



National Conference *of* State Legislatures

Policy Brief

WHO'S COVERED AND WHO'S NOT?

THE STATE OF CHILDREN'S HEALTH INSURANCE:

A PRIMER FOR STATE LEGISLATORS

by Michelle Herman

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The fluctuating economy, steep increases in private health insurance premiums and health care costs, and changes to public insurance programs all contribute to rising numbers of uninsured U.S. residents.¹ But the trend for children is more positive. Despite the fact that the total number of uninsured citizens is growing, the number of uninsured children decreased from 1997 to 2004, from 10.8 million to just over 8.2 million uninsured children, respectively. Even with this improvement, over 11 percent of children lack health insurance coverage. Certain groups of children are over-represented in the uninsured population: poor (below the federal poverty level, or FPL) or near-poor (between 100 percent and 200 percent of the FPL) children, those who are Hispanic or who have a non-U.S. citizen parent, and adolescents are more likely to be uninsured.

There are many reasons why children do not have health coverage. Lower-income families bear financial concerns and stresses—such as securing employment and housing—that frequently push obtaining health insurance low on their list of priorities. Even in cases where employers offer insurance coverage, premiums often are too expensive for lower-income parents. Some groups may face language and cultural barriers. Parents may not know about public health care coverage options or eligibility guidelines. Complicated application processes and strict verification requirements also may create problems.

Because they administer Medicaid and the State Children's Health Insurance Program (SCHIP), states not only have great responsibility for insuring children, they also have significant flexibility in deciding who and what to cover. The number of uninsured children has not increased as in the total U.S. population, in part because public programs have expanded to cover them. In particular, SCHIP—a federal and state partnership launched in 1997—gave states new federal funds and flexibility in program design and administration. States used this flexibility to expand coverage and develop innovative enrollment and outreach strategies. The result was an increase in enrollment of children, with significant increases occurring among low-income children: as of 2004, SCHIP had enrolled almost 4 million children.² SCHIP has influenced Medicaid enrollment as well; Medicaid enrollment increased for children following SCHIP implementation, and SCHIP prompted simplification reforms in Medicaid enrollment and re-enrollment processes.³ This paper provides an overview of national children's health coverage, and what options states can use to cover uninsured kids.

WHY DO CHILDREN NEED HEALTH INSURANCE?

Health care experts unequivocally agree on the importance of covering children. Lack of health insurance is a substantial barrier to health care.⁴ Uninsured children have much higher health risks than do covered children. They are more likely to go without health services, may avoid or delay care when it is needed, and are less likely to receive the proper medical care for childhood illnesses such as sore throats, earaches and asthma. Children who have health insurance are more likely to have a usual place of care and reliably receive preventive and medical services. One study found that among near-poor children, 36 percent of uninsured children had an unmet medical need, compared to 9 percent of children with public insurance and 14 percent of those with private coverage.⁵ Another recent report found that almost one-third of uninsured children received no medical treatment during a one-year period between 2002 and 2003.⁶

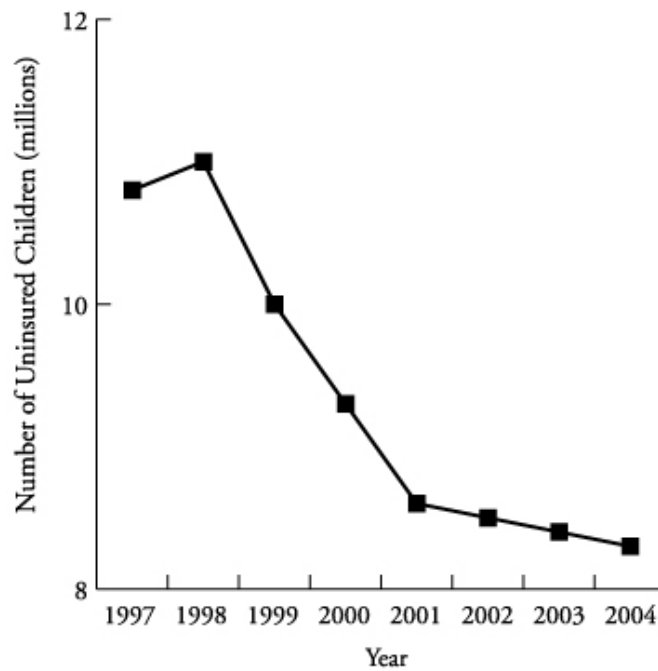
The harmful consequences of the lack of health coverage are felt in other areas as well. As Nicole Ravenell, policy and research director at the Southern Institute on Children and Families, comments, “Health insurance is part of obtaining a good quality of life. When kids get sick or have health-related needs such as glasses, they can not concentrate in school or may miss school completely. Continued illness affects school performance and, in the long-run, can affect future workforce participation. Results from a lack of health coverage are long-term.” Uninsured children face greater threats to healthy behavioral developments than do insured children, according to one study.⁷ Another study discovered that uninsured children are 25 percent more likely to miss school than insured children.⁸

Covering kids improves the health care system overall because it encourages more cost-effective service utilization and closes the gaps in health service disparities. Some studies show that covered children are more likely to seek office-based or clinic care, thus saving the higher costs that might be associated with emergency department care.⁹ Health care coverage also can reduce racial disparities. In a 2005 study, investigators compared unmet health care needs and having a usual source of care between uninsured black, white and Hispanic children before and after SCHIP enrollment. Before enrollment, white children were more likely to have a usual source of care and less likely to have unmet health care needs. After SCHIP enrollment, all three groups demonstrated improvements in access, continuity and quality of care. The preexisting disparities decreased across groups in access, unmet need and continuity of care.¹⁰

WHO’S COVERED AND WHO’S NOT?

Although the proportion of persons who are uninsured has increased in this country since 1998, the proportion of children who are uninsured slightly declined during the same period. There are 77.6 million children in the United States. As figure 1 shows, in any given year since 1997, between 8 million and 11 million children lacked health insurance.

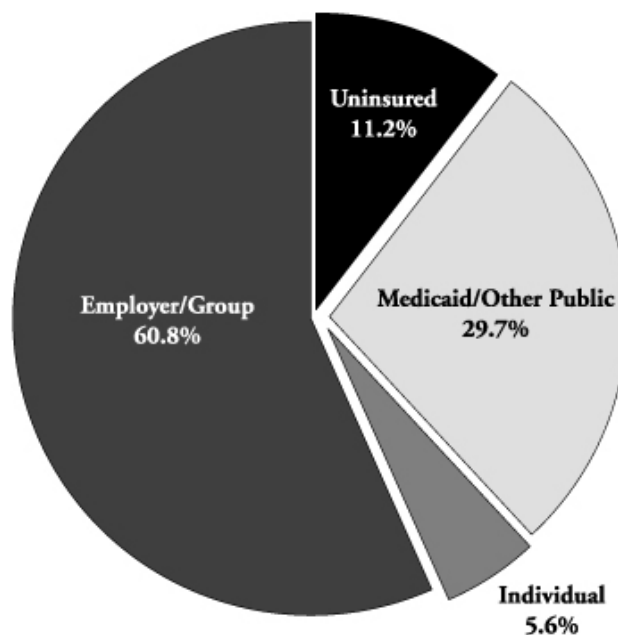
Figure 1: Number of Uninsured Children in the United States, 1997-2004



Source: U.S. Census Bureau, Current Population Survey, 2005.

The majority of children have private, employer-sponsored insurance and just over one-quarter have publicly funded coverage as shown in figure 2. According to the U.S. Census Bureau, more than 15 percent of children lacked health insurance in 1998; this decreased to 11.2 percent by 2004.

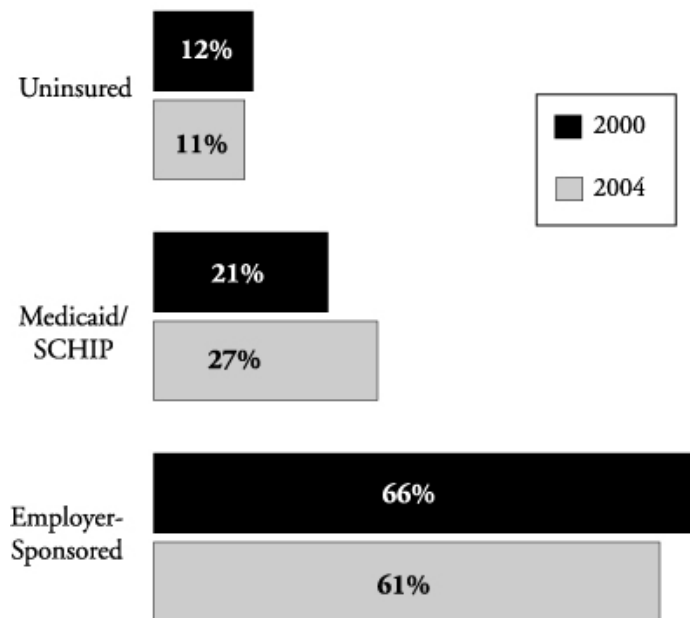
Figure 2: Type of Children's Coverage, 2004



Source: U.S. Census Bureau, Current Population Survey, 2005.

Private coverage among all children rose and then decreased between 1996 and 2002,¹¹ probably reflecting a fluctuating economy. Factors related to the decline of private coverage by employer include increasing health care costs, the rising unemployment rate and increases in the number of children living in poverty.¹² Figure 3 illustrates coverage trends in this decade. Although the rate of private insurance coverage decreased from 66 percent to 61 percent, the rate of public coverage increased. In 2003, more than 25 million children were enrolled in Medicaid and 4 million were enrolled in SCHIP.¹³

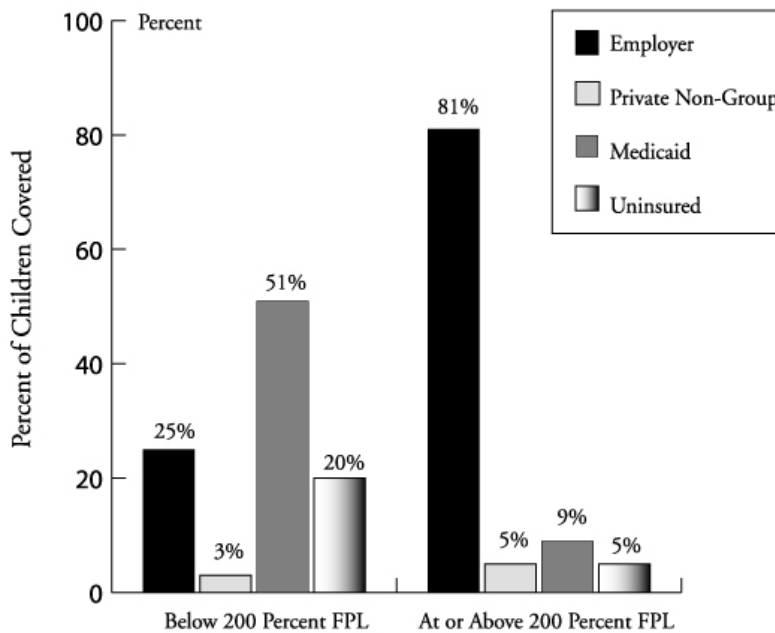
Figure 3. Changes in Rates of Type of Children's Insurance, 2000 to 2004



Source: U.S. Census Bureau, Current Population Survey, 2005.

Income plays a role in determining coverage. The higher the family income, the more likely a child will have health insurance. As figure 4 demonstrates, children whose families earn incomes under 200 percent of the FPL (\$38,700 for a family of four) are almost four times as likely to be uninsured as children whose family income is more than 200 percent of the FPL.

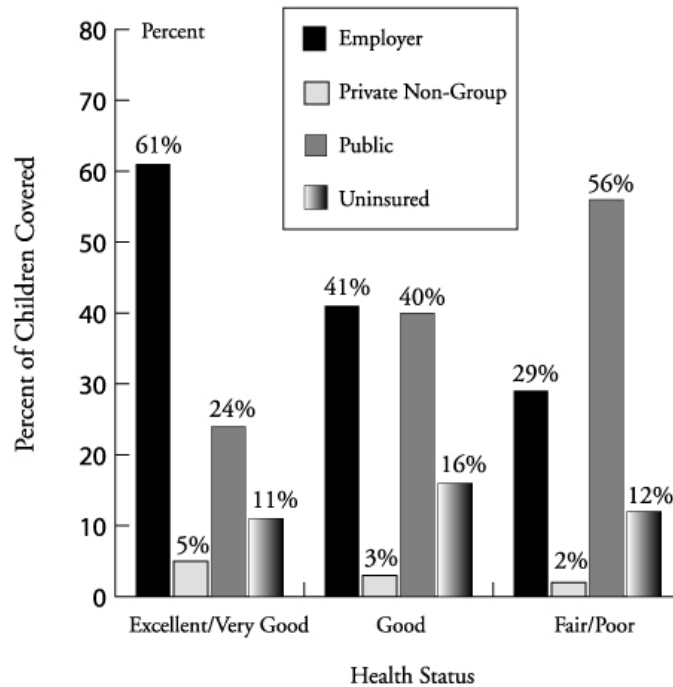
Figure 4. Health Insurance Coverage of Children by Income Level, 2003



Source: Hoffman, Carbaugh, and Cook, 2004.

As shown in figure 5, children with the lowest uninsurance rate tend to also have the best health status. Income level affects children’s health status as well as type of coverage. Children in fair or poor health are more likely to be enrolled in public programs.

Figure 5. Health Status and Insurance Coverage, 2003

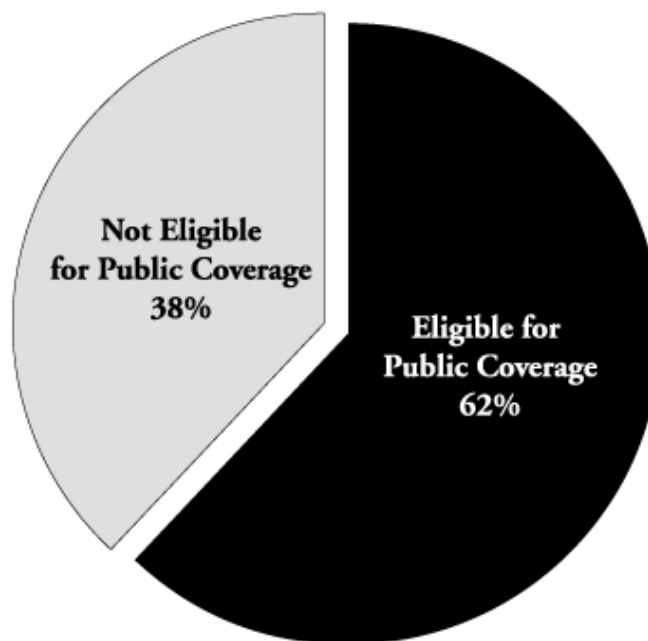


Source: Hoffman, Carbaugh, and Cook, 2004.

Policymakers have made impressive strides to improve coverage for low-income children. The 1997 SCHIP implementation was the primary factor in the 1.8 million increase in the number of insured children between 1999 and 2002.¹⁴ By 1999, all states had established SCHIP programs. Enrollment in public coverage increased from 21.4 million in 1996 to 36 million children in 2002, spurred by SCHIP implementation.¹⁵ The percent of poor and near poor children who were uninsured decreased by approximately 25 percent between 1998 and 2003.¹⁶ At the same time, the declining economy and rising health care costs made it more difficult for employers and workers to afford premiums, and the percent of poor children covered by private health insurance plans decreased from 19.5 percent to 15.6 percent during the same time period.¹⁷

Unfortunately, increased access to public coverage does not mean that all eligible children enroll and participate in public programs.¹⁸ As figure 6 illustrates, despite large increases in the number of children in public coverage, many eligible children were still not enrolled. In 2002, 62 percent of uninsured children were eligible for but were not enrolled in public coverage. Forty-five percent of this group were eligible for SCHIP while 55 percent were eligible for Medicaid.

Figure 6. Uninsured Children by Eligibility Status, 2002



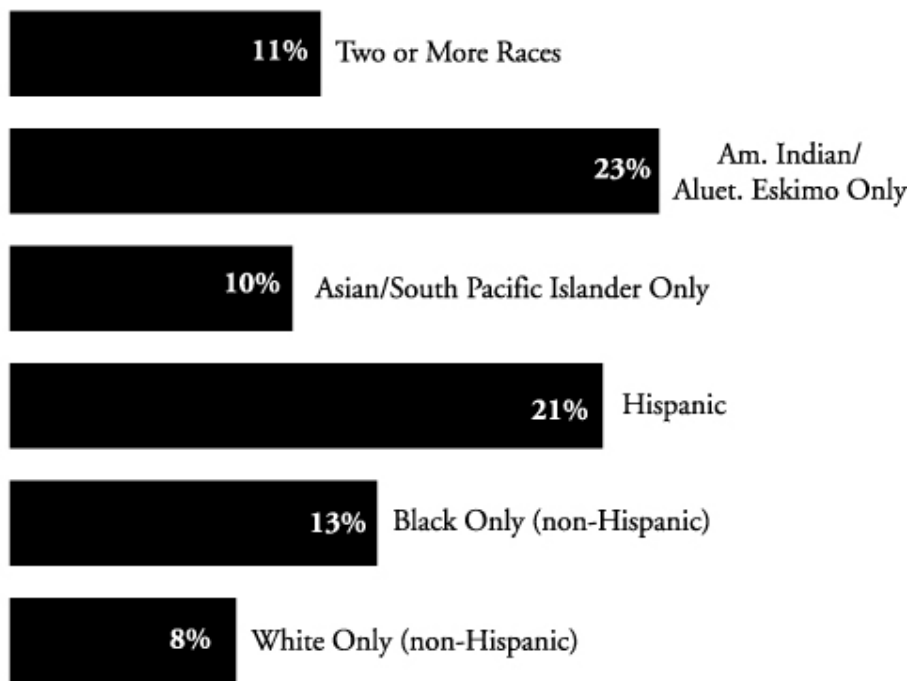
Source: Hoffman, Carbaugh, and Cook, 2004.

Several possible reasons could explain why eligible children are not enrolled in public programs. Parents may lack key information about coverage, may experience difficulties with the enrollment process or may not be able to afford the premiums. Some families may lack interest in public health insurance generally or have a negative view of the Medicaid and SCHIP application processes. Coverage status is not always stable; enrolled children may lose coverage due to changes in eligibility or complications with the renewal process,¹⁹ and it is unclear how many children are able to regain their coverage. Outreach and enrollment initiatives in the SCHIP program may not have reached some families or may have been curtailed in some states.

Immigrants to the United States are less likely to have insurance coverage. The rate of uninsured children in low-income families that have at least one non-citizen parent is 74 percent higher than that of children who have citizen parents.²⁰ Although children are more likely to be U.S. citizens than are immigrant parents, there are problems that keep them from accessing coverage. In 2002, 12.4 percent of children with citizen parents and 21.6 percent of children in mixed-status families were uninsured. Here too, the primary coverage gap lies in access to private insurance: 34.9 percent of lower-income citizen parents had employer-sponsored insurance in 2002 as compared to 22.1 percent of families with at least one immigrant parent. This reflects the lower likelihood of immigrants to hold jobs which offer health insurance coverage, and children are less likely to be uninsured when their parents are uninsured. A recent study of health insurance coverage discovered that immigration by undocumented persons was a factor in Los Angeles County's increase in uninsured residents. The authors speculated that their findings may hold true for the rest of the U.S.²¹

Race and ethnicity are closely associated with children's health insurance status. As shown in figure 7, white children are least likely to be uninsured, while Hispanic and American Indian children are most likely, at 21 percent and 23 percent, respectively. African-American children have a rate of uninsurance almost twice that of white children at 13 percent. Racial and ethnic disparities in health status and health insurance coverage persist across income lines; one study found that when comparing children across all income groups, black, Hispanic and Native American children were more likely than low-income white children to be uninsured. The same study found that white children were in better health than racial and ethnic minorities.²²

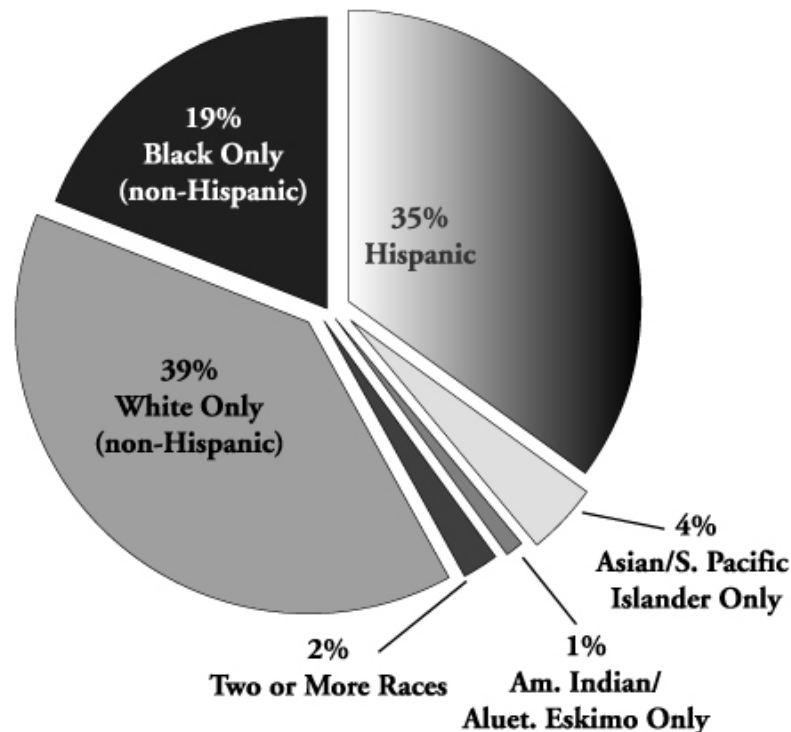
Figure 7. Uninsured Rate by Race or Ethnicity, 2004



Source: U.S. Census Bureau, Current Population Survey, 2005.

These rates of uninsurance are not proportional to shares of the total child population. Of the 77.6 million children in the United States in 2003, white children comprised almost 60 percent of the total population, but only 39 percent of the uninsured population. On the other hand, while Hispanic children comprised less than 20 percent of the total U.S. population of children, they represented 35 percent of the uninsured population—almost as large a share as white children. If this disparity persists, the number of uninsured children who are Hispanic soon will outnumber white uninsured children, despite the fact that Hispanic children represent a far smaller proportion of all U.S. children. Figure 8 illustrates the percent of children uninsured by race or ethnicity.

Figure 8. Percent of Children Uninsured by Race or Ethnicity, 2003



Source: Hoffman, Carbaugh, and Cook, 2004.

Hispanic children—including children born in the U.S. to citizen or non-citizen parents, and legal and undocumented immigrants—are more likely than white children to be uninsured. Hispanic parents are more likely than whites to work in low-wage, low-skill jobs that offer fewer benefits. As a result, a larger proportion of Hispanic families have lower incomes and lack of access to employer-sponsored coverage.²³ Additionally, due to a swell in Latin-American immigration and a higher birth rate among Hispanics during the past 25 years, the percentage of Hispanic children has doubled since 1997; Hispanics now comprise the largest U.S. minority group.²⁴ Progress in covering these children—both in Spanish-speaking citizen families and in families with one citizen and one non-citizen parent—is more likely to come from public than from private coverage. Barriers to eligibility for public programs remain. These include restrictions for non-citizens and most undocumented immigrants, language barriers, and fear of jeopardizing immigration status.

Geography also plays a part in health insurance coverage. Children have different levels of insurance coverage depending upon where they live. In 2004, children in the south and west of the United

States were about 1.5 times more likely to be uninsured than those in the Northeast and Midwest.²⁵ Although eligibility for public programs did not vary greatly across regions, employer-sponsored insurance rates and racial/ethnic and income distribution of the population did vary in ways that are correlated with uninsurance rates. Table 1 illustrates this trend: the states with the five lowest uninsured rates are located in the northern or midwestern regions of the U.S., while the states with the highest rates are in the south and west.

Table 1. States with the Lowest and Highest Rates of Uninsured Children, 2003

State	Rate of Uninsured
States with Lowest Child Uninsured Rates	
New Hampshire	5.2%
Vermont	5.5%
Rhode Island	5.6%
Minnesota	6.2%
Wisconsin	6.6%
States with Highest Child Uninsured Rates	
Texas	21.6%
Nevada	18.9%
Montana	16.4%
Florida	15.6%
Oklahoma	15.3%

Source: Hoffman, Carbaugh, and Cook, 2004.

HOW CAN STATES COVER KIDS?

Although experts concur that providing health insurance coverage for more than 8 million uninsured children is a national priority, disagreement remains about the appropriate role for public programs, private insurance, and other approaches. Many experts recommend that public programs be expanded. Others propose private insurance reform, aimed at the small business sector and the children of the working poor, since half of the uninsured are self-employed or work in firms with fewer than 25 employees. Often, states are using both approaches as they consider coverage options.

After SCHIP implementation in 1997, states made concerted efforts to expand eligibility and streamline enrollment. They invested in education, outreach and enrollment-assistance activities, and other strategies that increased participation in public programs. These efforts helped to decrease children's uninsurance rates considerably.²⁶ After 2001, state budget constraints, coupled with the higher costs of and lower access to employer-sponsored insurance, slowed progress in insuring children. As a result, states not only are pressed to cover the remaining 8 million uninsured children, but also struggle to avoid any backsliding from recent gains. While facing these challenges, states have identified several strategies that can extend coverage.

Simplifying Eligibility and Enrollment in Public Programs

Maintaining eligibility levels and investing in outreach programs are important strategies to avoid losing kids who currently are enrolled. A 2002 report from the Commonwealth Fund illustrates the importance of retaining coverage for low-income families and notes that, “if every person with private or public coverage at the beginning of a given year retained coverage throughout the next 12 months, the number of low-income children who are uninsured would decline by close to two-fifths over the course of a year.”²⁷ States have invested in simplification procedures to make application and renewal forms easier to complete and more accessible to parents. Examples include simplifying applications, eliminating asset tests, face-to-face interviews and verification requirements, and instituting presumptive eligibility and continuous eligibility.²⁸ Several states—such as California, Georgia, Pennsylvania, Texas and Washington—have electronic or online application forms or renewals.

A set of recommendations from the 100 % Campaign (a collaboration of three children’s health organizations that works to increase health coverage for California children) to California policymakers and administrators provides additional ideas for keeping children publicly covered:²⁹

- Implement a rapid renewal process, eliminate complicated forms, and require new information only if a child’s eligibility changes;
- Improve process efficiencies by coordinating renewal dates for families that have different children in each of the programs;
- Communicate effectively with families and remind them when to renew coverage; and
- Offer incentives for accessing benefits, such as premium discounts to families that obtain timely well-child care.

Developing Connection Among State Programs

The Southern Institute on Children and Families’ Eligibility Process Improvement Center helps government agencies, health care purchasers and providers identify and improve procedural problems in the eligibility determination, application and renewal processes for state-managed human services programs. Drawing from quality improvement methods that target efficiency and accuracy, the project has helped reduce unnecessary administrative processes. Changes include simplifying customer information gathering, eliminating unnecessary verification and face-to-face interview requirements, following-up with customers prior to closure or denial, and using reminders for eligibility workers and customers. Indiana extended eligibility periods for its Food Stamp and Medicaid programs and coordinated the eligibility redetermination periods for clients who are enrolled in several programs.³⁰ In Washington, each time a family completes a TANF or Food Stamp recertification, the 12-month Medicaid certification period is rolled forward in the Automated Client Eligibility System.³¹ Delaware tested a Verification Checklist to help staff to reduce over- or under-verifying of eligibility requirements for children and families that are applying for or renewing their Medicaid or SCHIP coverage.

Most states with separate SCHIP programs have joint applications for the Medicaid program and SCHIP. The federal government mandates a “screen and enroll” policy in SCHIP to connect Medicaid-eligible children to Medicaid.³² The effects of this requirement can be profound. As of October 1, 2002, Arizona had enrolled more than 100,000 children in Medicaid as a result of SCHIP applications. Kansas and North Carolina enrolled 26,913 and 71,322 children, respectively, in 2002 in Medicaid as a result of SCHIP outreach activities.



Targeting hard-to-reach groups

Targeted intervention to traditionally hard-to-reach populations can increase the proportion of insured children. A recent study in *Pediatrics* identified a “hard to reach population” of children in Colorado who were eligible for but not enrolled in SCHIP. They found that this population was more likely to be Hispanic, uninsured for a longer time, and considered to be in fair or poor health and/or have behavioral problems. The children who were easiest to enroll were more recently insured, more often had a usual source of primary care and were less likely to be Hispanic. The findings suggest that the system failed to enroll the children with the greatest need for the programs.³³ States have increasingly realized the value of working with local community groups—such as hospitals and health centers, community groups, religious organizations, schools and social service agencies—to assist with outreach programs. Local efforts can best tailor strategies to a specific community’s needs, resulting in more effective targeting. Families may be more comfortable with local community groups due to previous involvement, and their increased contact and familiarity can increase trust and their ease in enrolling children.³⁴

Expanding eligibility

With the implementation of SCHIP, states extended eligibility to groups of children who had previously been ineligible for Medicaid. States have flexibility to cover additional groups of children within Medicaid itself if they choose to, either through the Medicaid state plan or through waivers. Some populations that can benefit from eligibility expansions include children in families with higher incomes than mandatory Medicaid income requirements, children involved in state-subsidized adoptions, certain children with special needs and some children who are older than age 19. Some states, such as Wisconsin, use the Tax Equity and Financial Responsibility Act (TEFRA—or Katie Beckett) Option to expand Medicaid eligibility to children whose physical or mental illness meets requirements for institutional Medicaid but who would rather remain at home, regardless of income level. States will have additional options under recently passed reconciliation provisions, including options for children with disabilities to buy into Medicaid coverage. States can apply for Medicaid waivers, which give them permission to make further changes in their Medicaid program. (For more information about state options for expanding Medicaid eligibility, refer to *States Use of Medicaid Options for Expanding Children’s Eligibility*, listed in the reference box following this report.)

Reaching Children by Covering Parents

Decreasing the number of parents insured has implications for children as well: Parental coverage increases children’s participation in public health insurance programs. Furthermore, policies that cover individuals, as opposed to entire families, do not attend to parents’ health and psychological needs, which may create related problems for children.³⁵ Rhode Island’s RIte Care program, for example, was expanded to cover parents in 1998; by 2001, the number of children enrolled had increased by 47 percent. In comparison, when children were offered coverage only between 1995 to 1998, the number of children enrolled increased by only 10 percent.³⁶ Some states that extended public coverage to parents of enrolled children have rolled back or delayed the expansions due to budget constraints.³⁷

Examples of efforts by states to extend public coverage or strengthen private coverage are listed in Table 2.

Table 2: State Practices that Increase Coverage

<p>Illinois All Kids.³⁸ Governor Blagojevich signed a bill in November 2005 that extends health coverage to all of Illinois' uninsured children. According to the proposal, parents of uninsured children will pay a monthly income-based premium that generally will cost less than private coverage. To make the new coverage affordable, the state plans to generate savings from shifting 1.6 million beneficiaries currently enrolled in other state health insurance programs to a managed care system.</p> <p>The Santa Clara County Children's Health Initiative (CHI), California.³⁹ CHI, a coalition of community organizations, county agencies and the local Medicaid Health plan offer Healthy Kids, a new insurance program for children up to 300 percent of the FPL who are not eligible for Medicaid or SCHIP. The program also conducts a massive outreach campaign to enroll uninsured children for the public programs for which they are eligible. CHI led to an increased enrollment of almost 13,500 kids in Medicaid and SCHIP and of more than 15,600 kids in Healthy Kids in its first two years of operation.</p> <p>Rite Share, Rhode Island. Rhode Island uses Medicaid and SCHIP funds to subsidize employer-sponsored premiums for eligible workers. Rhode Island saves an average of \$178 per month for every family enrolled in its Rite Share premium assistance program as compared to its Medicaid program.⁴⁰</p> <p>Indiana. Caseworkers perform all case management activities for each case to which they are assigned, regardless of the number of programs in which the client is enrolled. The caseworker becomes knowledgeable in all phases of case management, which increases the families' knowledge of other programs for which they are eligible.⁴¹</p> <p>Nassau County, New York. New York redesigned its Community Medicaid application to make it more user-friendly. The new procedure for acceptance and review resulted in the elimination of a backlog of 7,500 applications and reduced by half the time between the date of walk-in applications and when the applications are processed.⁴²</p> <p>CoveringKids Louisiana. This initiative built a statewide outreach partnership with Wal-Mart. Employees helped disseminate Medicaid applications, brochures and posters to customers and held Wal-Mart back-to-school enrollment events. The media attention it created reached a potential audience of 1 million people.</p>

CONCLUSION

States have had great success in leveraging Medicaid and SCHIP programs to provide health care coverage for children, but recent fiscal stress has led to enrollment barriers and program cutbacks in some states. States, along with the federal government and private sector, are tasked to not only prevent backsliding of recent progress in children's coverage, but also to identify a solution to cover the remaining 8 million uninsured children. States depend heavily on federal matching funds—which cover 50 percent to 84 percent of program costs—for Medicaid and SCHIP programs. The future scope of federal support for these programs is under debate. Although in 2005, states' economies began to improve and recover from the strain of the recession in the last four years, states already have weathered significant budget cuts and cost containment strategies in recent years, and federal cuts to states could further sap their efforts to meet demands for coverage. Previous work done by states in expanding coverage will be helpful as they face these challenges.

ADDITIONAL RESOURCES

Covering Kids and Families. A Robert Wood Johnson initiative that works to reduce the number of uninsured children and adults who are eligible for but not enrolled in public health care coverage programs. <http://coveringkidsandfamilies.org>

- **Going Without: America's Uninsured Children.** A recent, extensive report from the Covering Kids and Families Initiative that documents that uninsured children in virtually every state and the District of Columbia do not receive all the medical care they need. <http://coveringkidsandfamilies.org/press/docs/2005BTSResearchReport.pdf>
- **Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP.** A 2003 report from the Covering Kids and Families Initiative that presents evidence on why it is important for states and communities to consider preserving the gains in children's health insurance coverage made during the past several years. http://coveringkidsandfamilies.org/ckf/files/maintaining_the_gains.pdf

The David and Lucile Packard Foundation. The Packard Foundation's journal *The Future of Children* provides timely, objective information based on the best available research on children's issues. Refer to the Spring 2003 issue, Health Insurance for Children. http://www.futureofchildren.org/pubs-info2825/pubs-info_show.htm?doc_id=161387

Kaiser Family Foundation. Publishes extensive information on private and public coverage, and state and national activities that address the uninsured population. www.kff.org

Mathematica Policy Research Inc. Provides various reports and briefs on health policy topics that summarize policy implications and solutions and provide recommendations for policymakers to put results into practice. <http://www.mathematica-mpr.com/health/>

Maternal and Child Health Policy Research Center. Provides extensive information and analysis of financing and service delivery issues that affect children and adolescents. <http://www.mchpolicy.org/index.html>

- **State's Use of Medicaid Options for Expanding Children's Eligibility.** <http://www.mchpolicy.org/documents/MedicaidEligibilityOptionsFactSheet.pdf>

Southern Institute on Children and Families, Eligibility Process Improvement Center. Helps customers improve the accuracy, efficiency and effectiveness of the eligibility process within public benefit programs that support lower-income children and families. <http://www.kidsouth.org/EPIC/index.asp>

Urban Institute. Provides extensive data about trends and policies that affect low-income families and the role of state and federal governments in financing and administering key programs. <http://www.urban.org>



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Notes

¹ Stephen Berman, "Mandated Child Health Insurance: An Approach Whose Time Has Come?" *Pediatrics* 111, no. 4 (April 2003): 893-895.

² Vernon Smith and David Rosseau, *SCHIP Enrollment in 50 States*. (Lansing, MI: Health Management Associates, and Washington, D.C., Kaiser Commission for Medicaid and the Uninsured, September 2005).

³ Genevieve Kenney and Debbie Chang. "The State Children's Health Insurance Program: Successes, Shortcomings and Challenges," *Health Affairs* 23, no. 5 (September/October 2004): 51-62.

⁴ Paul Chung and Mark A. Schuster, "Access and Quality in Child Health Services: Voltage Drops," *Health Affairs* 23, no. 5 (September/October 2004): 77-87.

⁵ Robin Cohen and Barbara Bloom, "Trends in Health Insurance and Access to Medical Care for Children Under Age 19 Years: United States, 1998-2003," *Advance Data from Vital and Health Statistics*, no. 355 (Hyattsville, Md: National Center for Health Statistics, 2005).

⁶ *Covering Kids and Families. Going Without: America's Uninsured Children*. (Minneapolis, Minn.: State Health Access Data Assistance Center, and Washington D.C.: The Urban Institute, August 2005).

⁷ Children's Defense Fund Minnesota, *Covering Kids Fact Sheet*, accessed June 20, 2005 at <http://www.cdf-mn.org/PDF/Facts/CKfacts.pdf>.

⁸ *Ibid.*

⁹ *Ibid.*

¹⁰ Laura Shone et al., "Reduction in Racial and Ethnic Disparities After Enrollment in the State Children's Health Insurance Program" *Pediatrics* 115, no. 6 (June 2005): e697-e705.

¹¹ Thomas Selden, Julie Hudson, and Jessica Banthin, "Tacking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs* 23, no. 5 (September/October 2004): 39-50.

¹² Catherine Hoffman, Alicia Carbaugh and Allison Cook, *Health Insurance in America: 2003 Update*. (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, November 2004).

¹³ *Enrolling Uninsured Low-Income Children in Medicaid and SCHIP: Fact Sheet*, (Washington, D.C.: Kaiser Commission for Medicaid and the Uninsured, March 2005).

¹⁴ Genevieve Kenney and Debbie Chang, "The State Health Children's Insurance Program: Successes, Shortcomings, And Challenges." *Health Affairs* 23, no. 5 (September/October 2004): 51-62.

¹⁵ Thomas Selden, Julie Hudson, and Jessica Banthin. "Tacking Changes in Eligibility and Coverage Among Children, 1996-2002."

¹⁶ Robin Cohen and Barbara Bloom, "Trends in Health Insurance and Access to Medical Care for Children Under Age 19 Years: United States, 1998-2003."

¹⁷ *Ibid.*

¹⁸ John Holahan, Lisa Dubay, and Genevieve M. Kenney. Which Children are Still Uninsured and Why? *Future of Children* 13, no. 1 (Spring 2003): 55-79.

¹⁹ *Ibid.*

²⁰ Randy Capps, Genevieve Kenney, and Michael Fix. Health Insurance Coverage of Children in Mixed-Status Immigrant Families. *Snapshots of American's Families* no. 12. (Washington, D.C.: Urban Institute, October 2003).

²¹ Dana P. Goldman, "Legal Status And Health Insurance Among Immigrants," *Health Affairs*, 24, no. 6, (November/December 2005): 1640-1653.



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- ²² Sarah Staveteig and Alyssa Wigton, *Racial and Ethnic Disparities: Key Findings from the National Survey of American's Families* (Washington, D.C.: Urban Institute, February 2000).
- ²³ John Holahan, Lisa Duaby, and Genevieve Kenney, "Which Children are Still Uninsured and Why."
- ²⁴ Peter Cunningham and James Kirby. "Children's Health Insurance Coverage: A Quarter-Century of Change," *Health Affairs* 23, no. 5 (September/October 2004): 27-38.
- ²⁵ U.S. Census Bureau, Current Population Survey, *2005 Annual Social and Economic Supplement*.
- ²⁶ Lisa Dubay, "Gains in Children's Health Insurance Coverage but Additional Progress Needed," *Pediatrics* 114, (November 2004): 1338-1349.
- ²⁷ Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low Income Families* (Washington, D.C.: The Center on Budget and Policy Priorities, December 2002).
- ²⁸ Cindy Shirk, *Tough Choices: A Policymaker's Guide to Cost Containment Actions Affecting Children in Medicaid and SCHIP* (Portland, Maine: National Academy for State Health Policy, February 2004).
- ²⁹ Kristen Testa et al, *Children Falling Through the Health Insurance Cracks: Early Observations and Promising Strategies for Keeping Low-Income Children Covered by Medi-Cal and Healthy Families*. (Oakland, Calif: The 100% Campaign, January 2003).
- ³⁰ Southern Institute on Children and Families, *The Supporting Families Story: The Movement Toward Quality Improvement*.
- ³¹ Ibid.
- ³² Cheryl Austin Casnoff The State Children's Health Insurance Program: Five Years of Progress. (Presentation at AcademyHealth, Fifth Annual Child Health Services Meeting, Nashville, Tennessee, 2003)
- ³³ Stephen Berman, "Mandated Child Health Insurance: An Approach Whose Time Has Come?" *Pediatrics* 111, no. 4 (April 2003): 893-895.
- ³⁴ Laurie E. Felland and Andrea Staiti, *Communities Play Key Role in Extending Public Health Insurance to Children, Issue Brief no. 44* (Washington, D.C.: Center for Studying Health System Change, October 2001).
- ³⁵ Lisa Dubay, "Gains in Children's Health Insurance Coverage but Additional Progress Needed."
- ³⁶ Richard E. Curtis and Edward Neuschler, "Premium Assistance," *The Future of Children* 13, no 1 (Spring 2003): 214-223.
- ³⁷ Donna Cohen Ross and Laura Cox, *Health Coverage for Children and Families: New Tensions Emerge* (Washington, D.C.: Kaiser Family Foundation, October 2005).
- ³⁸ State of Illinois, "Health Care for All Kids." <http://www.allkidscovered.com/>, accessed November 2005.
- ³⁹ Christopher Trenholm, *Expanding Coverage for Children: The Santa Clara County Children's Health Initiative* (Washington, D.C.: Mathematica Policy Research Inc., June 2004).
- ⁴⁰ Ibid.
- ⁴¹ Southern Institute on Children and Families, *The Supporting Families Story: The Movement Toward Quality Improvement* (Charleston, S.C.: Southern Institute on Children and Families, November 2003).
- ⁴² Southern Institute on Children and Families, *The Movement Toward Quality: Eligibility Process Improvement Center* (Charleston, S.C.: Southern Institute on Children and Families, 2004).

