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State Strategies and Lessons Learned in Working Toward Coverage for All Children

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Executive Summary

In the past seven to ten years, states have implemented a range of strategies to increase the number of children who have insurance coverage and access to health care – primarily through Medicaid and the State Children's Health Insurance Program (SCHIP). In recent years, state coverage efforts have intensified. In 2008, nearly 25 states considered, developed, or implemented initiatives to cover all uninsured children.[1] As a result, recent national estimates from the U.S. Census Bureau indicate that the rate of uninsured children in the United States is dropping.[2] Between 1997, the year SCHIP was created, and 2007, the percentage of uninsured children in the U.S. declined from 15 percent to 11 percent.[3]

In June and July 2008, the National Academy for State Health Policy (NASHP) conducted two-day site visits in three states – Louisiana, New Mexico, and Oregon – to learn firsthand from state leaders, program administrators, policy makers, advocates, and community groups about the history, process, strategies, and lessons learned in advancing children's coverage initiatives. These states were selected from a group of approximately a dozen states that NASHP has been working with to support their efforts trying to cover all children and adolescents. NASHP identified these three states in part because of the scope of their coverage initiatives, state leadership, stakeholder involvement, varying programs, and diverse populations. At the time of the site visits, each of the study states was in a different stage of advancing or implementing children's health coverage initiatives. None of these states have fully achieved their plan of covering all children, but their experiences are instructive for others.

While each state has a unique approach to advancing children's coverage initiatives, several key themes and strategies emerged from discussions with state leaders. These strategies provide important considerations for other states that are considering or embarking on similar initiatives.

Key Themes

States are creating innovative proposals to provide coverage for children. The study states are increasing coverage for children by building on and enhancing existing coverage programs. Two of the three are working to combine public and private insurance program options to help families access health coverage. Also in two of the three of states, children's health coverage initiatives have served as catalysts for subsequent public insurance reform proposals to cover uninsured adults as well as children.

Strong state leadership at multiple levels of government and support from outside stakeholders have been essential to advancing children's health coverage initiatives in the study states. In each of these states, the governor has made children's coverage a priority and has charged state agencies and other entities, such as state task forces, with developing a comprehensive plan to cover all uninsured children. While gubernatorial leadership was critical to coverage advancements, state leaders indicated that stakeholder leadership at the state and local level was equally critical to both developing and advancing coverage initiatives.

Outreach, enrollment, and renewal systems – and the effectiveness of those systems – played a significant role in the development of states' coverage initiatives for children. In order to support a coverage proposal, policy makers wanted assurances that the state was working to enroll eligible but unenrolled children in existing programs. To varying degrees, each of the study states has focused on strengthening outreach, enrollment, and renewal systems.

Finally, ensuring access to health care is an important part of the states' coverage initiatives. State leaders

recognize that health insurance is important, but that coverage alone isn't enough to ensure access to care and keep children healthy. State children's health initiatives include efforts to increase provider availability by raising provider reimbursement rates and finding ways to increase the number of safety-net providers, including school based health centers and federally qualified health centers.

Highlights of State Strategies and Lessons Learned

State leaders identified several key strategies as instrumental to advancing children's coverage initiatives and lessons learned as a result of these efforts. These strategies are consistent with previous NASHP reports, which found that simplified enrollment and renewal processes, agency culture, state leadership, partnerships with other state agencies and groups, and marketing were essential factors in state efforts to cover all children continuously.[4, 5] The strategies and lessons learned, many of which were shared by the three study states, include the following.

- **Identify children's coverage "champions" both inside and outside the government, at both the state and local level**. Leadership, particularly from the governor, is a critical factor in a state's ability to successfully advance children's coverage initiatives. Leadership from other key stakeholders (legislators, the state health agency administrator, SCHIP program administrator, child advocates, and families) is also essential.

- **Create opportunities for governors and other state leaders to point to their own achievements, or "wins," with regards to children's coverage**. Children's coverage initiatives are more likely to survive changes in state leadership when senior officials such as the governor are able to take credit for aspects of coverage initiatives that were achieved during their administration, such as increases in enrollment.

- **Involve key stakeholders early in the process of developing children's coverage initiatives and keep them actively engaged as proposals advance**. Partnerships with state agencies, child advocates, families, and state health organizations (such as state medical societies) are critical to both developing reform initiatives and to ensuring ongoing buy-in and support for advancing and implementing the initiatives. Additionally, state and community groups provide invaluable guidance on how to strengthen programs, such as simplified renewal procedures.

- **Frame messages about children's coverage in ways that are "sellable" with policy makers and other key stakeholders**. Messages that have been successful in the study states include: children's coverage is relatively low-cost, it is critical to supporting uninsured working families who should not be penalized for working, and it is important to children's school readiness and success.

- **Take advantage of opportunities to advance initiatives and influence policy makers and use setbacks as stepping stones for further work.** Each study state developed strategies for advancing coverage initiatives and then modified those strategies as dictated by the changing political and policy landscape. While all the states experienced political setbacks, they continue to advance their children's coverage proposals by building on previous efforts and learning from their successes and failures.

- **Be willing to modify plans and programs to build ongoing support**. In addition to changing strategies, states were willing to modify aspects of their children's coverage initiative, such as income eligibility limits, in order to advance the proposal with key constituents and within the state legislature.

- **Strengthen outreach, enrollment, and renewal efforts to ensure that eligible children are enrolled in existing programs**. States are placing significant focus and resources on improving outreach, enrollment, and renewal systems to ensure that eligible children are enrolled in public coverage programs.

- **Identify feasible and sustainable financing strategies for funding children's coverage proposals**. Proposals for how to finance coverage initiatives are as important as the plan itself. State efforts to advance children's coverage can stall or stop without a viable and sustainable funding plan.

- **Recognize the power of incremental reform**. Incremental health care reform – whether by design or necessity – can help build a strong political and policy foundation for children's coverage expansions.

- **Make children's health care coverage "untouchable" so that even in tough fiscal climates, it is protected from budget cuts and level funding**. There appears to be no specific recipe for ensuring that children's coverage initiatives are spared from budget cuts, particularly when state budgets face significant shortfalls. However, a combination of the key strategies outlined above help assure that children's coverage programs and expansions can advance and withstand funding cuts.

Background

The movement to provide health care coverage to all children and adolescents has been growing over the past seven to ten years, but has intensified more recently as states build on the success of their SCHIP programs. In 2008, nearly 25 states considered, developed, or implemented initiatives to cover all uninsured children.[6] As testament to these efforts, 2008 national estimates from the U.S. Census Bureau indicate that the rate of uninsured children in the U.S. has dropped.[7] Between 1997, the year SCHIP was created, and 2007, the percentage of uninsured children in the United States declined from 15 percent to 11 percent.[8] For children with family incomes below 200 percent of the federal poverty level (FPL), the percentage of those uninsured fell by one-third during the same time period.[9]

NASHP has long tracked and supported state efforts to expand coverage for children, with support from the David and Lucile Packard Foundation. In recent years, with additional support from the W.K. Kellogg Foundation, NASHP has been tracking, reporting on, and supporting state efforts to continuously cover all children and youth. Through these activities, NASHP identified 16 states that, as of 2008, are advancing initiatives to provide health insurance coverage to all children. These efforts are marked by at least two essential factors: a commitment by the governor to cover all children continuously, and a proposed or enacted plan to do so.

This report, a product of this ongoing work, examines efforts in three states – Louisiana, New Mexico, and Oregon – to move toward coverage for all children. It builds on the recent NASHP report *Covering All Children: Issues and Experience in State Policy Development*, which highlighted key components of state children's coverage initiatives and the most common policy challenges and state responses.[10]

In June and July 2008, NASHP conducted two-day site visits in the three study states to learn firsthand from state leaders, program administrators, policy makers, advocates, and community groups about the history, strategies, and lessons learned in advancing children's coverage initiatives. These states were selected in part because of their diversity as well as their commitment to cover all children and youth. These states are at different places in the continuum of efforts to cover all children and have varying programs and diverse populations. NASHP has highlighted other states working toward covering all children, including Illinois, Pennsylvania, and Washington, in other publications.

Each state visited is unique in its approach to children's coverage, yet several key themes and strategies emerged from the discussions in these states. These themes are highlighted in this report, along with case studies that describe the strategies used to advance state children's coverage initiatives. The strategies these states employed and the lessons learned as a result offer important considerations for other states interested in advancing similar initiatives for children's coverage, as well as some lessons relevant to broader reform.

Overview of Children's Coverage Initiatives in Louisiana, New Mexico, and Oregon

The study states are using a range of coverage options to work toward covering all children; their plans are in different stages of implementation. To date, none of these states has yet implemented a plan aimed at covering all children, but considerable progress has been made in several areas. (Case studies describing each state's children's coverage initiative begin on page 12 of this report.)

Louisiana, a state that historically had low rates of children's public insurance coverage before the passage of SCHIP, has advanced a series of coverage expansions since initial implementation of LaCHIP (the state's SCHIP program) in 1998. In 2007, a state legislative proposal to extend coverage for children with family incomes up to 300 percent of the FPL unanimously passed the state legislature. Due to federal restrictions on state coverage of children introduced by the Centers for Medicare and Medicaid Services (CMS) in a letter dated August 17, 2007,[11] Louisiana was unable to extend coverage to this eligibility level. In spite of this setback, the state recently extended coverage to 250 percent of the FPL through its new LaCHIP Affordable Plan. In addition to increasing the eligibility income limit, Louisiana has successfully enhanced its outreach, enrollment, and renewal systems, such that the state can demonstrate that 95 percent of eligible children with family income up to 200 percent of the FPL or below are now enrolled in public coverage programs.

New Mexico Gov. Bill Richardson declared 2006 the Year of the Child in his annual State of the State address, in which he outlined goals in education, safety, and health. As a result, the state developed Premium Assistance for Kids (PAK) to provide access to more affordable health insurance for all children. PAK provides state health coverage premium subsidies of approximately 50 percent for specific coverage plans for children 12 and younger and for siblings of PAK enrollees up to 18 years, with no income limit. In 2007, Richardson announced his Health Solutions New Mexico Plan, emphasizing the need for health care coverage to be more affordable, care more accessible, and the system more accountable.[12] Even within the governor's broader reform proposal, he focused on children's coverage by aiming to cover all eligible but unenrolled children, increasing the income eligibility limit for SCHIP, and phasing in a requirement that all residents, including children, have health insurance. Several health reform bills were introduced in the state House and Senate in the 2008 New Mexico legislative session, including the Governor's Plan. However, many of the highest-profile health care reform bills, including the Governor's Plan, did not pass. Despite this setback, health care reform remains a top priority, and coverage expansions, including those for children, continue to proceed in New Mexico albeit with more incremental steps rather than expansive reforms.

In 2006, Gov. Ted Kulongoski advanced the Oregon Healthy Kids Program, which would have used funds from a proposed state tobacco tax to extend the SCHIP income eligibility limit to 300 percent of the FPL for children up to age 19 and allow families with incomes above 300 percent of the FPL to buy in to the coverage. The Oregon Healthy Kids Program plan was considered well-conceived and received bipartisan support in the state legislature. As a result, it passed. However, a separate proposal to finance the plan, a tobacco tax increase, which required a three-fifth's majority in the state's legislature, failed. After its defeat in the legislature, the tobacco tax proposal went before voters in a ballot initiative, known as Measure 50, during a special election in 2007. Measure 50 was met with significant opposition from a well-financed tobacco lobby and ultimately was defeated. The lessons learned from advancing the children's coverage initiative serve as important stepping stones for a potentially more expansive health reform initiative, which is currently being advanced in Oregon. It is expected that this plan will include – and may begin with – children's coverage.

Table 1: Children's Coverage Details for Study States

	Program Type	Eligibility by age and income (% of FPL)	Cost Sharing	Continuous Eligibility	Presumptive Eligibility	Outreach and Enrollment				Renewal		
						Face to Face Interview	Asset Test	Admin. Ver. of Income	Other	Face to Face Interview	Admin. Ver. of Income	Other
LA	Medicaid expansion (LaCHIP) Separate SCHIP (LaCHIP Affordable Plan)	Implemented Infants-5yrs: 133%-200% 6-18yrs: 100%-200% Implemented Infants-18yrs: 200%-250% Enacted[1] Infants-18yrs: up to 300%	For 250-300% FPL, premiums are $50/month plus co-pays	12 months	No[2]	No	No	No	Electronic outreach, enrollment and renewal system implemented by the state Support to communities for conducting O/E efforts Applications available in public schools and other community settings	No	No	Electronic, telephone and automated voice response renewal Pre-printed reapplication forms sent 30 days before renewal date
NM	Medicaid expansion Premium Assist. For Kids (PAK)	Implemented Infants-18yrs 185%-235% Implemented Infants-12yrs (up to 18yrs if part of sibling group) Above 235%	For 185-200% FPL, $2 co-pays for Rx's. For 200-235% FPL, co-pays for specific services range from $5-$25. For 235%+ NM will pay approx. 50% of premium for select private plan	6 months	Yes	No	$10,000 limit	No		No	No	Pre-printed reapplication forms sent 45 days before renewal date
OR	Separate SCHIP	Implemented Infants-5yrs: 133%-185% 6-18 yrs: 100%-185% Enacted[3] Infants-18yrs: Up to 300%	Up to 185% FPL no cost sharing required. For 185-300% FPL, cost sharing was to be determined	6 months	No	No	No	No	Brochures available in community offices	No	No	Joint renewal form

Key Themes for Advancing Coverage for Children

States are creating innovative proposals that combine public and private insurance program options to cover uninsured children, families, and adults. In some cases, children's health coverage initiatives have served as catalysts for subsequent proposals to cover uninsured adults.

Strong state leadership – including the governor, legislators, health agency administrator, SCHIP program administrator, state child advocates, and others – has been essential to advancing children's coverage initiatives. While leadership from the governor was necessary, it also was critical to have leadership from multiple agencies and groups at the state and community level. Several characteristics of leadership emerged from discussions with state leaders and other stakeholders in the study states. These leadership characteristics included:

- A clear and well-articulated vision for children's coverage supported by a plan for implementation and a viable financing strategy.
- A focus on data-driven decision-making that helps build integrity for program expansions and enhancements.
- Ongoing education of policy makers about the program, which helps sustain a commitment to coverage initiative efforts.
- Active engagement of community stakeholders to help ensure buy-in, support, and input from community groups.
- An active and engaged advocacy community (such as state child advocacy groups) that understands the important and unique role they can play in advancing coverage initiatives overall and in close partnership with state agencies.
- Implementation of improvement strategies to help ensure that state systems – especially outreach, enrollment, and renewal – are efficient and effective.

State outreach, enrollment, and renewal systems, and the effectiveness of those systems, affect the ability of states to advance children's coverage initiatives. For proposals to advance, particularly in the state legislature, states need to assure policy makers that children who are already eligible for existing public insurance programs are being enrolled. Finally, state leaders and advocates underscored the importance of developing and supporting plans and policies that ensure children have access to health care services. They recognize that health coverage is important but cannot on its own ensure that children are healthy.

Myriad factors played a role in the study states' ability to make advances in children's coverage; an important one is state leadership that is willing to make difficult changes to a complex health care system. As previously mentioned, the governor in each of the study states made children's coverage a priority and backed it up with a plan for achieving children's coverage.

Creating Children's Coverage Champions and Political Will

How the study states were able to cultivate this leadership and political will is less clear-cut. Nonetheless, it appears to involve several key factors, including:

- A willingness on the part of the governor(s) and state legislators to make changes;
- A recognition of the importance of health care coverage to child health and well-being;
- Rising health care costs and low rates of employer-sponsored health insurance;
- Political timing whereby key "windows of opportunity" presented themselves (e.g., state and national elections); and
- A strategic decision to expand children's health coverage because it was viewed as achievable and easier to advance than more comprehensive health reforms.

State health agency administrators and SCHIP program administrators played a key role – as navigators, strategists, and publicists – in cultivating leadership in their states. Agency leaders helped promote and reinforce a culture of state leadership by:

- Continuously educating and informing key policy makers, particularly those who might champion children's coverage and its importance;
- Helping create opportunities for the governor and other leaders to point to their own achievements, or "wins," with regards to children's coverage;
- Empowering state agency staff to seek and make improvements to existing insurance coverage programs and systems; and
- Being willing to let others take credit for children's coverage advances.

Finally, the study states found effective ways to frame messages about children's coverage that were "sellable" with policy makers and other key stakeholders, particularly the general public and families. The most common messages included that children's coverage is low-cost, particularly relative to other populations (including seniors, people with disabilities); it supports uninsured working families who should not be penalized for working; and it is essential to children's school readiness and academic success. In both New Mexico and Louisiana, gubernatorial administrations have promoted children's health care coverage as an important component of the state's economic development.

Building Feasible and Sustainable Financing Strategies

Plans for financing a children's coverage initiative are as important as the initiative's coverage options. Without a feasible and sustainable financing strategy, a children's coverage proposal will likely fail in the state legislature or will not be implemented because it lacks a viable financing mechanism.

As mentioned, the Oregon Healthy Kids program was considered a well-conceived and viable children's coverage plan, and it was successfully enacted. However, the state was unable to implement the program because the financing strategy, which relied on an increased tobacco tax, failed in both the state legislature and through a voter ballot initiative. The state has since worked to diversify the financing for its current coverage initiative, which includes a focus on children's coverage options. Leaders in Oregon hope the

financing strategy can help protect aspects of its children's coverage plan from potential budget cuts in the future.

Engaging Key Stakeholders for Advancing Coverage Initiatives

Stakeholders such as child advocates, health care provider organizations, families, and other groups have been important partners in advancing children's coverage initiatives in the study states. These states engaged stakeholders early in the process of developing their children's health initiatives, and relationships were kept active in order to advance and implement the proposals.

The states used both formal and informal processes to encourage stakeholder engagement. In Oregon, the state Medicaid Advisory Committee (MAC) was charged by the governor with developing the Oregon Healthy Kids Plan of 2007. The Oregon MAC held statewide public meetings and sought input on the plan. More recent health care proposals are being developed by the Oregon State Health Fund Board, a state health care reform entity that was established by state statute in 2007 and is composed of seven citizen members with varied expertise, including consumer advocacy, finance, and labor.

In Louisiana, grassroots efforts to engage community stakeholders in advancing children's coverage were instrumental in building widespread support and educating state legislators about the initiative. Louisiana leaders found that state legislators were responsive to constituents who voiced support for children's coverage.

Developing Children's Coverage Initiatives that Extend beyond Eligibility

Outreach, enrollment, and renewal system improvements are important in these study states. Consequently, these states are putting significant resources such as funding and staff time into strengthening them. Improvements include changes to state policies (e.g., continuous eligibility, presumptive eligibility); processes for enrollment and renewal (simplified applications, administrative renewal); and infrastructure (electronic renewal systems, new roles for eligibility workers, changes to local enrollment offices).

States also are concerned about children's access to health care services; they recognize that insurance coverage is important but cannot on its own keep children healthy. Each of these states is facing significant health care provider shortages, particularly Louisiana, where Hurricanes Katrina and Rita caused providers to leave the state. To address these shortages, the study states are trying to improve provider availability. Strategies include increasing provider rate reimbursements and using state funds to increase the availability of safety net providers, including school based health centers and federally qualified health centers. For instance, in Louisiana, as the state incrementally increased the state's SCHIP income eligibility limit, the state boosted the number of school-based health centers from 25 in 1997 to 65 in 2008.

Capitalizing on Key Windows of Opportunity

The study states developed and implemented multi-pronged strategies for advancing children's coverage initiatives. Key elements included public awareness, policy maker education, grassroots engagement of stakeholders, door-to-door polling, and media relations. States then modified these strategies as needed based on the political and policy environment at the time. By being flexible, states were able to capitalize on opportunities to advance children's coverage initiatives.

Using Successes and Failures as Stepping Stones for Ongoing Work

While all three states experienced political setbacks, they continued to advance their children's coverage proposals by building on previous efforts and learning from their successes and failures. The states used what they learned to inform new strategies.

Finally, the study states worked to make children's health care coverage "untouchable" so that even in tough fiscal climates, it would be protected from budget cuts and level funding. There is no sure-fire way to ensure that children's coverage advances will withstand budget cuts, particularly when states face significant revenue shortfalls. However, a combination of the strategies outlined above can help ensure that children's coverage initiatives are spared.

Overview of Louisiana's Children's Coverage Initiative

The Louisiana State Children's Health Insurance Program, known as LaCHIP, was phased in in three stages, resulting in coverage for children in families with income up to 200 percent of the FPL by 2001. In 2007, the Louisiana Legislature unanimously voted to extend the income limit to 300 percent of the FPL. However, the Aug. 17, 2007, directive from the Centers for Medicare and Medicaid Services (CMS) led the state to limit its proposed expansion of LaCHIP to 250 percent of the FPL. In June 2008, the state rolled out its new LaCHIP Affordable Plan, which covers children in families wiht income between 200 percent and 250 percent of the FPL.

Today, the program is one of a few state programs considered by state leaders to be "untouchable" in terms of budget cuts or level funding. Nearly 95 percent of eligible low-income children are enrolled in either Medicaid or SCHIP, and nearly two-thirds of Louisiana families are served by one of these programs.

Louisiana phased in LaCHIP in three key stages. In 1998, Phase I expanded coverage to 133 percent of the FPL. In 1999, Phase II expanded coverage to 150 percent of the FPL. And in 2001, Phase III expanded coverage to 200 percent of the FPL. In 2007, the Louisiana legislature unanimously voted to extend the LaCHIP income limit to 300 percent of the FPL. However, the Aug. 17, 2007, directive from CMS[13] led the state to limit its proposed expansion of LaCHIP to 250 percent of the FPL. In June 2008, the state rolled out its new LaCHIP Affordable Plan, which covers children in families with income between 200 percent and 250 percent of the FPL. One of the last states in the country to implement SCHIP, Louisiana has made significant advances in children's coverage since the 1998 inception of LaCHIP.

LaCHIP has enjoyed bipartisan support to consistently increase its income eligibility limit over the years, even in the aftermath of Hurricanes Katrina and Rita and budget shortfalls. Today, the program is one of a few programs considered by state leaders to be "untouchable" in terms of funding. Nearly 95 percent of eligible low-income children are enrolled either in Medicaid or SCHIP, and more than half of Louisiana families are served by one of these programs. Current and former leaders in the governor's office, state legislature, state health agency, and advocacy groups attribute several factors to LaCHIP's success: the power of incremental change; leadership and ownership of the program at multiple levels of state government throughout three administrations; significant grassroots engagement with community stakeholders; a strong focus on outreach, enrollment, and renewal; and attention to data-driven decision-making.

Incremental Change Built a Solid Foundation for Program Expansions

During LaCHIP's early years, the state health care policy context was marked by policy maker concern over escalating health care costs. This was fueled by one of the country's largest expenditures of Medicaid funds under the Louisiana Disproportionate Share Program.[14] Concerns over rising health care costs led the state legislature to place a cap on Medicaid spending. Given this environment, SCHIP was not initially an easy "sell" to state policy makers. As a result, the state used a phased-in approach to SCHIP implementation, expanding children's coverage over several years.

Despite these early challenges, there were several key windows of opportunity that helped lay the groundwork for LaCHIP coverage expansions. In 1997, a small planning group was formed under the leadership of Dr. Donald Hines, a family practice physician and chair of the state's Senate Health and Welfare Committee. This group's work was essential to establishing a solid political and policy foundation for LaCHIP. Moreover, because of important education efforts by state administrators and advocates, policy makers

came to recognize that children's coverage is relatively low-cost, critical to supporting working families without health insurance who should not be penalized for working, and important to children's school readiness and success.

There also was significant initial interest from Louisiana's insurance industry in contracting with the state to serve eligible SCHIP children under existing private plans. When the state decided on a Medicaid-expansion SCHIP program that did not require premiums or co-pays, the private market became disinterested. Nonetheless, it resulted in critical early support and buy-in from the state's health insurance industry for SCHIP.

Additionally, given the state's historically low coverage rates for low-income children, family advocates – particularly for families of children with special health needs – pushed the legislature to do more for children's health care. In retrospect, the incremental implementation of LaCHIP – a necessity given the political environment in Louisiana at the time – is considered by state leaders to be a key factor in the success of both initial and subsequent program expansions and enhancements.

State Leadership Made the Difference

Once LaCHIP was established, Louisiana experienced little opposition to subsequent eligibility increases and policy enhancements. By the summer of 2000, the program had become untouchable in terms of state budget cuts. Strong bipartisan leadership in both the Governor's office and from the legislature as well as support from other state leaders at all levels of government was key to Louisiana's children's coverage initiatives.

Former Secretary of Health and Hospitals David Hood, who served under Gov. Murphy "Mike" Foster Jr.[15] beginning in 1998, is credited with advancing children's coverage during the early years of LaCHIP. Foster and Hood made children's coverage a priority, and it was considered untouchable in terms of state budget cuts, even in critical budget times. During the Foster administration, the state increased eligibility for LaCHIP to 200 percent of the FPL during a budget shortfall year. The Louisiana House proposed an amendment to the state budget that would have made a 1 percent across-the-board cut for all state agencies (except nursing homes) in order to secure funding for the SCHIP expansion. The amendment did not pass in the Senate. However, the Senate did appropriate financing from the general fund so that LaCHIP's income eligibility could be increased to 200 percent of the FPL.

LaCHIP grew to be a popular program – the most popular I've seen in my career. My role was to make expansion of Medicaid my top priority and to get out of the agency's way when it came to implementation. Once LaCHIP was established, it was untouchable in terms of budget cuts.

David Hood, former Secretary of Health and Hospitals (1998-2004)

In 2004, Kathleen Blanco[16] became the governor of Louisiana. Under her administration, children's health coverage was again made a top priority. Blanco held a health care reform summit early in her term. In 2006, Blanco and Department of Health and Hospitals Secretary Fred Cerise began looking at ways to cover all children. Those discussions included outlining a proposal to increase SCHIP coverage to 300 percent of the FPL, create a buy-in program for families above 300 percent of the FPL, and mandate health care coverage for all children. In the end, the administration made the strategic decision to continue building on the successes of its children's health program over time as a way to maintain statewide support. Blanco's

proposal to increase LaCHIP's income eligibility limit to 300 percent of the FPL passed unanimously in the state legislature.

In 2008, Bobby Jindal, DHH secretary in 1996 and 1997 prior to LaCHIP's implementation, became governor of Louisiana. Like his predecessors, Jindal made children's insurance coverage a priority. During the 2007 gubernatorial campaign, Jindal expressed support for increasing the eligibility limit to 300 percent of the FPL for LaCHIP. He provided significant state leadership in order to get federal approval to extend coverage to 250 percent of the FPL[17] and reaffirmed his support for a further increase – to 300 percent of the FPL – at a 2008 press conference. In June 2008, Jindal held a press event to celebrate the enrollment of 11,000 additional children in LaCHIP and declare his commitment to enrolling all eligible children.

In addition to gubernatorial support for LaCHIP, state legislative support has been instrumental to program expansion over the years. As noted above, the program received such widespread legislative support that HB 542, which enables coverage of children up to 300 percent of the FPL, unanimously passed the Louisiana Legislature in 2007. Strong grassroots education of legislators has been credited with fostering ongoing legislative support for the program.

> *We didn't put a firewall between SCHIP and our Medicaid program so we had to "fix" Medicaid for children. In retrospect, that has been a huge factor in our progress.*
>
> **Ruth Kennedy, Director of LaCHIP**

Finally, leadership within the LaCHIP program itself was essential to program advancements, many of which extend far beyond income eligibility increases. Hallmarks of this leadership include: a focus on data-driven decision-making; ongoing education of policy makers about the program; attention to outreach, enrollment, and renewal; active engagement of community stakeholders; and implementation of quality improvement strategies. State and community groups describe a state policy environment where they have been consistently "asked to the table" to provide guidance to LaCHIP. They most frequently cite efforts to simplify LaCHIP enrollment and renewal procedures as an area where they were actively involved in program improvements.

Outreach, Enrollment, and Renewal: Core Pillars of Coverage Expansions

Efforts to improve outreach, enrollment, and renewal for children eligible for Medicaid and LaCHIP have played a significant role in children's coverage initiatives in Louisiana. LaCHIP's outreach and enrollment program began with a relatively small investment of $500,000 in 1998. Given this level of investment, the state had to use a strong grassroots approach, relying heavily on LaCHIP/Medicaid eligibility staff to conduct outreach rather than contracting with an outside entity. Today, the LaCHIP/Medicaid Eligibility Division operates a state-administered electronic enrollment and renewal system.

In 2000, the state established an aggressive renewal effort to get children re-enrolled in LaCHIP and Medicaid. Data at the time indicated that 22 percent of children enrolled in the program were losing public health coverage because their families were not submitting their renewal forms. The state responded by educating families about the importance of health coverage, training caseworkers, and simplifying administrative renewal procedures. Among other changes, the state now uses an ex-parte renewal process for children who receive food stamps; 60 percent of renewals are now obtained through this process alone. Families can re-enroll via electronic, telephone, and automated voice response.

Because of the success of Louisiana's outreach, enrollment, and renewal efforts, the state can demonstrate that 95 percent of eligible children with family incomes at or below 200 percent of the FPL are enrolled in either Medicaid or LaCHIP. This rate has reinforced support for children's health initiatives, especially among members of the state legislature.

Ensuring Access to Care

Despite the state's success with outreach and enrollment, Louisiana, like many states, has experienced health care provider shortages and low provider participation rates in Medicaid (i.e., a 50 percent provider participation rate), causing concern among many state leaders about children's access to care. In 2007, in an attempt to get more providers to participate in Medicaid and LaCHIP, the state increased its Medicaid and LaCHIP reimbursement rates. The state adjusted its Medicaid reimbursement rates to be consistent with those of Medicare, resulting in a Medicaid reimbursement rate that is 90 percent of the Medicare rate. The state now uses Medicare rates as a reference point for Medicaid rates. State leaders believe that increasing reimbursement rates was a significant step in addressing health care access issues. Despite the rate increases, the state still is experiencing a physician shortage; the issue was compounded by Hurricanes Katrina and Rita, which caused providers to leave Louisiana.

Key Lessons Learned in Louisiana

- Recognize the power of incremental change in building a solid policy, programmatic, and political foundation for children's coverage expansions and enhancements.
- Ensure broad support at all levels of government (governor, legislators, and state agency administrators) by continuously educating and updating policy makers about the advances made through the children's health initiatives.
- Ensure that new governors can point to children's coverage "wins," such as program components or enhancements for which they can take credit.
- Make children's health care coverage "untouchable" so that even in tough fiscal climates it is protected from budget cuts and level funding.
- Recognize the ability of small investments to enable significant program changes, such as small investments in outreach and enrollment that build a solid foundation for further enhancements.
- Combine coverage increases with enhanced outreach, enrollment, and renewal strategies to ensure maximum coverage of children who are eligible for SCHIP and Medicaid.
- Engage "front-line" workers in identifying ways to improve enrollment and renewal processes.
- Identify clear and focused messages that are "sellable" with state policy makers.
- Implement strategies such as increased provider reimbursement to help ensure that enrollees are able to access care.
- Actively engage community stakeholders in developing and promoting children's coverage and attend to consumer satisfaction for its inherent value to improve program performance.

Case Study: New Mexico

Overview of New Mexico's Children's Coverage Initiative

Gov. Bill Richardson declared 2006 the "Year of the Child" in his annual State of the State address. He outlined key goals in education, safety, and health. His health care goals included:

- Covering all children 5 and younger (at the time there were an estimated 21,000 uninsured children 5 and under);
- Enrolling all of the eligible but unenrolled children; and
- Creating the Premium Assistance for Kids (PAK) program.

In October 2007, Richardson unveiled a universal health care coverage proposal for New Mexico. As part of this broader plan, the governor proposed expanding SCHIP eligibility to 300 percent of the FPL and Medicaid eligibility to 200 percent of the FPL, with the goal of enrolling all eligible but uninsured children between fiscal years FY 2009 and FY 2013. The governor's proposal also included a requirement, to be phased in over time, that state residents, including children, have health insurance.

See: NASHP Covering All Kids Webpage at www.nashp.org

Gov. Bill Richardson declared 2006 the "Year of the Child" in his annual State of the State address. He outlined key goals in education, safety, and health, noting that improvements to children's lives were an important part of the state's economic development: "A future where every child can grow up healthy, attend world-class schools, go to a good college, get a good paying job, and raise their families right here in New Mexico."[18]

At the time, the governor's health care goals included:

- Covering all children 5 and younger (at the time there were an estimated 21,000 uninsured children age 5 and under);
- Enrolling all of the eligible but unenrolled children; and
- Creating the Premium Assistance for Kids (PAK) program.

As a result of this enhanced focus on children's coverage, the state created the PAK program. The program covers uninsured children up to age 12 who are ineligible for Medicaid or SCHIP due to income, and children up to age 19 if they have an eligible sibling enrolled in the program. (Through its SCHIP program, New Mexico covers children in families with income up to 235 percent of the FPL and who have not voluntarily dropped insurance within the last six months). The PAK program has no income or asset test and is entirely state funded. There are currently three health insurance providers that offer children comprehensive coverage plans through the PAK program. The state pays half of the applicable monthly PAK plan premium for a child or adolescent enrolled in the program.

In 2007, Richardson introduced his Health Solutions New Mexico Plan, emphasizing the need for health care coverage to be more affordable, care more accessible, and the system more accountable.[19] The proposal included four major components:

- **Insurance reform:** Changes to existing insurance code, such as guaranteed issuance of policies to anyone requesting them, shortening or removing pre-existing conditions provisions, and restrictions on how insurance companies rate certain groups and individuals.
- **Phased-in health coverage participation:** Mandated health coverage for residents and mandated participation by employers with six or more employees.

- **Transition to electronic claims and records:** Electronic claims filing and medical records by providers.
- **Creation of a health coverage authority:** Establishment of a single point of accountability at the state level responsible for public program oversight, combined insurance pools, cost savings, and health care quality.

Children's health coverage was integral to the governor's 2007 broader reform proposal. The proposal included income eligibility increases for SCHIP coverage, a focus on enrolling the eligible but unenrolled, and a coverage mandate. Through this proposal and other ongoing state efforts, Richardson seeks to create a culture of coverage in New Mexico, which his administration considers important to the state's overall economic development. Although the governor's Health Solutions New Mexico Plan and other health reform bills did not pass during the 2008 legislative session, making advances in health coverage, especially for children, remains a priority. The administration is prepared to advance children's coverage incrementally by first covering all children up to age 5, then up to age 12, and finally all children and youth up to age 18.

After the NASHP site visit, Richardson called a special session of the New Mexico Legislature to address health care for children, among other issues. The legislature appropriated and the governor approved $22.5 million to insure 17,000 eligible but unenrolled children in Medicaid and SCHIP by June 2010.

> *When it comes to advancing children's coverage in a state, leaders need to have a bold vision for change and then start by putting a stake in the ground and expanding it.*
>
> **Michelle Welby, Gov. Bill Richardson's Health Policy Advisor**

Creating Opportunities for Coverage

Health care access, streamlined outreach and enrollment systems, and access to employer-sponsored coverage are hallmarks of current coverage initiatives in New Mexico's coverage initiatives. Insure New Mexico! (INM) is a bureau of the New Mexico Human Services Department's Medical Assistance Division; its goal is to address the state's high rate of uninsured residents and low rate of employer-sponsored health coverage. INM provides coverage to eligible state residents through comprehensive benefit packages that are designed to be easily accessible to those seeking coverage.

State leaders have identified the low rate of employer-sponsored insurance coverage in New Mexico as a barrier to uninsured working families trying to access health coverage. INM allows employers to offer health coverage through state programs for their employees, their dependents, and their spouses.

INM is responsible for the development and oversight of new health care initiatives in the state. Eligible New Mexico residents have access to health care coverage through one of four programs that comprise INM. These programs are:

- **New MexiKids**: No-cost or low-cost health coverage through Medicaid or SCHIP for eligible families with children from birth through age 18 with incomes up to 235 percent of the FPL.
- **State Coverage Insurance (SCI)**: A cost-sharing health insurance plan funded through a HIFA 1115 waiver for low-income adults ages 19 through 64 without health insurance with incomes up to 200 percent of the FPL.
- **Premium Assistance for Kids (PAK)**: Insurance coverage for children up to age 12, or up to age 18 with siblings under the age of 12 who are in the program, and who do not qualify for New MexiKids due to income. There is no income limit.
- **Premium Assistance for Maternity (PAM)**: State funded pregnancy-only coverage (pre- and post-

natal care, delivery, and other pregnancy-related services) for women who are uninsured but are ineligible for Medicaid due to income or whose insurance does not cover maternity care.

Enhancing Outreach, Enrollment, and Renewal Efforts

Over the past year, the Medical Assistance Division has expanded dramatically its outreach and enrollment activities to increase enrollment in INM programs. These changes were the result of enrollment data and evaluation of outreach efforts indicating that previous activities – mainly health fairs and insurance enrollment during school registration – did little to increase enrollment. The division formed a data analysis committee composed of the state's three contractor-managed care organizations (MCOs), the state primary care association, and other state agencies to gather and analyze data to determine the best approach for boosting enrollment. Based on an in-depth analysis of Census data (population, ethnicity, age, uninsured, poverty levels), the committee identified 16 of the state's 33 counties with the greatest potential for enrollment through targeted outreach efforts.

From this initial analysis, the Medical Assistance Division developed an enhanced marketing and outreach plan that includes the following activities:[20]

- Strengthening partnerships with key agencies and groups, such as the Indian Health Service, Department of Public Health, managed care organizations, and the New Mexico Primary Care Association to maximize outreach efforts and minimize duplication.
- Establishing new partnerships with groups such as the Archdiocese of Santa Fe, the Mexican Consulate, and other community organizations to assist with outreach efforts.
- Educating and certifying community brokers in INM and Medicaid programs so they can assist families with program applications and enrollment.
- Developing more accessible (multi-lingual) and professional brochures, fliers, and promotional materials.
- Promoting all INM programs, rather than just one program, at outreach events.
- Establishing targeted outreach at school events not linked to school registration, including back-to-school nights, school fairs, and open houses.
- Using school athletic events such as high school football games as promotional opportunities for outreach and enrollment.
- Purchasing print, radio, and television time for campaign advertising.
- Creating a mailing database of partner agencies, clinics, hospitals, and child care centers for mailings and communications about INM programs.
- Marketing INM products, specifically Medicaid and SCHIP, more like commercial products to broaden overall appeal of coverage to reduce the stigma of Medicaid.

In addition to enhancing outreach strategies, the division obtained funding commitments from the state's three contracted MCOs to help with marketing. Each MCO allocated funds for its own INM marketing effort. Finally, media buys resulted in additional sponsorships, including baseball game sponsorship and McDonald's tray liners.

Strengthening Renewal of Insurance Coverage

In October 2007, the Medical Assistance Division implemented its Medicaid Renew Pilot Project, an initiative designed to streamline Medicaid renewal procedures for children and families. The project processes statewide Medicaid renewals from one central office. Historically, renewals were processed by county Medicaid offices and required an application. A pre-populated renewal form replaced the application. Families can now renew coverage via e-mail, mail, fax, or phone. Families receiving cash assistance, food stamps, or

other Medicaid categories still must be recertified for public insurance through an interview process in the county Medicaid office.

As a result of the project, the state has seen a dramatic reduction in the number of days before families are recertified. Renewals that used to take 30 days now take approximately 10 days. Additionally, the renewal rate has increased from 40 percent to approximately 60 percent per month. Recently, New Mexico removed the "pilot" status of the project and increased staffing, and the state is in the process of shifting more Medicaid categories to the project.

Key Lessons Learned in New Mexico

- Advance coverage for all by taking a bold vision at the gubernatorial and legislative levels.
- Link children's insurance coverage to strategies for building economic development so that state policy makers, business leaders, and the general public recognize health care's role in creating a sound and vital state infrastructure (e.g., schools, health care coverage).
- Change the culture of bureaucratic and "siloed" systems by focusing on how public insurance programs can improve the way they do business, especially through outreach and enrollment.
- Strengthen outreach, enrollment, and renewal policies and procedures to ensure coverage of eligible children and families.
- Enhance the availability of providers, including safety net providers, to ensure access to health care services.
- Partner with state agencies, managed care organizations, and other state and community groups to maximize outreach and enrollment.
- Engage the private sector, especially managed care organizations, to assist with marketing efforts to increase enrollment in public insurance programs.
- Consider how public insurance coverage design can help improve rates of employer-sponsored insurance.

Case Study: Oregon

Overview of Oregon's Children's Coverage Initiative

In 2007, Gov. Ted Kulongoski signed a law creating the Healthy Kids Program to provide health care coverage for all of the state's 117,000 uninsured children, regardless of income. The program was considered well-conceived and generally received bipartisan support. Legislation was passed to establish a coverage program for all children. However, a separate proposal to finance the plan, known as the Healthy Kids Program Fund – which called for an 84.5 cent increase in the state's tobacco tax – was met with significant political opposition from a well-financed tobacco lobby. After the tobacco tax increase was defeated in the state legislature, the question of whether to increase the tobacco tax to fund the state's coverage program was put to voters on November 6, 2007, in a ballot initiative known as Measure 50. Although many in the state expected Measure 50 to pass, it failed by a 59 percent to 41 percent vote. Without adequate funding, the state was unable to implement the Healthy Kids Program.

Children's coverage remains a top priority in Oregon. However, the children's coverage initiative is now part of broader efforts to reform health care in the state.

Children's coverage initiatives in Oregon are part of a state commitment to health care access dating back to the late 1980s. In 1987, a decision by the Oregon Legislature to discontinue funding of soft-tissue transplants under Medicaid led to a debate over covered services under the program.[21] A work group appointed by then-Gov. Neil Goldschmidt was formed to determine the scope and financing of state health care coverage.

Among other principles, the workgroup agreed that all citizens should have access to basic health care, that society is responsible for financing health care for low-income individuals, and that funding must be explicit and economically sustainable.[22] A series of bills passed by the state legislature over several sessions established the initial framework for the Oregon Health Plan (OHP), which remains today. OHP is a public/private partnership designed to ensure coverage for all Oregonians through Medicaid reform, insurance for small businesses, and a high-risk medical insurance pool.

In 2006 Gov. Ted Kulongoski advanced the Oregon Healthy Kids Program, which would have used funds from a proposed state tobacco tax to extend SCHIP coverage to 300 percent of the FPL and allow children in families with income above 300 percent to buy in to the coverage. The Oregon Healthy Kids Program was considered well-conceived and generally received bipartisan support. As a result the Oregon Legislature passed the bill to establish a coverage program for all children. However, the proposal to finance the program, called the Healthy Kids Program Fund, was met with significant political opposition, first from state legislators and then from a well-financed tobacco lobby.

The tobacco tax-funded Healthy Kids Program Fund failed during the 2007 legislative session after a long legislative battle. The question of whether to increase the tobacco tax to fund the state's coverage program was put to voters on November 6, 2007, in a ballot initiative known as Measure 50.[23] Although many expected Measure 50 to pass, it failed by a 59 percent to 41 percent vote. The lessons learned from this children's coverage initiative effort – both its successes and failures – are considered by state leaders and advocates to be important stepping stones for Oregon's current health care reform proposal.

Engaging Stakeholders Early in Coverage Initiatives

In 2006, Kulongoski charged the state's MAC, a committee required by federal Medicaid statute, with developing recommendations for the Healthy Kids Program. The governor's vision included health coverage for all uninsured Oregon children up to age 19, comprehensive health care benefits, efforts built on existing public insurance programs, and simplified enrollment.

The MAC sought public testimony and held six public meetings across the state to gain input from consumers, providers, advocates, and other community members regarding the scope of the Healthy Kids Program. Public meetings asked participants to weigh-in on questions such as:[24]

- How far up the family income ladder should government subsidize children's coverage?
- How much can a family afford to contribute to its children's health care?
- How can the state help find, enroll, and keep children enrolled in a health plan?
- How does the state encourage more businesses to offer health care benefits for their employees' children?

Meeting participants stressed the importance of ensuring affordability of health insurance, requiring premium sharing based on family income, and conducting outreach and public education, particularly in schools and child care centers. The public meetings also helped identify problems with the original Healthy Kids Program design, including that premiums and co-pays were not affordable for families with incomes below 225 percent of the FPL and that presumptive eligibility was considered important to getting eligible children enrolled in programs. State leaders consider community and stakeholder input crucial to the program's overall design, to recommendations outlined in the plan, and to subsequent strategies that were used to advance the program during the legislative session.

Adjusting Plans and Strategies to Keep Children's Coverage Moving

While there was strong support for the Healthy Kids Program overall, key aspects of its initial design were opposed by some policy makers, including an original eligibility cap of 350 percent of the FPL, concerns about coverage of undocumented children, and the need to ensure access to care. In a compromise, the state lowered eligibility for the program to 300 percent of the FPL, did not include provisions for coverage of undocumented children, and included increased funding grants for safety-net providers (e.g., school-based health centers, federally qualified health care centers) to ensure access to services for all children.

Identifying a Viable and Sustainable Funding Source

The biggest barrier to implementing the Healthy Kids Program was funding. Prior to advancing the Healthy Kids Program, state leaders determined that a tobacco tax would be the most sustainable source of funding. At the time, this strategy seemed highly feasible. The Oregon tobacco tax was 84.5 cents less than that of the neighboring state of Washington.

Despite analyses regarding this funding strategy, the proposed tobacco tax became the downfall of the Healthy Kids Program. Well-organized and committed state advocacy groups (including state heart and lung associations, medical association, and labor groups) could not match the efforts, funding, and political tactics of the tobacco lobby. State advocacy groups contributed a total of $3 million to a campaign effort to pass the tobacco tax increase ballot initiative, compared to the $12 million spent by the tobacco lobby to thwart the increase. Additionally, the tobacco lobby spearheaded a legislative strategy to get the tobacco tax included as an amendment to the Oregon Constitution, which concerned voters. Additionally, public marketing efforts by the tobacco lobby, called "Oregonians Against the Blank Check," presented the tobacco tax as a "blank check" for funding.

Ensuring Outreach and Enrollment

As with the other states, enrollment of eligible children in existing public insurance programs is a significant issue in Oregon. Approximately 60,000 children in families with incomes at or below 185 percent of the FPL – nearly half of the estimated uninsured children in Oregon – are eligible but not enrolled in public insurance coverage. Oregon has had insufficient state funding for efforts to enroll eligible children and families in current public insurance programs.

State leaders recognize outreach and enrollment as a key issue, both for current programs and for proposed children's coverage initiatives. Kulongoski's goal is to reach and enroll all eligible but unenrolled children in existing children's coverage programs. As part of current health care reform proposals, the state has proposed providing grant funding to community organizations to conduct outreach and a $50 per child application assistance fee. Meanwhile, state child advocacy groups view outreach and enrollment as fundamental to the success of children's coverage and access to health care.

Incorporating Children's Coverage as Part of Overall Health Care Reform

The 2007 initiative aimed at covering all children has acted as a catalyst, energizing stakeholders throughout the state to support broad coverage reform. Kulongoski has expressed his commitment to covering all Oregonians, particularly children. While passage of funding for the Healthy Kids Program was not successful, the administration continues to advance health care reform, building on what was done and learned in previous coverage initiatives. Children's coverage remains a top priority in Oregon but is now part of a health care reform proposal designed to cover both children and adults.

State leaders and advocates report that the health care reform climate has changed over the past year, with an interest in targeting coverage for children and adults as part of an overall state health reform initiative. The Healthy Oregon Act (SB 329), passed in 2007, established the Oregon Health Fund Board and charged it with developing a comprehensive plan to ensure affordable, quality health care for all Oregonians. Increasing coverage for uninsured children and adults and containing costs are key goals of the proposal. This new plan was released in September 2008, and subsequent to statewide meetings to obtain the public's input, it will be presented to the state legislature during the 2009 legislative session.

Kulongoski's priorities for the 2009 legislative session include ensuring affordable health care for all children and continuing to expand enrollment for uninsured adults in the OHP.[25] The governor's 2009-11 budget will recommend financing, from both new and existing sources, to achieve his children's coverage goal. As a result of lessons learned from the Healthy Kids Program financing strategy, the governor's 2010 budget includes diversified funding to help the state reach and enroll eligible children in the state's SCHIP program.

Key Lessons Learned in Oregon

- Engage key stakeholders early in the process of developing plans to expand health care coverage.
- Identify early on key legislators and other state policy makers who will champion children's coverage expansion efforts.
- Identify a viable, sustainable, and "winnable" funding source to support health care reform.
- Consider how to embed funding for children's health coverage into state general revenue funds.
- Identify a "Plan B" for advancing children coverage expansions in the event that initial administrative and legislative strategies are unsuccessful.
- Ensure that comprehensive and effective outreach, enrollment, and renewal efforts are developed to ensure that eligible children are enrolled in existing programs.
- Provide support to safety-net providers – including local health departments and school-based health centers – to help ensure access to care for low-income children.

Conclusion

The work of Louisiana, New Mexico, and Oregon offers a snapshot of the strategies states can use to advance health insurance coverage for children. Their experiences offer important lessons for other states considering or embarking on similar initiatives.

Certain aspects of public health coverage design were crucial to state efforts, as was ensuring that children eligible for existing programs were considered in the development of initiatives aimed at covering all children. Incremental change, though defined differently by each state, was a common theme. States began initiatives with strong leadership and a plan for covering all children. However, along the way, compromises were made and changes to the original plan negotiated so that initiatives continued to advance. Through it all, states celebrated their successes and used setbacks as lessons for crafting future efforts and maintaining a focus on their goal: ensuring health care coverage for all children, all the time.

Notes

1 M. Hensley-Quinn., C. Hess, B. Ladon, and S. Steadman. *Covering All Children: Issues and Experience in State Policy Development*. (Portland, ME: National Academy for State Health Policy. April 2008.)

2 U.S. Census Bureau, Current Population Survey 1998 to 2008 Annual Social and Economic Supplements.

3 Ibid.

4 U. Ukaegbu and S. Schwartz. *Seven Steps Toward State Success in Covering Children Continuously*. (Portland, ME: National Academy for State Health Policy. October 2006.) Accessed at: http://www.nashp.org/Files/seven_steps.pdf.

5 M. Hensley-Quinn., et. al. *Covering All Children: Issues and Experience in State Policy Development*.

6 Ibid.

7 U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the U. S.: 2007, August 2008, 24.

8 U.S. Census Bureau, Current Population Survey 1998 to 2008 Annual Social and Economic Supplements.

9 Ibid.

10 A copy of this report is available at: http://www.nashp.org/Files/shpbriefing_allkidsissues.pdf.

11 For more information on CMS's August 17th letter to the states (http://www/cms.hhs/smd/downloads/SHO81707.pdf), see NASHP's State Health Policy Brief, *The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs*, April 2008.

12 Press release. Health Solutions New Mexico Plan. October 25, 2007. Accessed at: http://www.hsd.state.nm.us/pdf/newsroom/nr/Health_Solutions_NR_2007.pdf.

13 CMS's letter to state health officials dated August 17, 2007, (SHO #07-001) included new requirements related to crowd-out for states that have or were planning to increase their SCHIP program's income eligibility limit above 250 percent of the FPL. For more information on the August 17, 2007, letter to the states, see NASHP's State Health Policy Brief, *The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs*, April 2008. (http://www.nashp.org/Files/shpbriefing_cmsdirective.pdf)

14 The Louisiana Medicaid Disproportionate Share Program ranked second in the nation for highest expenditures under Medicaid in 1998. In 2001, an audit of the Office of Inspector General found more than $4 million in overpayments by the federal government to the program.

15 Republican Gov. Murphy "Mike" Foster Jr. served as Louisiana's governor from January 1996 to January 2004.

16 Democrat Gov. Kathleen Blanco served as Louisiana's governor from January 2004 to January 2008.

17 As a result of the CMS August 17, 2007 directive, Louisiana was only able to obtain federal approval to increase the income eligibility limit for LaCHIP to 250 percent of the FPL even though the state enacted an increase to 300 percent of the FPL.

18 Gov. Bill Richardson Outlines Year of the Child Agenda, Governor's Office press release, January 17, 2006. http://www.governor.state.nm.us/press/2006/jan/011706_01.pdf.

19 Press release. Health Solutions New Mexico Plan. October 25, 2007. Accessed at: http://www.hsd.state.nm.us/pdf/newsroom/nr/Health_Solutions_NR_2007.pdf.

20 Insure New Mexico! Solutions. Outreach and Enrollment Strategic Plan Summary. 2007. http://www.hsd.state.nm.us/insure.html.

21 Oregon Health Plan: An Historical Overview. Oregon Department of Human Services, Office of Medical Assistance Programs. July 2006. Accessed at: http://www.oregon.gov/DHS/healthplan/data_pubs/ohpoverview0706.pdf.

22 Ibid.

23 In Oregon, a three-fifth's majority is needed to pass a tax increase. While the Healthy Kids Program Plan passed by majority vote, the funding portion of the bill was introduced as separate legislation because of this state requirement. If Measure 50 passed, the tax would have been an amendment to the state's constitution – a change that is not uncommon in the state.

24 Healthy Kids Plan: Medicaid Advisory Committee Recommendations. Office for Oregon Health Policy and Research. May 2006. Accessed at: http://www.oregon.gov/OHPPR/MAC/docs/HealthyKidsReport.pdf.

25 Letter to the Oregon Health Fund Board. Office of Gov. Ted Kulongoski. June 10, 2008. Accessed at: http://www.oregon.gov/OHPPR/HFB/docs/Meeting_Materials_HFB/2008/Governor_Letter_to_OHFB_6.10.08.pdf.

Table Notes

1 In July 2007, Gov. Blanco signed legislation, (HB 542) that created a separate SCHIP program to cover children with family income between 200 percent and 300 percent of the FPL; however CMS approved up to 250 percent of the FPL.

2 Louisiana has legislative authority to implement presumptive eligibility, should the Department of Health and Hospitals choose to implement it.

3 Gov. Kulongoski signed the "Healthy Kids" legislation which included an increase in the state's SCHIP income eligibility limit to 300 percent of the FPL. The legislation also authorized a buy-in program for children with family income above 300 percent of the FPL. However, separate legislation that would have funded the Healthy Kids program failed in a ballot initiative vote.