnerable citizens (and noncitizens). The state has been a consistent leader in developing and implementing its SCHIP program, Healthy Families, and although the state has not resolved the larger question of how to structure universal coverage at the state-wide level, California offers several clear and well-documented lessons from the experiences of its nearly 30 county-based children's health initiatives, known as Healthy Kids programs.

"From the get-go, we said we are covering all kids. We didn't care whether they had a green card, a blue card or whatever color card—a kid is a kid."

— Leona Butler, Chief Executive Officer, Santa Clara Family Health Plan⁴⁶

Healthy Kids was first established in 2001 in Santa Clara County, located in the San Francisco Bay area. The program was the result of what seemed then to be a unique collaboration among a group of stakeholders in the community committed to universal coverage for children, augmented by the leadership of Leona Butler, the chief executive officer of the Santa Clara Family Health Plan. Also known as Children's Health Initiatives, the Healthy Kids program provides comprehensive insurance coverage to all uninsured children up to age 18 who have family incomes up to 300 percent of the FPL and are not eligible for Medi-Cal or Healthy Families, without regard to immigration status. The programs are administered by a county-based health plan and enrollment is conducted through one-on-one assistance designed to help ensure that children are connected to a coverage program, regardless of whether it is Healthy Kids or Medi-Cal or Healthy Families; very few children walk away uninsured.

Santa Clara County has been widely hailed as a success, and several independent evaluations of the program have underscored its contribution toward increasing children's coverage, improving access to a usual source of health care (90 percent of enrollees), and reducing unmet health needs.⁴⁷ As a result, more than half of California's counties have replicated the Healthy Kids model. To date, 30 of the state's 58 counties have implemented children's health initiatives, serving more than 80,000 children.⁴⁸ Because a large portion of Healthy Kids enrollees were expected to be noncitizen (often undocumented) children, the programs were by definition not eligible for state or federal Medicaid matching funds, so alternate financing streams had to be identified. In 2004, Santa Clara, San Mateo, and San Francisco counties did receive approval for a special section 1115 Medicaid waiver that enabled the counties to receive state and federal funds for citizen children with family incomes between 250 and 300 percent of the FPL, but that funding is not available to support the broader coverage effort.

The absence of federal financing for the vast majority of the county-based initiatives, along with difficult economic times, has left them extremely vulnerable in the long-term. Although each county initially secured a diverse base of public and private support to subsidize the Healthy Kids program, few of the counties have sufficient funds to enroll all of the children who have been identified as uninsured and potentially eligible. An increasing number of programs have capped enrollment in the past three years, and 20,000 children are currently on waiting lists for Healthy Kids.⁴⁹ And the failure of the major push for universal health coverage and health system reform in the spring of 2008 has made the county initiatives less and less secure. On July 21, 2008, Alameda County, one of the state's early and more progressive leaders in implementing Healthy Kids, announced that it will be closing its program due to lack of permanent funding.⁵⁰

GETTING TO THE FINISH LINE

As another round of debate over SCHIP reauthorization nears and economists and health policy experts continue to contemplate the pieces that could potentially be fit together to restructure the health system, states are indeed serving, in the words of Supreme Court Justice Louis Brandeis, as "laboratories for democracy." State experiences provide valuable lessons for designing coverage expansions and can also inform the national landscape and encourage more active federal leadership in pursuing incremental expansions of health coverage. At the same time, the challenges that have emerged provide a cautionary tale about the long-term sustainability of coverage initiatives that do not include a guarantee of federal support, particularly during these difficult economic times. This issue is one that resonates with all states and is one of the key reasons federal leadership may be necessary in order for any state-based reform effort to ultimately succeed.

ENDNOTES

1. U.S. Census Bureau, "Health Insurance Coverage: 2007," August 26, 2008; available at www.census.gov/hhes/www/hlthins/hlthin07/hlth07asc.html.
2. It should be noted that these estimates have been adjusted to compensate for a data limitation, known as the Medicaid "undercount," in the Current Population Survey, which under-reports Medicaid and SCHIP enrollment. Experts agree that this undercount results in artificially inflated estimates of the number of uninsured children and warrants adjustments to the data. U.S. Census Bureau, "Health Insurance Coverage: 2007," and Julie L. Hudson and Thomas M. Selden, "Children's Eligibility and Coverage: Recent Trends and a Look Ahead," *Health Affairs* Web Exclusive, August 16, 2007, available at <http://content.healthaffairs.org/cgi/reprint/26/5/w618?maxtoshow=&HITS=10&hits=10&RESULTFORMA T=&author1=Hudson&fulltext=Children&andorexactfulltext=and&searchid=1&FIRSTIND EX=0&resourcetype=HWCIT>.
3. In June 2008, New Jersey was the ninth state to enact universal children's coverage legislation. For more information on state coverage initiatives, see Henry J. Kaiser Family Foundation, "State Coverage Initiatives for Children," August 20, 2008; available at www.kff.org/uninsured/kcmu051607oth.cfm. This table lists 26 states that have either enacted universal coverage or have made significant expansions.
4. Vermont is the only state that has no constitutional or statutory requirement for a balanced budget. For more information see Ronald K. Snell, "State Balanced Budget Requirements: Provisions and Practice," National Council of State Legislatures; available at www.ncsl.org/programs/fiscal/balbuda.htm.
5. Alan Weil, "State Coverage Initiatives: Lessons for the Nation," testimony before the U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health, July 15, 2008; available at www.nashp.org/Files/Weil_Ways_and_Means_Testimony_July15_2008.pdf.
6. The legislation gradually phased in mandatory Medicaid coverage of children under age 19 with family incomes below the poverty line. Today, all children living in poverty are eligible for Medicaid. This group became known as "the Waxman kids," named for Rep. Henry A. Waxman (D-CA), who has championed many expansions to the Medicaid statute over the past three decades.
7. Kathleen Farrell, Centers for Medicare & Medicaid Services, email correspondence with author, September 30, 2008. For information related to access to and quality of care through SCHIP, see Agency for Healthcare Research and Quality, "Access and Quality in SCHIP and Medicaid"; available at www.ahrq.gov/chiri/chirifind.htm#access.
8. For more information, see "The Basics: SCHIP Financing," National Health Policy Forum, March 28, 2007; available at www.nhpf.org/pdfs_basics/Basics_SCHIPFinancing.pdf.
9. Chris L. Peterson, "What Happens to SCHIP After March 31, 2009?" Congressional Research Service report, July 22, 2008 (not publicly available), order code RS22922. If the availability of the FY 2008 and FY 2009 allotments were extended through the end of FY 2009, shortfalls of federal SCHIP funds would total approximately \$1.8 billion in 28 states.
10. Kaiser Commission on Medicaid and the Uninsured, "Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA): The Revised CHIPRA Bill (H.R. 3963) Compared to the Original Bill (H.R. 976)," November 2007; available at http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/schip_reauth/chipra2_summary.pdf.
11. The Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173) included \$10 billion in funding above the baseline level to enable all states to continue coverage at current levels, even if they had previously exceeded their allotments. These funds are available through March 31, 2009.
12. Dennis G. Smith, "SCHIP Reauthorization: Preparing for Another Round in Congress," Heritage Foundation, Web Memo #1994, July 16, 2008; available at www.heritage.org/Research/HealthCare/wm1994.cfm.

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13. See Centers for Medicare & Medicaid Services, letter to state health officials, SHO#07-001, August 17, 2007, available at www.cms.hhs.gov/smdl/downloads/SHO081707.pdf; and letter to state health officials, SHO#08-003, May 7, 2008, available at www.cms.hhs.gov/SMDL/downloads/SHO050708.pdf.
14. Lake Research Partners and American Viewpoint, “New Bipartisan Survey Finds Americans Strongly Support Expanding SCHIP and Extending Health Coverage to More Uninsured Children,” July 2007; available at <http://ccf.georgetown.edu/index/cms-file-system-action?file=ccf%20publications/public%20opinion/new%20bipartisan%20survey.pdf>.
15. Several states also use state-only funds to offer coverage to immigrant children who are not otherwise eligible for federally subsidized coverage through Medicaid or SCHIP.
16. Kaiser Family Foundation, “State Coverage Initiatives.”
17. Kaiser Family Foundation. “State Coverage Initiatives.”
18. Bill Schaffer, Pennsylvania Insurance Commission, correspondence with author, September 2008.
19. National Academy for State Health Policy, “States Aiming for All Kids All the Time: Coverage Initiative Details,” September 2008; available at: www.nashp.org/Files/CAK_Table_2-08-08.pdf.
20. For more information about premium assistance, see Joan Alker, “Choosing Premium Assistance: What Does State Experience Tell Us?” Kaiser Commission on Medicaid and the Uninsured, May 2008, available at <http://ccf.georgetown.edu/index/cms-file-system-action?file=ccf%20publications/program%20design/choosing%20premium%20assistance.pdf>; and Cynthia Shirk and Jennifer Ryan, “Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?” National Health Policy Forum, Issue Brief 812, July 17, 2006, available at www.nhpf.org/pdfs_ib/IB812_PremiumAssist_07-17-06.pdf.
21. The Personal Responsibility and Work Opportunity Reconciliation Act was enacted in 1996, replacing the Aid to Families with Dependent Children (AFDC) program with Temporary Assistance for Needy Families (TANF). This legislation is known as welfare reform. Legal immigrants who have not been granted lawful permanent residency status are ineligible for Medicaid and SCHIP for their first five years in the country. The statute does include exceptions for certain categories of immigrants, including refugees and asylees.
22. Center for Children and Families, “States Moving Forward: Child Health Coverage,” Georgetown University Health Policy Institute, September 2008; available at <http://ccf.georgetown.edu/index/child-health-coverage>.
23. Undocumented immigrants are those who do not fit into one of the categories of legal residence. Two groups account for most undocumented immigrants: (i) those who entered the country without valid documents, including people crossing the border clandestinely and (ii) those who entered with valid visas but overstayed their visas’ expiration or otherwise violated the terms of their admission. There are an estimated 1.8 million undocumented children residing in the United States. For more information see, Jeffrey S. Passel, Randy Capps, and Michael Fix, “Undocumented Immigrants: Facts and Figures,” Urban Institute, January 12, 2004; available at www.urban.org/UploadedPDF/1000587_undoc_immigrants_facts.pdf.
24. Twelve-month continuous eligibility allows children to stay enrolled for a full year, even if there are changes in family income. Donna Cohen Ross, Aleya Horn, and Caryn Marks, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles*, executive summary, Kaiser Commission on Medicaid and the Uninsured, January 2008; available at www.kff.org/medicaid/upload/7740_ES.pdf.
25. Martha Heberlein *et al.*, “States Moving Forward: Children’s Health Coverage in 2007–2008,” Georgetown University Health Policy Institute, September 2008; available at <http://ccf.georgetown.edu/index/cms-file-system-action?file=ccf%20publications/uninsured/statesmovingforward08.pdf>.

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26. Some employers offer health coverage plans to their employees but do not subsidize that coverage, requiring the employee to shoulder all of the premium costs. In addition, some coverage plans include high premiums, deductibles, and other fees that make purchasing the coverage unaffordable. Private health insurance coverage for a family averages more than \$12,000 per year.
27. Commonwealth of Pennsylvania, "CHIP: Pennsylvania's Children's Health Insurance Program"; available at www.chipcoverspakids.com/.
28. David and Lucile Packard Foundation, "Insuring America's Children: States Leading the Way Including the Finish Line Project"; available at www.packard.org/genericDetails.aspx?RootCatID=3&CategoryId=160&ItemID=3831&isFromModule=1.
29. Alan Weil, Cathy Hess, and Alice Weiss, National Academy for State Health Policy (NASHP), email correspondence with author, September 2008. For more information about NASHP's activities, visit www.nashp.org.
30. George L. Hoover, "Pennsylvania's CHIP Expansion to Cover All Uninsured Kids," Commonwealth of Pennsylvania Insurance Department; available at www.statecoverage.net/0107/hover.ppt.
31. Center for Children and Families, "Cover All Kids: Pennsylvania's Statewide Campaign to Expand Eligibility," Georgetown University Health Policy Institute; available at <http://ccf.georgetown.edu/index/cover-all-kids>.
32. Hoover, "Pennsylvania's CHIP Expansion."
33. For more information on COMPASS, see Center for Children and Families, "Pennsylvania: Streamlined Enrollment & Renewal Through Technology," Georgetown University Health Policy Institute; available at <http://ccf.georgetown.edu/index/pennsylvania-full-example>.
34. George Hoover, Pennsylvania Insurance Department, email correspondence with author, August 28, 2008.
35. To obtain savings, state policymakers made a number of policy changes to Medicaid and SCHIP, including a shift from 12 months' continuous eligibility to a 6-month renewal period, eliminating self-declaration of income, and eliminating the state-funded program for immigrant children not eligible for Medicaid or SCHIP.
36. For more information, see Center for Children and Families, "Washington: Coverage to All Children," Georgetown University Health Policy Institute; available at <http://ccf.georgetown.edu/index/washington-background>.
37. State of Washington, *Second Substitute Senate Bill 5093*, 60th Legislature, February 14, 2007; available at <http://apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Senate%20Passed%20Legislature/5093-S2.PL.pdf>.
38. Because of the August 17 directive, the state has not submitted a proposal to CMS to cover children between 250 and 300 percent of the FPL but will cover this group of children with state-only funds.
39. Center for Children and Families, "States Moving Forward."
40. For more information on Apple Health for Kids, see Department of Social and Health Services, "Washington: Apple Health for Kids," State of Washington; available at www.applehealthforkids.wa.gov.
41. State of Washington, *Second Substitute Senate Bill 5093*.
42. Theresa Mosqueda, Washington Children's Alliance, email correspondence with author, September 30, 2008. For more information, see Children's Alliance, "Cover All Kids Update," 2008; available at www.childrensalliance.org/4Download/advocacy/2008/Health_Policy_Paper_2008.pdf.

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43. Hawaii Covering Kids, “Hot Happenings: Keiki Care”; available at www.coveringkids.com/news/Section_253.asp.
44. For more information about the Keiki Care benefit plan, see Hawaii Medical Service Association, “Keiki Care Plan”; available at www.hmsa.com/healthplans/individual/keikicare/. See also Hawaii Covering Kids, “Free Health Insurance Programs for Children and Youth,” February 2008; available at www.coveringkids.com/hot_happenings/KidsHealthInsChart022808.pdf.
45. Barbara Luksch, Hawaii Covering Kids, email correspondence with author, September 18, 2008.
46. Jennifer Ryan, “Local Coverage Initiatives: Solution or Band-Aid for the Uninsured?” National Health Policy Forum, Issue Brief 803, June 29, 2005; available at www.nhpf.org/pdfs_ib/IB803_LocalCoverageInitiatives_06-29-05.pdf.
47. David and Lucile Packard Foundation, “New Study of Children’s Health Initiatives in Three Counties Shows Dramatic Gains in Well-Being for Children and Families,” news release, November 19, 2007; available at www.packard.org/newsDetails.aspx?RootCatID=2&CategoryID=48&ItemID=3729.
48. California Children’s Health Initiatives, “Local CHIs,” September 3, 2008, available at www.cchi4kids.org/localchis.php; Liane Wong, David and Lucile Packard Foundation, telephone conversation with author, September 11, 2008.
49. Hillary Frazer, Christopher Schnyer, and Liane Wong, “Challenged by Their Success: Healthy Kids Program Enrollment Caps and Waiting Lists,” Institute for Health Policy Solutions California, Policy Brief, 5, no. 4 (October 2005); available at www.100percentcampaign.org/assets/pdf/rsc-051001.pdf; Waiting list estimate provided by Liane Wong, telephone conversation with author.
50. First 5 LA, “Alameda County Ends Healthy Kids Program,” July 21, 2008; available at www.first5la.org/articles/alameda-county-ends-healthy-kids-program.



The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.

APPENDIX: Eight States Pursuing Universal Coverage for Children, 2008

STATE	Uninsured Children Before Expansion	Current Medicaid/SCHIP Eligibility Levels (income as % of FPL)	Expansion Programs' Eligibility Levels for Medicaid/SCHIP (income as % of FPL)	Immigrant Coverage?	Affected by August 17 Directive?	Implementation Status and Enrollment Since Expansion
Hawaii	16,000	300% SCHIP Medicaid expansion	Keiki Care — State-subsidized program — No income limit	Yes*	No Implemented before directive	— Keiki Care began April 1, 2008 — 2,000 children enrolled as of July 2008
Illinois	250,000	200% Separate SCHIP	All Kids — Subsidized buy-in above 300% — Sliding scale premium up to 800%	Yes*	No SCHIP state-funded between 200% and 300% of FPL	— Expansion implemented in July 2006 — 240,000 children enrolled as of August 2008
Maine	21,700	200% Separate SCHIP	DirigoChoice [†] — State-funded premium assistance and buy-in up to 300% — Unsubsidized buy-in above 300%	Yes [‡]	No	— Expansion implemented in 2005 — Enrollment data not available
Massachusetts	91,000	300% Separate SCHIP	Children's Medical Security Plan [§] — Subsidized buy-in — No income limit Commonwealth Choice — Unsubsidized buy-in — No income limit	Yes [¶]	No Implemented before directive	— Expansion implemented in 2007 — 54,560 children enrolled as of June 2008
Pennsylvania	133,000	300% Separate SCHIP	Cover All Kids — Unsubsidized buy-in above 300%	Yes ^{**}	No Implemented before directive	— Cover All Kids implemented in March 2007 — 51,368 children enrolled as of September 2008

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* Children are eligible, regardless of immigration status.
[†] Currently in a transition period due to budget constraints and other issues.
[‡] DirigoChoice is available to sole proprietors and individuals and families who are employed by small businesses, regardless of immigration status. Enrollees must have resided in the state for at least 60 days.

§ Children's Medical Security Plan (CMSP) covers preventive and nonpreventive outpatient care, dental services, family planning, and prescription drugs and medical equipment. Does not cover hospitalization. Depending on income, some families pay a monthly premium for CMSP coverage, while others pay no premium. Most services require a small copayment.

¶ CMSP offers coverage for children, regardless of income or citizenship status. Families can also purchase coverage for their children in Commonwealth Choice, regardless of immigration status.

** Pennsylvania provides coverage to noncitizen children who are not otherwise eligible for Medicaid or SCHIP with state-only funds. The state does not provide coverage for undocumented immigrants.

APPENDIX: Eight States Pursuing Universal Coverage for Children, 2008 (continued)

STATE	Uninsured Children Before Expansion	Current Medicaid/SCHIP Eligibility Levels (income as % of FPL)	Expansion Programs' Eligibility Levels for Medicaid/SCHIP (income as % of FPL)	Immigrant Coverage?	Affected by August 17 Directive?	Implementation Status and Enrollment Since Expansion
Washington	70,000	250% Separate SCHIP	Apple Health for Kids — State-subsidized buy-in up to 250% — Unsubsidized buy-in above 300% (not implemented)	Yes ^{††}	Yes Plan not submitted	— Expansion to 300% of FPL and buy-in scheduled for January 2009 — 32,000 children enrolled as of April 2008
Wisconsin	98,000	300% SCHIP Medicaid expansion	BadgerCare+ — Unsubsidized buy-in above 300%	No ^{††}	Yes SCHIP state-funded between 250% and 300% of FPL	— Expansion implemented in February 2008 — 50,655 children enrolled as of August 2008
Vermont	8,000	300% Separate SCHIP	Catamount Health — State/federal-funded premium assistance and buy-in up to 300% — Unsubsidized buy-in above 300%	Yes ^{§§}	No Implemented before directive	— Expansion implemented in October 2007 — Enrollment data not available

^{††} Coverage offered to all children in the state-funded program, regardless of immigration status.

^{‡‡} Noncitizen and undocumented children are eligible only for BadgerCare+ emergency services. For more information, see "Emergency Services," BadgerCare+ Eligibility Handbook, chap. 39; available at www.emhandbooks.wi.gov/bcplus/.

^{§§} Families can purchase coverage for their children through Catamount Health, regardless of immigration status. Only U.S. citizens and permanent legal residents are eligible for subsidies.

Source: Center for Children and Families, "States Moving Forward: Child Health Coverage," Georgetown University Health Policy Institute, available at <http://ccf.georgetown.edu/index/child-health-coverage>; M. Hensley-Quinn et al., "Covering All Children: Issues and Experience in State Policy Development," National Academy for State Health Policy, April 2008, available at www.nashp.org/Files/shpbriefing_allkidsissues.pdf; and Kaiser Family Foundation, "State Coverage Initiatives for Children," available at www.kff.org/uninsured/kcmu051607oth.cfm. Enrollment estimates were provided by state representatives through email correspondence with the author in September 2008.