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Delaware

District of Columbia

Florida

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Uninsured Children in the South
Third Edition

November 2007

Southern Institute
ON CHILDREN & FAMILIES

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Uninsured Children in the South
Third Edition

Prepared For

Henry J. Kaiser Family Foundation

Prepared By

Southern Institute on Children and Families
500 Taylor Street, Suite 202
Columbia, SC 29201
(803) 779-2607
www.thesoutherninstitute.org

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Data Work Group Members:

Arkansas	Rhonda Sanders, Director Health Legislative Affairs Arkansas Advocates for Children & Families
Florida	Nancy Ross, Consultant Children's Medical Services Florida Department of Health
Missouri	Linda Haus, Program Development Specialist Missouri Family Support Division Missouri Department of Social Services
Oklahoma	Connie Steffee, Manager Reporting and Statistics Oklahoma Health Care Authority
South Carolina	Pete Bailey, Chief Health & Demographics Statistics Section South Carolina State Budget & Control Board
Virginia	Judith Cash, Deputy Director Child Health and Virginia *Covering Kids & Families* Virginia Health Care Foundation
Washington, **DC**	Terri Thompson, Program and Policy Coordinator District of Columbia Income Maintenance Division

Policy Work Group Members:

Alabama	Cathy Caldwell, Deputy Director Alabama Children's Health Insurance Program
	Gretel Felton, Director Certification Support Division Alabama Medicaid Agency
Kentucky	Julia Costich, Chair Department of Health Services Management College of Public Health University of Kentucky
Louisiana	Ruth Kennedy, Medicaid Deputy Director, SCHIP Director Louisiana Department of Health & Hospitals
	Kyle Viator, Director of Operations Louisiana Department of Health & Hospitals
Oklahoma	Tywanda M. Cox, Policy Coordinator Oklahoma Health Care Authority
	Joanne Terlizzi, Director Policy Development Oklahoma Health Care Authority
North Carolina	Pat Garrett, Project Director *Covering Kids & Families* North Carolina Pediatric Society Foundation

In addition to the work group members, the following individuals were instrumental in obtaining state level data for this report:

Alabama	Albert Woolbright, Director Statistical Analysis Division Department of Public Health
Arkansas	Mary McGehee, Senior Research Analyst Center for Health Statistics Department of Health and Human Services
Delaware	Douglas Rich, Management Analyst Health Statistics Center Division of Public Health

Florida Helen Marshall, PRAMS Coordinator
Youjie Huang, Administrator
Bureau of Epidemiology
Chronic Disease Surveillance and Evaluation
Florida Department of Health

Georgia Hui Zhang, Epidemiologist
Maternity & Child Health Epidemiology Section
Georgia Division of Public Health

Maryland Hal Sommers, Research Statistician
Department of Health & Mental Hygiene

Missouri Venkata Garikapaty, Public Health Epidemiologist
Department of Health and Human Services

Oklahoma Alicia Lincoln, PRAMS Project Manager
Maternal and Child Health Division
Department of Health

South Carolina Mirela Dobre, PRAMS Coordinator
Division of Biostatistics
Public Health Statistics and Information Services
Department of Health and Environmental Control

Texas Cherilyn Young, PRAMS Director
Eric Miller, PRAMS Coordinator
Department of State Health Services

Virginia Michelle White, PRAMS Coordinator
Division of Injury & Violence Prevention
Department of Health

West Virginia Melissa Baker, Epidemiologist
Office of Maternal, Child and Family Health

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Uninsured Children in the South
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Executive Summary

In the area of public policy, there are few issues more compelling than the need to assure that children are not denied access to preventive and primary health care because of the inability to pay. Research has shown that public and private health insurance coverage improves children's access to primary health care (Kenney, Haley & Tebay, 2006; Kaiser Commission on Medicaid and the Uninsured, 2006; Dubay & Kenney, 2001).

It is equally important that the mothers of these children have private or public health coverage prior to and during pregnancy, as well as coverage to pay for delivery and postpartum services (March of Dimes, 2007). Coverage for the entire family is linked to better health for all family members; when parents are covered, children are also much more likely to have coverage, even when they have separate health plans (Robert Wood Johnson Foundation, 2007).

Over the past twenty years a series of public policies have been enacted to significantly expand health coverage for children in lower-income families. A major expansion in public policy occurred in 1986 when the federal law was amended to open the door for pregnant women and their infants at or below the federal poverty level to be eligible for Medicaid without having to be on welfare. Additional amendments were enacted by Congress in succeeding years to increase the age and income ranges at which children are eligible for Medicaid. In 1997, another expansion in public coverage occurred when the State Children's Health Insurance Program (SCHIP) was signed into law. Today, Medicaid and SCHIP provide coverage for approximately 60% of all children at or below the federal poverty level and about 40% of children living at or above 100% and up to 200% of the federal poverty level [1](Schwartz, Hoffman & Cook, 2007). More than four in ten births across the nation are paid for by Medicaid and in some southern states more than 50% of all deliveries are covered by Medicaid (National Governors Association Center for Best Practices, 2005).

Medicaid and SCHIP are now primary funding mechanisms for providing health coverage for poor and lower-income children and pregnant women. In order to make informed decisions about the impact of current policies on uninsured children and pregnant women and to determine future directions in coverage, states need data that help define the potential role Medicaid and SCHIP can play in further reducing the number of lower-income children and pregnant women who are without coverage.

The Southern Institute on Children and Families released its first report on ***Uninsured Children in the South*** in November 1992. The report provided estimates of uninsured children by state with age and income breakouts related to Medicaid. In 1996, the second report on ***Uninsured Children in the South*** was released. This report provided the same breakouts and

[1] 100% of the federal poverty level in 2007 is $20,650 for a family of four; 200% is $41,300, according to the Department of Health and Human Services poverty guidelines.

also the decline or increase in the number of uninsured children between 1989 and 1993. This third edition of ***Uninsured Children in the South*** is the first since the inception of SCHIP. In addition to providing state-by-state estimates of uninsured children in the southern region, this report also provides state estimates of uninsured pregnant women at the time of delivery to the extent that these data are available. Support for all three reports has been provided by the Henry J. Kaiser Family Foundation.

This report defines the southern region as the following 17 states and the District of Columbia. This report contains fact sheets showing estimates of uninsured children for each of these states as well as for the District of Columbia. Where available, estimates of uninsured pregnant women are also included on state fact sheets.

Alabama	Louisiana	South Carolina
Arkansas	Maryland	Tennessee
Delaware	Mississippi	Texas
Florida	Missouri	Virginia
Georgia	North Carolina	West Virginia
Kentucky	Oklahoma	

The source of the estimates of uninsured children is the Annual Social and Economic Supplement (ASEC) of the Current Population Survey (CPS). The source of the estimates of pregnant women is the Centers for Disease Control and Prevention (CDC)-funded Pregnancy Risk Assessment Monitoring System (PRAMS) for the ten states that had PRAMS data available. Vital statistics birth records were used when available for states that could not supply PRAMS data.

Estimates of Uninsured Children

Of the just over 9 million uninsured children up through age 18 in the United States in 2005-2006 (US Census, August 2007) a total of 4.2 million (46%) resided in the southern region. The percentage of uninsured children in the South is disproportionately high since only 38% of all children in the United States live in the 17 southern states and the District of Columbia. Analysis of the state and regional data shows the following:

- Uninsured children as a percentage of a state's population of children age 18 and younger ranged from a high of 20.5% in ***Texas*** to a low of 6.3% in ***Alabama***.

- More than 33% (1.4 million) of all uninsured children in the South live in ***Texas***.

- More than 40% of uninsured children in the southern region lived in families with incomes at or below the federal poverty level.

- Among uninsured children in the South, adolescents (ages 13-18) are more likely than younger children (ages 0-12) to be uninsured.

- The proportion of uninsured children in each age group in the southern region mirrored the national age group distribution of uninsured children.

Expansion and Program Design of Medicaid and SCHIP Programs

The State Children's Health Insurance Program (SCHIP) provides additional opportunities for uninsured children to obtain health coverage, either as a stand-alone program or as an expansion of Medicaid eligibility levels. Medicaid and SCHIP have worked together to reduce the number of lower-income uninsured children. Coverage gains have helped to increase access to health services for millions of children. However, more than 9 million children (12% of all US children) remain uninsured. The majority of uninsured children are from lower-income families and are potentially eligible for Medicaid or SCHIP, but are not enrolled.

States have significant flexibility in how they design their Medicaid and SCHIP programs and how they use their SCHIP funds. States can use their SCHIP funds to expand Medicaid, establish a separate SCHIP program, or do both under a combination approach. With the enactment of SCHIP, several southern states have taken a leading role in accessing this new funding opportunity for covering uninsured children.

The following information highlights how southern states have designed their Medicaid and SCHIP programs for children.

Expanded Eligibility Levels

As of July 2006, all but two southern states (***Oklahoma and South Carolina***)[2], covered children at or above 200% of the federal poverty level. All southern states have expanded Medicaid or SCHIP eligibility above the minimum federal requirements.

- Fifteen southern states and the District of Columbia have expanded Medicaid coverage to infants at an eligibility level above the federal minimum requirements ***(Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and West Virginia)***.

- Eight southern states and the District of Columbia have expanded Medicaid eligibility for pre-school children beyond the federal minimum requirements ***(Arkansas, Kentucky, Louisiana, Maryland, Missouri, North Carolina, Oklahoma and South Carolina)***.

- Eight southern states and the District of Columbia have expanded Medicaid eligibility for older children above the federal minimum requirements ***(Arkansas, Kentucky, Louisiana, Maryland, Missouri, Oklahoma, South Carolina and Virginia)***.

[2] In 2007, both Oklahoma and South Carolina have enacted legislation to expand public health coverage to more children. Oklahoma raised its eligibility to 300% of the federal poverty level and South Carolina raised its eligibility to 200% of the federal poverty level.

Program Design

- Ten southern states have expanded Medicaid programs and established a separate state program ***(Delaware, Florida, Georgia, Kentucky, Maryland, Mississippi, North Carolina, Texas, Virginia and West Virginia)***.

- Five southern states and the District of Columbia provide Medicaid and SCHIP coverage to children up to age 19 through an expanded Medicaid program ***(Arkansas, Louisiana, Missouri, Oklahoma and South Carolina)***.

- One southern state (***Tennessee)*** reinstated a previously eliminated health coverage program funded by SCHIP, launching a new separate SCHIP program in April 2007. The state's Medicaid program provides coverage for infants at an eligibility level greater than the mandatory federal level.

Actions States Can Take to Reduce the Number of Uninsured Children

Actions states can take to provide health coverage for children are outlined in this report. These action strategies rely heavily on Medicaid and SCHIP in recognition of the substantial financial role they play in providing coverge for children in families who cannot afford to purchase private health insurance. A federal Medicaid waiver is not required to take the following actions to reduce the number of uninsured children:

- ✓ **Design Income and Eligibility Levels to Align Medicaid and SCHIP Coverage** – Align age and income eligibility levels to eliminate the problem of children of different ages in the same family needing to enroll or re-enroll in different programs.

- ✓ **Increase Medicaid and SCHIP Eligibility Levels** – Cover children up to 200% of the federal poverty level to reduce the number of uninsured children in lower-income families.

- ✓ **Design and Implement Outreach Programs to Target Unenrolled Children Most Likely to be Eligible for Medicaid and SCHIP** – Study state-by-state data in this report to identify children most likely to be uninsured and then design and implement outreach programs to reach these target populations.

- ✓ **Expand the Use of Outstationed Eligibility Workers and Application Assisters** – Increase the number of sites where families may go to apply for public coverage to make Medicaid and SCHIP coverage more accessible and to help families complete the application process.

- ✓ **Utilize Joint Medicaid and SCHIP Renewal Applications and Forms** – Utilize joint renewal forms for Medicaid and SCHIP to simplify the renewal process for both families and eligibility workers.

- ✓ **Develop Family-Friendly Applications, Renewal Forms and Notices** – Implement continuous testing on the readability of applications, forms and notices as necessary to make sure written communication is clear to family members enrolling or re-enrolling in Medicaid and SCHIP.

- ✓ **Eliminate the Face-to-Face Interview Requirement** – Allow Medicaid and SCHIP mail-in or on-line application and renewal forms to improve access to public coverage, especially for working families.

- ✓ **Reduce Verification Requirements** – Reduce verification requirements and fully use available information from other programs to help in making eligibility determination decisions. For instance, some states are performing data matches with vital statistics to prove citizenship requirements.

- ✓ **Remove the Asset Test** – Eliminate the asset test to simplify the application and renewal process for both families and eligibility agencies. This allows families to maintain resources that they can access during times of economic need.

- ✓ **Allow Continuous Eligibility** – Allow seamless continuing coverage to enhance continuity of health care.

- ✓ **Adopt Presumptive Eligibility** – Allow families to access covered services immediately to better promote early care for medical conditions.

Conclusion

States in the southern region have made great strides in expanding Medicaid and SCHIP coverage for children and pregnant women, but leadership and action are needed to significantly reduce the number of children and pregnant women who are without health coverage. More than 4.2 million uninsured children reside in the southern region, and nationally, 12.9 million women of childbearing age are uninsured (March of Dimes, 2007). The past two years have seen a rise in uninsured rates for children in many of the southern states, reversing a trend towards reducing the number of uninsured children. Reducing the number of uninsured children and pregnant women is a major public policy priority. Providing health coverage for lower-income children and pregnant women addresses several public goals, including improving access to preventive and primary care. Coverage for pregnant women assures a healthier start in life for their children. Supporting health coverage for lower-income families in the southern region will help maximize health and well-being throughout the South.

Introduction

In the area of public policy, there are few issues more compelling than the need to assure that children are not denied access to preventive and primary health care because of the inability to pay. Lack of health coverage affects many American families, including many working families. Eight out of ten of the non-elderly uninsured live in families with at least one working adult (Fronstin, 2006), and a lack of coverage can severely strap a family's financial stability.

Research has shown that public and private health insurance coverage improves children's access to primary health care (Kenney, Haley & Tebay, 2006; Kaiser Commission on Medicaid and the Uninsured, 2006; Dubay & Kenney, 2001; Newacheck, Stoddard, Hughes & Pearl, 1998). Children without health coverage as compared to their publicly and privately insured peers are a third less likely to have a regular source of primary care, ten times more likely to miss out on some needed medical care, as well as less likely to have a preventive health visit, or in fact to receive any medical care at all in the course of a year (SHADAC & Urban Institute, 2005).

It is equally important that the mothers of these children have private or public health coverage prior to and during pregnancy, as well as coverage to pay for delivery and postpartum services (March of Dimes, 2007). In a recent study of more than 2,500 women delivering at public hospitals in 16 states, nearly 50% had no coverage immediately prior to pregnancy and 23% were not insured at the time of delivery. A common reason among these women for lack of timely prenatal care was lack of insurance (Regenstein, Cummings & Huang, 2005). In another study, uninsured pregnant women reported nearly twice the rate of unmet medical needs as compared to insured pregnant women (Bernstein, 1999).

Children's access to health coverage is tied to parental and family coverage. Coverage for the entire family is linked to better health for all family members; when parents are covered, children are much more likely to have coverage even when they are covered by different health plans than their parents (Robert Wood Johnson Foundation, 2007). As health care costs and health insurance premiums continue to spiral upward, access to employer sponsored programs continues to shrink and more families become uninsured (Zuckerman & Cook, 2006). The health of working parents can be compromised when they do not have health coverage, since health insurance promotes parents' access to care (Kaiser Commission on Medicaid and the Uninsured, 2007). Financial stability of families also is tied to whether the family has health coverage, since mounting medical bills can overwhelm family finances. In a recent survey of parents living below 200% of the federal poverty level, lower-income parents[1] who were uninsured were three times as likely to have no regular source of care than their insured counterparts; 35% postponed or did not get medical care due to inability to pay as compared to 10% of their insured counterparts; 39% said that medical bills had a major effect on their family as compared to 27% of their insured counterparts, and 36% spent less on basic needs in order to pay for health care as compared to 22% of their insured counterparts (Kaiser Commission on Medicaid and the Uninsured, 2007).

[1] Lower-income children are those children in families with incomes at or below 200% of the federal poverty level. In 2007, 200% of the federal poverty level for a family of four is equivalent to $41,300 a year.

Over the past 20 years a series of public policies have been enacted to significantly expand health coverage for children in lower-income families. A breakthrough in public policy occurred in 1986 when the federal law was amended to open the door for pregnant women and their infants at or below the federal poverty level to be eligible for Medicaid without having to be on welfare. Additional amendments were enacted by Congress in succeeding years to increase the age and income ranges at which children are eligible for Medicaid. In 1997, another major breakthrough in public coverage occurred when the State Children's Health Insurance Program (SCHIP) was signed into law. Today, Medicaid and SCHIP provide coverage for approximately 60% of all poor children and about 40% of near-poor children[2] (Schwartz, Hoffman & Cook, 2007).

Progress also has been made in covering lower-income pregnant women through Medicaid and SCHIP. Medicaid and SCHIP allow for greater access to health care services, which is a critical component to assuring healthier pregnancies and better birth outcomes. With health coverage, pregnant women are able to receive prenatal care in their first trimester, providing an opportunity for early detection of complications. Medicaid expansion programs covering women up to 200% of the federal poverty level have led to increases in the number of pregnant women receiving prenatal care in the first trimester (Association of State and Territorial Health Officials, 2003). In addition, Medicaid and SCHIP play critical roles in paying for births across the nation. Nationally, more than four in ten births are paid for by Medicaid and SCHIP (National Governors Association Center for Best Practices, 2005).

By contrast, 72% of uninsured parents do not qualify for Medicaid or SCHIP, and states have not expanded eligibility levels or simplified enrollment procedures for lower-income parents on par with children and pregnant women (Kaiser Commission on Medicaid and the Uninsured, 2007).

Medicaid and SCHIP are now primary funding mechanisms for providing health coverage for poor and lower-income children and pregnant women. Still, more than one in five poor children and 17% of near-poor children remain uninsured even though most are likely to be eligible for Medicaid or SCHIP (Schwartz, Hoffman & Cook, 2007).

Despite the gains made in expanding health coverage through these programs, the ranks of the uninsured have grown, and reauthorization and expansion of SCHIP remains a contentious issue. In order to make informed decisions about the impact of current policies on uninsured children and pregnant women and to determine future directions in coverage, states need data that help define the potential role Medicaid and SCHIP can play in further reducing the number of lower-income children and pregnant women who are without coverage.

First and Second Editions of Uninsured Children in the South

The Southern Institute on Children and Families released its first report on ***Uninsured Children in the South*** in November 1992. It was one of the first reports to provide estimates of uninsured children by state with age and income breakouts related to Medicaid. In 1996,

[2] Poor is defined as at or under 100% of the federal poverty level ($20,650 for a family of four in 2007) and near poor is over 100% up to 200% of the federal poverty level ($41,300).

the second report on ***Uninsured Children in the South*** was released. This report provided the same breakouts and also the decline or increase in the number of uninsured children between 1989 and 1993. Support for the current and two previous reports has been provided by the Henry J. Kaiser Family Foundation.

Third Edition of Uninsured Children in the South

The current report is the first since the inception of SCHIP. In addition to providing estimates of uninsured children in the southern region, this report provides some estimates of uninsured pregnant women at the time of delivery. This report also examines the policies related to Medicaid and SCHIP that are in effect in each of the southern states. As with the two previous editions, support for this report has been provided by the Henry J. Kaiser Family Foundation.

This third edition of ***Uninsured Children in the South*** first describes the Medicaid and SCHIP policies in place in the southern region for children, since these two programs are the primary avenue for insuring children who would otherwise be uninsured. The next section of the report provides estimates of uninsured children in each southern state from the following perspectives:

- Number of uninsured children in 2005-2006 with the distribution of uninsured children by age and income ranges.

- Change in the rate of uninsured children between 1999 and 2004.

This report includes estimates of uninsured children for each of the following states and the District of Columbia, which comprise the southern region as defined in this report:

Alabama	Louisiana	South Carolina
Arkansas	Maryland	Tennessee
Delaware	Mississippi	Texas
Florida	Missouri	Virginia
Georgia	North Carolina	West Virginia
Kentucky	Oklahoma	

Following is a description of Medicaid and SCHIP policies in the southern region for pregnant women, since a large proportion of births in the region, like the nation as a whole, are paid for by Medicaid and SCHIP programs. Contained in this section is a table showing eligibility levels in each southern state for pregnant women and a chart of the percentage of births paid for by Medicaid in each state in the region. Next is a discussion of actions states can take to reduce the number of children and pregnant women who do not have health coverage.

The final section of the report contains fact sheets for each of the 17 southern states and the District of Columbia. The fact sheets contain state-specific eligibility levels for Medicaid and SCHIP for children, and age and poverty level breakdowns for uninsured children in

each state. Not all states in the southern region were able to provide data on the insurance status of pregnant women. For states that supplied information on pregnant women, there also are charts showing health coverage prior to pregnancy as well as the source of payment for health care during pregnancy and at delivery.

Source of Estimates of Uninsured Children

The source of the estimates of uninsured children is the Current Population Survey (CPS). The CPS is a monthly survey conducted by the US Census Bureau; data on health insurance coverage is collected through the Annual Social and Economic Supplement (ASEC). Uninsured in this data set means the lack of any health insurance, including Medicaid or SCHIP, for an entire year. The 2007 CPS estimates are for the 2006 calendar year.

The Henry J. Kaiser Family Foundation analyzed most of the CPS figures used in this report in September 2007, aggregating 2006-2007 CPS data to ensure a large enough sample size to make stable estimates at the state level. In addition, the Southern Institute on Children and Families accessed CPS data directly, analyzed these data, and created many of the tables and all of the graphs and charts for this report.

Source of Estimates of Uninsured Pregnant Women

The source of the data estimates related to uninsured pregnant women is the Centers for Disease Control and Prevention (CDC)-funded Pregnancy Risk Assessment Monitoring System (PRAMS) for the ten states that had PRAMS data available for recent years. Data from Vital Statistics birth records were provided by two states. Further information on the methodology is provided in Appendix 1.

Medicaid and SCHIP Eligibility and Policy for Children in the Southern States

Medicaid and the State Children's Health Insurance Program (SCHIP) have worked together to reduce the number of lower-income uninsured children. SCHIP provides additional opportunities for uninsured children to obtain health coverage, either as a stand-alone program or as an expansion of Medicaid eligibility levels. Coverage gains have helped to increase access to health services for millions of children. However, more than 9 million children (12% of all US children) remain uninsured. The majority of uninsured children are from lower-income families and are potentially eligible for Medicaid or SCHIP, but are not enrolled.

Federal law requires states to cover infants and children under age 6 with family incomes up to 133% of the federal poverty level and children age 6 through age 18 with family incomes up to 100% of the federal poverty level under Medicaid (Table 1). States have the option to expand Medicaid coverage beyond these minimum levels and many have opted to do so. The SCHIP program, enacted under the Balanced Budget Act of 1997, was designed to build on Medicaid to provide insurance coverage for lower-income children who are uninsured but are not eligible for Medicaid.

Table 1 Federal Minimum Medicaid Age and Income Eligibility Levels		
Age	**Federal Poverty Level**	**Annual Income* (Family of Four)**
Age 0-5	133%	$27,464.50
Age 6-19	100%	$20,650.00

*Expressed as a percentage of the 2007 federal poverty level
Source: http://www.cms.hhs.gov/MedicaidEligibility/downloads/MedGlance05.pdf

States have significant flexibility in how they design their Medicaid and SCHIP programs and how they use their SCHIP funds. States can use their SCHIP funds to expand Medicaid, establish a separate SCHIP program, or do both under a combination approach. With the enactment of SCHIP, several southern states have taken a leading role in accessing this new funding opportunity for covering uninsured children.

The following highlights how southern states have designed their Medicaid and SCHIP programs for children:

Expanded Eligibility Levels

As of July 2006, all but two southern states (***Oklahoma and South Carolina***)[3], covered children at or above 200% of the federal poverty level. All southern states have expanded Medicaid or SCHIP eligibility above the minimum federal requirements.

- Fifteen southern states and the District of Columbia have expanded Medicaid coverage to infants at an eligibility level above the federal minimum requirements ***(Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and West Virginia)***.

- Eight southern states and the District of Columbia have expanded Medicaid eligibility for pre-school children beyond the federal minimum requirements ***(Arkansas, Kentucky, Louisiana, Maryland, Missouri, North Carolina, Oklahoma and South Carolina)***.

- Eight southern states and the District of Columbia have expanded Medicaid eligibility for older children above the federal minimum requirements ***(Arkansas, Kentucky, Louisiana, Maryland, Missouri, Oklahoma, South Carolina and Virginia)***.

[3] In 2007, both Oklahoma and South Carolina have enacted legislation to expand public health coverage to more children. Oklahoma raised its eligibility to 300% of the federal poverty level and South Carolina raised its eligibility to 200% of the federal poverty level.

Program Design

- Ten southern states have expanded Medicaid programs and established a separate state program ***(Delaware, Florida, Georgia, Kentucky, Maryland, Mississippi, North Carolina, Texas, Virginia and West Virginia)***.

- Five southern states and the District of Columbia provide Medicaid and SCHIP coverage to children through age 18 under an expanded Medicaid program ***(Arkansas, Louisiana, Missouri, Oklahoma and South Carolina)***.

- One southern state ***(Tennessee)*** reinstated a previously eliminated health coverage program funded by SCHIP, launching a new separate SCHIP program in April 2007. The state's Medicaid program provides coverage for infants at an eligibility level greater than the mandatory federal level.

Table 2 provides Medicaid and SCHIP eligibility levels in effect July 2006 in each of the southern states and the District of Columbia. The federal minimum eligibility levels are provided for comparison. The shaded areas indicate where states have exceeded federal minimum income eligibility levels for age groups. Appendix 2 shows income and family size delineations of the federal poverty level.

Table 2 Medicaid and State Children's Health Insurance Program (SCHIP) Eligibility Levels for Children in the South, July 2006				
State	**Medicaid**			**SCHIP**
	Birth-Age 1	**Ages 1-5**	**Ages 6-19**	**Ages 0-19**
Federal Minimum	**133%**	**133%**	**100%**	
Alabama	133%	133%	100%	200%
Arkansas	200%	200%	200%	
Delaware	200%	133%	100%	200%
District of Columbia	200%	200%	200%	
Florida	200%	133%	100%	200%
Georgia	200%	133%	100%	235%
Kentucky	185%	150%	150%	200%
Louisiana	200%	200%	200%	
Maryland	200%	200%	200%	300%
Mississippi	185%	133%	100%	200%
Missouri	300%	300%	300%	
North Carolina	200%	200%	100%	200%
Oklahoma	185%	185%	185%	
South Carolina	185%	150%	150%	
Tennessee	185%	133%	100%	250%
Texas	185%	133%	100%	200%
Virginia	133%	133%	133%	200%
West Virginia	150%	133%	100%	220%

Source: Cohen Ross, Cox & Marks (January 2007), updated by Southern Institute on Children and Families June 2007.

Determining Eligibility in the Enrollment Process

Simplification of the application and renewal processes in Medicaid and SCHIP benefits both eligible families and state eligibility workers. Reducing the complexity of the eligibility process can and does relieve the paperwork burden allowing eligibility staff to become part of the community's effort to help families meet basic needs (Shuptrine, 2001). In the past, the federal government has provided minimum requirements that states must perform in order to determine family or child eligibility for Medicaid or SCHIP. Many states have implemented simplification processes, but some of these are being affected by new federal requirements of the Deficit Reduction Act of 2005 (DRA). Prior to the passage of the DRA,

the only eligibility requirement for which states had to obtain documentation was the immigration status for qualified aliens (CMS, 2001). Since July 2006, states have been required to document the citizenship and identity of children, parents and pregnant women enrolling or re-enrolling in Medicaid. These new requirements do not affect those applying for or covered by a separate state program under SCHIP. However, the federal "screen and enroll" requirement that calls for states to determine applicants' eligibility for Medicaid prior to enrolling them in SCHIP adds a level of complexity in terms of separating the citizenship and identity eligibility requirements for these programs.

The new requirements are already showing effects on enrollment and re-enrollment in some states. In Louisiana, when the new requirements were rolled out in July 2006, more than 7,500 children dropped off the rolls by October 2006. Procedural closures (applicant not providing all necessary documents for processing) at renewal more than tripled from 5% to 16-17% (Cohen Ross, Cox & Marks, 2007). While Louisiana is taking steps to stem the tide of these closures to otherwise eligible families, the number of uninsured children in the state has begun to rise again after a steady decline. Virginia also has seen a decline since July 2006 in enrollment of children in the Medicaid program since the implementation of the DRA requirements. The state received 12,000 fewer applications by November 2006, and has seen steady increases in enrollment to their SCHIP program which does not have those documentation requirements (Cohen Ross, Cox & Marks, 2007). Many other states in the region have also seen increases in uninsured numbers which may in part be due to the inability to adequately address the effects of the new DRA requirements on their most vulnerable populations.

Table 3 shows the required and optional documentation for states in determining Medicaid eligibility.

Table 3

Medicaid Documentation Checklist

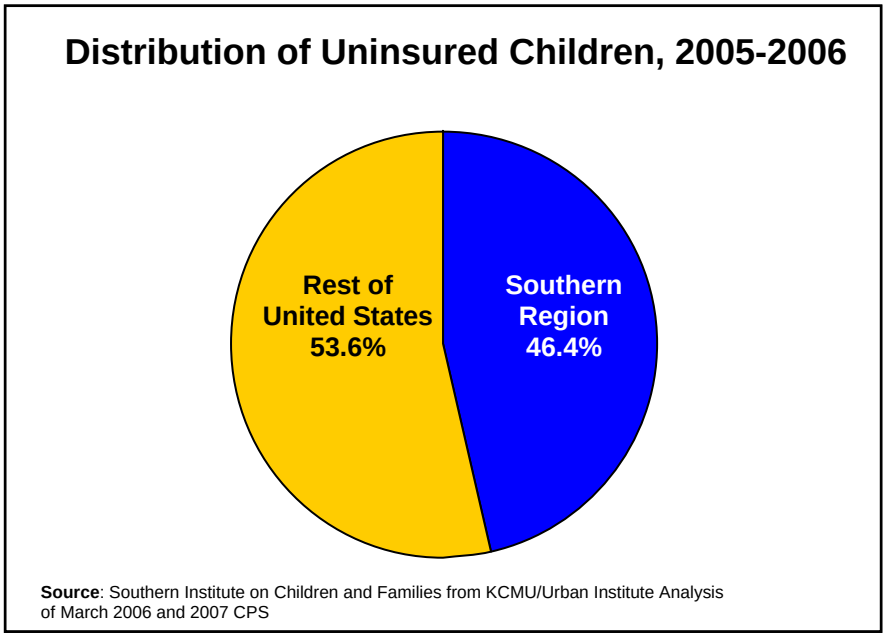
Documentation Requirements for Applicants	Federal Requirements to Provide Documentation	State Option to Allow Self-Declaration
Immigration status for qualified aliens	X	
Citizenship	X	
Identity	X	
Income		X
Resources		X
Date of birth		X
Residency		X
Social Security Number		X
Child care expenses		X

Source: Adapted using information effective as of July 1, 2006, by the Southern Institute on Children and Families from the Centers for Medicare & Medicaid Services, 2001.

Uninsured Children in the Southern States

As states have expanded eligibility for Medicaid and SCHIP and simplified application processes, the percent of lower-income uninsured children has been reduced over the last decade. These coverage gains have helped millions of lower-income children gain access to health services, but more than 9 million children remain uninsured (Kaiser Commission on Medicaid and the Uninsured, 2007), including more than 4 million in the South (Chart 1). Southern children account for 46% of the nation's uninsured children, but represent only 38% of all children in the United States.

Chart 1



Uninsured Children as a Percentage of the State Population Age 18 and Younger

Table 4 ranks the southern states by the uninsured rate for children age 18 and younger using 2005 and 2006 data. The uninsurance rate for children ranges from a high of 20.5% in ***Texas*** to a low of 6.3% in ***Alabama,*** with the average for the region being 14.1%. About 1.4 million uninsured children (33% of all uninsured children in the South) live in ***Texas***. Nine southern states and the District of Columbia have uninsured rates below the national average of 11.6% (***Alabama, Arkansas, Kentucky, Maryland, Missouri, South Carolina, Tennessee, Virginia and West Virginia)***.

Table 4 Ranking by Percentage of Southern States' Uninsured Population Age 18 and Younger, 2005-2006		
State	**Percentage of Uninsured Children**	**Number of Uninsured Children**
Texas	20.5%	1,405,819
Florida	19.1%	816,979
Mississippi	15.6%	127,822
North Carolina	13.2%	305,690
Louisiana	12.9%	145,259
Georgia	12.4%	313,465
Oklahoma	12.2%	113,735
Delaware	12.0%	25,666
Arkansas	11.0%	78,845
South Carolina	10.7%	115,115
Virginia	9.6%	185,020
Maryland	9.0%	131,086
Missouri	8.7%	127,484
Kentucky	8.6%	90,496
West Virginia	8.3%	34,451
Tennessee	8.0%	121,456
District of Columbia	7.8%	9,221
Alabama	6.3%	72,886
Southern Region	**14.1%**	**4,220,498**
United States	**11.6%**	**9,088,652**

Source: KCMU/Urban Institute analysis of March 2006 and March 2007 CPS.

Uninsured Children by Age and Income Levels

In the southern region, as in the rest of the United States, the majority of uninsured children are of school age (Table 5). In eight states, children age 13-18 account for 40% or more of uninsured children. Medicaid eligibility levels are most generous for infants in all states. Six- to 18-year-olds are only required to be covered if their families' incomes are up to 100% of the federal poverty level ($20,650 for a family of four); although some states have expanded coverage up to 200% of the federal poverty level for children in all age groups.

Table 5					
Distribution of Uninsured Children in the Southern Region by Age, 2005-2006					
State	**< 1 Year old**	**Ages 1-5**	**Ages 6-12**	**Ages 13-18**	**Total Number of Uninsured Children**
Alabama	4.9%	28.9%	22.0%	44.2%	72,886
Arkansas	8.2%	15.8%	31.6%	44.4%	78,845
Delaware	7.7%	27.6%	31.7%	33.1%	25,666
District of Columbia	6.5%	23.2%	22.0%	48.4%	9,221
Florida	7.0%	24.6%	34.7%	33.7%	816,979
Georgia	4.5%	27.4%	31.4%	36.7%	313,465
Kentucky	8.8%	22.7%	28.4%	40.2%	90,496
Louisiana	5.3%	21.2%	36.3%	37.1%	145,259
Maryland	7.4%	24.7%	29.6%	38.4%	131,086
Mississippi	5.1%	17.7%	32.2%	45.0%	127,822
Missouri	8.1%	22.0%	26.0%	44.0%	127,484
North Carolina	5.1%	21.2%	35.7%	38.0%	305,690
Oklahoma	7.7%	20.6%	30.3%	41.4%	113,735
South Carolina	7.7%	25.9%	30.8%	35.7%	115,115
Tennessee	5.0%	20.2%	37.7%	37.1%	121,456
Texas	6.4%	25.1%	32.7%	35.8%	1,405,819
Virginia	5.2%	28.1%	26.8%	39.9%	185,020
West Virginia	6.2%	12.1%	30.9%	50.8%	34,451
Southern Region	**6.3%**	**24.1%**	**32.4%**	**37.2%**	**4,220,498**
United States	**6.2%**	**23.0%**	**32.2%**	**38.5%**	**9,088,652**

Source: KCMU/Urban Institute analysis of March 2006 and March 2007 CPS.

Table 6 shows the distribution of uninsured children by family income. In all southern states about one-third or more of uninsured children lived in families with incomes at or below the federal poverty level. Since most southern states cover children in families up to 200% of the federal poverty level through Medicaid or SCHIP, many of these children are eligible for coverage but are not enrolled. The large share of uninsured children living in families with incomes below poverty suggests that families lack information about the potential eligibility of their children or have problems accessing and completing the Medicaid and SCHIP enrollment processes. Efforts to enroll children need to be directed to the states' poorest

citizens and Medicaid outreach needs to be on par with SCHIP outreach in states with separate programs.

Table 6

Distribution of Uninsured Children in the Southern Region by Family Income as Related to the Federal Poverty Guidelines, 2005-2006

State	Total Number of Uninsured Children	Under 100% FPL	100%-199% FPL	200% + FPL
Alabama	72,886	63.8%	18.6%	17.6%
Arkansas	78,845	47.0%	28.0%	25.0%
Delaware	25,666	32.2%	33.6%	34.2%
District of Columbia	9,221	48.6%	24.4%	27.0%
Florida	816,979	40.6%	30.7%	28.7%
Georgia	313,465	46.2%	28.5%	25.3%
Kentucky	90,496	41.1%	31.5%	27.3%
Louisiana	145,259	51.8%	17.2%	31.0%
Maryland	131,086	43.9%	28.0%	28.1%
Mississippi	127,822	60.6%	26.3%	13.1%
Missouri	127,484	45.6%	28.8%	25.6%
North Carolina	305,690	37.9%	30.9%	31.2%
Oklahoma	113,735	44.4%	26.4%	29.2%
South Carolina	115,115	33.2%	31.7%	35.1%
Tennessee	121,456	42.2%	31.8%	26.0%
Texas	1,405,819	42.2%	32.6%	25.2%
Virginia	185,020	37.9%	32.3%	29.8%
West Virginia	34,451	34.6%	20.5%	45.0%
Southern Region	**4,220,498**	**42.9%**	**30.1%**	**27.0%**
United States	**9,088,652**	**41.6%**	**28.6%**	**29.7%**

Source: KCMU/Urban Institute analysis of March 2006 and March 2007 CPS.

Change in Number of Uninsured Children from 1999 to 2006

Nationwide, there was a significant drop in the proportion of uninsured children (-1.5%) between 1999 and 2004. The number of uninsured children in the southern region declined slightly, but that decline was not statistically significant for most of the individual states. Among those states showing a significant difference[4] in rates over time, the most dramatic decrease in uninsured children occurred in **Louisiana,** which achieved a reduction of more than 15% in the proportion of uninsured children through several actions that simplified their processes and expanded eligibility. **South Carolina** also saw a reduction of greater than 9%. By contrast, two states, **Delaware** and **Missouri,** had a significant increase in the percentage of uninsured children over this time period.

However, by 2006 many of these gains in coverage had eroded. From 2004 to 2006, there was a statistically significant increase in the uninsured rate for children in the US Some of the recent increase in the uninsured rate for children is likely due to the stringent documentation requirements included in the DRA. Of the five southern states (FL, LA, MS, NC, VA) with statistically significant changes in their uninsured rates among children from 2004 to 2006, all experienced increases in the percentage of children who were uninsured over that period.[5]

[4] Statistically significant difference is at the 95% confidence level.
[5] Statistically significant difference is at the 90% confidence level.

Table 7			
Trends in Uninsured Children in the Southern Region, 1999-2004			
State	**Percent of Children who were Uninsured 1999**	**Percent of Children who were Uninsured 2004**	**Percentage Point Change in Uninsured 1999-2004**
Alabama	10.4%	7.4%	-2.9%
Arkansas	12.8%	7.6%	-5.1%
Delaware	7.0%	12.8%	5.8%*
District of Columbia	14.8%	7.8%	-7.0%
Florida	17.0%	15.9%	-1.1%
Georgia	11.7%	12.4%	0.7%
Kentucky	11.5%	8.4%	-3.1%
Louisiana	23.8%	8.2%	-15.6%*
Maryland	9.4%	9.8%	0.4%
Mississippi	14.1%	14.4%	0.2%
Missouri	3.6%	8.7%	5.1%*
North Carolina	12.2%	11.4%	-0.8%
Oklahoma	16.9%	17.9%	1.0%
South Carolina	17.4%	8.1%	-9.3%*
Tennessee	8.9%	10.4%	1.5%
Texas	23.4%	21.8%	-1.6%
Virginia	12.7%	9.0%	-3.7%
West Virginia	11.5%	9.2%	-2.4%
Southern Region	**15.3%**	**13.7%**	**-1.6%**
United States	**13.1%**	**11.6%**	**-1.5%***

* Difference is statistically significant at 95%; no significance testing was conducted on the combined data for all southern states.
Note: Due to changes in CPS methodology, data from this table cannot be compared with the data for 2005-2006 that is reported in other sections of this paper. Children are all individuals under 19 years old.

Source: KCMU/Urban Institute analysis of 2000 and 2005 CPS.

Uninsured Children within Medicaid/SCHIP Age and Income Eligibility Levels Who Are Not Covered

There is considerable potential for states to use Medicaid and SCHIP to reduce the number of uninsured children. It is essential to recognize that many eligible children are still not covered by these public programs. For example, across the region, 43% of uninsured children are in families that live in poverty yet are not covered by Medicaid or SCHIP. While income is not the sole criteria for eligibility, it is highly likely that the majority of these children are eligible but not enrolled. While we have seen states significantly simplify eligibility procedures, there are still problems in reaching and retaining eligible children in the Medicaid and SCHIP program. Lack of information about the availability of Medicaid and SCHIP coverage, eligibility policy and procedural barriers that impede access and other factors affect the ability of many lower-income families to gain Medicaid or SCHIP coverage for their children.

Medicaid and SCHIP Eligibility and Policy for Pregnant Women in the Southern States

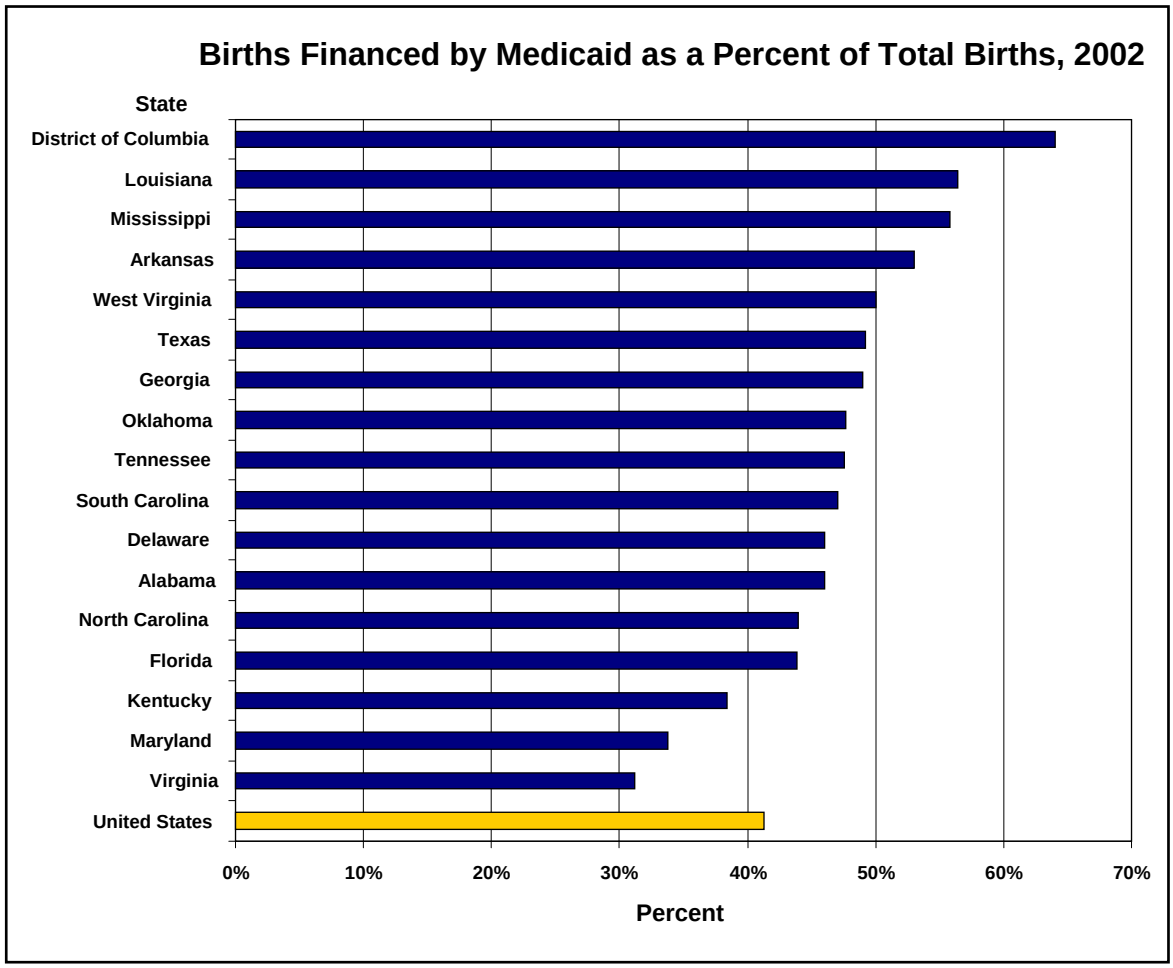
The health status of children is linked to the health status of their mothers prior to and during pregnancy. A large number of lower-income women have no health care coverage prior to pregnancy. That means many lower-income women may not be accessing health care prior to their pregnancies. Preconception care helps women manage pre-existing conditions and practice positive health behaviors that would lead to better pregnancy outcomes. Women's poor pre-pregnancy health is a risk factor for poor birth outcomes (Haas, Meneses & McCormick, 1999), which in turn often leads to long-lasting health problems for the children they bear.

The number of uninsured women of childbearing age has continued to rise from 12.1 million in 2002 to 12.9 million in 2005 (March of Dimes, 2007). These statistics are particularly alarming because studies have found that uninsured women receive fewer prenatal services and that health insurance coverage is essential to ensure that pregnant women have access to the medical care they need (Institute of Medicine, 2001; Regenstein, Cummings & Huang, 2005). In 2004 and 2005, several states (Mississippi, Alabama, North Carolina, Tennessee, Louisiana and South Carolina) in the southern region have seen a rise in infant mortality rates that had long been declining. Experts believe these increases are related to pre-existing health problems of lower-income mothers, as well as to cut-backs in public coverage for many lower-income women (Eckholm, 2007).

Federal law now requires that Medicaid cover eligible women with household incomes at or below 133% ($27,464.50 for a family of four) of the federal poverty level during their pregnancies and for 60 days postpartum. As such, Medicaid covers medical expenses for more than 40% of all US births to lower-income pregnant women, and an even larger percentage of births in most of the southern region. As states have emerged from their budget crises of the past few years, many states have expanded eligibility levels and enrollment policies for maternal and child health (MCH) populations (National Governors Association Center for Best Practices, 2005). Chart 2 shows the percentage of births in the

southern region that was financed by Medicaid in 2002, ranging from 31% to 64%. The US average for Medicaid-financed births was 41%; the District of Columbia and 13 states in the southern region exceeded the national average for Medicaid-financed births. Refer to Appendix 5 for the supporting data table on births financed by Medicaid in the southern region.

Chart 2



Source: Kaiser Family Foundation, 2006. http://www.statehealthfacts.org

Many states have extended program eligibility levels beyond federally mandated requirements, implemented state health reforms and created special program initiatives targeted to childbearing women and their infants. Some states took advantage of a 2002 federal rule that allowed them to extend prenatal coverage to pregnant women under SCHIP. Despite serious budget shortfalls in 2003, most states did not reduce eligibility levels under Medicaid or SCHIP for pregnant women, children or children with special health care needs. Since then, several states have increased eligibility levels to cover more pregnant women by these programs. Table 8 identifies eligibility levels for pregnant women as well as processes in place for the states in the southern region and the District of Columbia.

Table 8 Pregnant Women Eligibility Levels and Enrollment Policies for Medicaid and SCHIP, July 2006				
State	**Income Eligibility Level Percent of Federal Poverty Line**	**Asset Test**	**Presumptive Eligibility**	**Unborn Child Option**
Federal Minimum	**133%**			
Alabama	133%	No	No	
Arkansas[1]	175%	$3,100	Yes	Yes
Delaware	200%	No	Yes	
District of Columbia	200%	No	Yes	
Florida	185%	No	Yes	
Georgia	200%	No	Yes	
Kentucky	185%	No	Yes	
Louisiana	200%	No	Yes	
Maryland	250%	No	Yes	
Mississippi	185%	No	Yes	
Missouri	185%	No	Yes	
North Carolina	185%	No	Yes	
Oklahoma	185%	No	Yes	
South Carolina[2]	185%	$30,000	Yes	
Tennessee[3]	185%	No	Yes	
Texas	185%	No	Yes	Yes
Virginia[4]	166%	No	Yes	
West Virginia	150%	No	Yes	
Total Southern States		**2**	**17**	**2**

1. Arkansas asset limit is shown for a family of three.
2. South Carolina has an "assumptive" eligibility process through which pregnant women can obtain 30 days of coverage pending documentation of eligibility factors.
3. Tennessee plans to adopt the SCHIP unborn child option in 2007.
4. Virginia expanded its SCHIP-funded coverage for pregnant women from 150% to 166% of the federal poverty level in September 2006.

Source: Cohen Ross, Cox & Marks, January 2007.

- All but one southern state ***(Alabama)*** have established eligibility levels for pregnant women broader than the federal minimum of 133% of the federal poverty level.

- Four states ***(Alabama, Arkansas, Virginia and West Virginia)*** have eligibility levels set below 185% of the federal poverty level.

- Two states in the region currently have an asset test for pregnant women ***(Arkansas and South Carolina)***.

- One state (***Alabama)*** does not have presumptive eligibility for pregnant women.

Two states **(*Arkansas and Texas)*** currently offer coverage under the unborn child option, which allows states to use SCHIP funds to pay for services to fetuses that are carried by women who meet the income and asset standards for eligibility but are not otherwise eligible for Medicaid, and one state ***(Tennessee***) recently implemented the option in 2007.

Pregnancy Risk Assessment Monitoring System

The Pregnancy Risk Assessment Monitoring System, known as PRAMS, is a surveillance project initiated in 1987 by the Centers for Disease Control and Prevention (CDC) in cooperation with state health departments. State participation in PRAMS is voluntary. State-specific data are gathered for PRAMS on maternal attitudes and experiences before, during and shortly after pregnancy. The population-based survey samples all women in a state who recently had a live birth, thus allowing findings to be applied to the state's entire population of women who have recently delivered a live-born infant. PRAMS provides data to state health officials and policy makers to use for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health. The goal of the PRAMS project is to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity and maternal morbidity.

A review and analysis of the most recent PRAMS data is provided for each southern state, where available, in Table 9 and in the state fact sheets at the end of this report. All southern states were asked to provide data on pregnant women's health coverage. All states do not participate in PRAMS, and some of those that do participate were unable to provide the data. Vital statistics data, if available, were collected in cases where states were unable to provide PRAMS data.

The majority of PRAMS states were able to submit 2004 data concerning the type of coverage used for delivery, which is shown in Table 9. Women could list more than one form of payment for the delivery services; thus percentages do not add to 100%. States labeled the responses to questions related to health coverage somewhat differently, and the charts reflect the wording and data provided by that state. The data show that in all states reporting either PRAMS or Vital Records, Medicaid paid for 24% to 60% of births.

Table 9 Method of Payment at Delivery: PRAMS & Vital Statistics Data, 2004					
	Medicaid	**Private Health Coverage+**	**Personal Income**	**Military/ CHAMPUS**	**Other**
Alabama*	51%	47%	17%	3%	2%
Arkansas	55%	38%	24%	2%	1%
Delaware[1]	44%	54%	2%		0%
Florida*	46%	51%	19%		7%
Georgia[2]	56%	44%	13%	3%	9%
Maryland	30%	65%	7%		0%
Missouri ***	48%	54%	18%		2%
North Carolina	54%	48%	21%		2%
Oklahoma[3]	52%	41%	23%	2%	9%
South Carolina	54%	42%	23%	7%	1%
Texas	60%	37%	19%		3%
Virginia[4]	24%	67%	5%		4%
West Virginia*+[5]	56%	43%	14%		5%

+ Private health insurance includes employer-based group as well as personal non-group health plans.

***** Alabama and Florida data are from 2003.

****** For Delaware & Virginia Vital Statistics data are used.

*******Missouri data are from 2005.

***+** West Virginia includes births from July 1, 2004-December 31, 2004

1. In Delaware, Other methods of payments at delivery include: Unknown at 0.10%.

2. In Florida, Other method of payment is Florida's Medicaid Managed Care plan, Medipass.

3. In Georgia, Other methods of payments at delivery include: Still owe for the delivery, 9.12% and Other, 0.33%.

3. In Oklahoma, Other methods of payments at delivery include: Indian Health or Tribal, 5.60% and Other, 3.60%.

4. In Virginia, Other methods of payments at delivery include: Unknown at 3.89%.

5. In West Virginia, Other methods of payments at delivery include: State Maternal and Child Health Program, 3.00% and Other, 2.00%.

Coverage for Adults

Trends indicate that a growing number of Americans are living without health coverage. Of the nearly 47 million uninsured non-elderly Americans, more than 9 million are children (Kaiser Commission on Medicaid and the Uninsured, 2007). Until 2005, increases in the number of children qualifying for Medicaid and SCHIP prevented additional children from becoming uninsured. But for non-elderly adults, public coverage plays a smaller role and the percentage of adults without coverage increased. An estimated 37 million non-elderly adults are uninsured, comprising 80% of all uninsured Americans. Most (more than eight in ten)

uninsured adults are from working families. About 70% of uninsured adults are from families with at least one full-time worker and 12% are from families with only part-time workers (Kaiser Commission on Medicaid and the Uninsured, 2007). As employer-sponsored health care coverage is eroding and the cost of health care coverage and services is rising, more and more adults are without health coverage (Zuckerman & Cook, 2006).

Although most lower-income children are eligible for Medicaid and/or SCHIP, most adults are ineligible unless they are disabled, pregnant or have dependent children (Kaiser Commission on Medicaid and the Uninsured, 2007). Less than half (47%) of parents in families earning less than 200% of the federal poverty level are even offered health coverage through their employer (Robert Wood Johnson Foundation, 2007). Across the country, the rate of uninsured parents among states ranges from 6% to 29%. Of uninsured parents, 69% are in lower-income families (defined as families with incomes below 200% of the federal poverty level). Yet, the minimum level at which states must offer Medicaid coverage to parents is, on average, 42% of the federal poverty level ($8,658 for a family of four in 2006) (Kaiser, Commission on Medicaid and the Uninsured, 2007). Some states have chosen to cover parents at higher levels, but the majority of states have parent eligibility levels below poverty (Appendix 6).

Data show that some 85% of children eligible for, but not enrolled in an SCHIP plan, have uninsured parents (Robert Wood Johnson Foundation, 2007). Research shows that when parents are covered, the children in these families are far more likely to be covered, even if it is under a different health plan (Robert Wood Johnson Foundation, 2007). In turn, when parents are covered, access to care and financial security is promoted for the entire family.

Discussion of Issues that Impede Health Coverage Opportunities for Uninsured Children and Pregnant Women in the Southern States

As insurance coverage opportunities in the private sector continue to shrink, it becomes even more crucial that public health coverage programs like Medicaid and SCHIP enroll and retain every eligible individual. What follows is a discussion of some of the issues that may impede health coverage opportunities, as well as some of the actions states may be able to take to ensure eligible children and pregnant women receive coverage. Appendix 7 shows how states in the region fare on simplification procedures for public coverage of adults as compared to children.

Joint Application and Renewal Forms

Almost all states with separate Medicaid and SCHIP programs utilize a joint application for the purpose of administrative efficiency and to prevent families from having to complete a second application if they are found ineligible for one program. As of July 2006, all the southern states with separate programs used joint applications. At the same time, only five southern states used joint renewal forms.

Aligning Eligibility Levels within Public Programs

Coordination of coverage across Medicaid categories and SCHIP can be difficult in some states. Having children in the same family potentially eligible or enrolled in two separate programs with differing names, eligibility requirements and renewal timelines can be a barrier for families to obtain and to keep health coverage for their children. States can align the Medicaid eligibility levels for families to help reduce the confusion and complex processing of public health coverage. For instance, in Maryland all children regardless of age are eligible for Medicaid if their families earn up to 200% of the federal poverty level. The state also has a separate program that sits on top of its Medicaid program and covers those children in families with income greater than 200% and up to 300% of the federal poverty level. The Maryland program design means that children in the same family are much more likely to have the same access to coverage as well as a greater opportunity to have the same provider, which can lead to better access to preventive and primary care.

Medicaid and SCHIP Eligibility Levels

States have the option of covering children at incomes above the federally mandated Medicaid levels. All southern states except Alabama have expanded eligibility above required minimums as they have implemented SCHIP. In seven southern states, eligibility levels in Medicaid are aligned by age, facilitating the coverage of all children in a family within the same program. All states in the southern region and the District of Columbia had expanded eligibility levels for their SCHIP populations to 200% of poverty or higher as of July 2006, except for **South Carolina** and **Oklahoma**.[6]

Family-Friendly Applications, Renewal Forms and Notices

When Medicaid and SCHIP applicants and recipients do not complete questions in an application or fail to act on requests made in written notices, they can be denied coverage or have their cases closed. One notable reason for procedural closures stems from difficulties many new and renewing applicants have with understanding the material that is available to them concerning applications and renewals.

Nearly half of all American adults, or about 90 million people, have limited literacy skills. Health literacy is the capacity to find and understand health information and services and to make informed health-related decisions (Lane, Blanco, Ford & Mirenda, 2005), and those with low literacy have difficulty understanding and acting upon health information (Institute of Medicine, 2004). Over the past few years, states have focused attention on simplifying applications for child health coverage, and while the renewal forms and notices also have been assessed, improvements to these forms have been implemented at a slower pace. The Southern Institute on Children and Families has worked with the MAXIMUS Center for Health Literacy on several projects focused on improving the readability and accessibility of health coverage applications, renewal forms and notices used by states and counties in the

[6] In 2007, South Carolina passed legislation to expand the income eligibility levels for their Medicaid children up to 200% of the federal poverty level and Oklahoma passed legislation to expand eligibility to children up to 300% in their SCHIP program.

eligibility process (Lane, Blanco, Ford & Mirenda, 2005; Lane, Winchester, Blanco, Ford & Palumbo, 2006).

Outstationed Eligibility Workers and Application Assisters

Outstationed eligibility workers and application assisters allow families to obtain enrollment and renewal assistance without the need to go to a local welfare office. Federal law requires that states outstation Medicaid eligibility determination staff at Disproportionate Share Hospitals and Federally Qualified Health Clinics for determining eligibility for lower-income pregnant women and children. States have the option to outstation eligibility staff at sites other than these, including children's hospitals and schools.

According to a "Dear State Medicaid Director Letter" from the Centers for Medicare & Medicaid Services (CMS), states that had outstationed eligibility staff beyond federal law and regulation requirements experienced "…increased enrollment, a higher level of staff satisfaction and lower turnover rates and increased overall program satisfaction on the part of families and the provider community" (Westmoreland, 2001). However, a 2005 study by the National Association of Community Health Centers, Inc. (NACHC) found that only three states were fully compliant (outstationed workers paid for by the state in every health center and every high-volume site) with the Medicaid outstationing requirements (McKinney, 2005).

Application assisters can help to simplify the application and renewal processes by providing families with one-on-one help completing applications. Application assistance sites may include community-based organizations, schools, Head Start facilities, child care centers and sites operated by other community partners that families can trust and with whom families can easily communicate. Some states have agreements with community partners to provide application assistance to families in exchange for monetary reimbursement.

Local eligibility agencies also can outstation eligibility staff to conduct outreach and to assist families in applying for health care coverage. Medicaid and SCHIP administrative funds can be used to fund local eligibility staff outreach and outstationing.

The national *Covering Kids & Families* (CKF) initiative (2001–2007) funded by the Robert Wood Johnson Foundation and directed by the Southern Institute on Children and Families was the largest single initiative of its kind focused on assisting potentially eligible children and adults in obtaining and keeping public health coverage. Although that initiative ended in May 2007, many of the efforts and work of those who participated in CKF are continuing. This initiative demonstrated the impact that application assistance in non-traditional settings can have on increasing the enrollment and renewal of those eligible for public coverage.[7]

[7] For information on the impact of key strategies utilized by CKF grantees and local projects, see *Covering Kids & Families: Promising practices from the nation's single largest effort to insure eligible children and adults through public health coverage* located at http://www.thesoutherninstitute.org/docs/publications/CKF%20Promising%20Practices%204-07.pdf

For information on the barriers and opportunities related to outstationing public health coverage eligibility, see *Offering Public Health Coverage Enrollment in Health Care Settings* located at http://www.thesoutherninstitute.org/docs/publications/HBE%20Report.pdf

Face-to-Face Interview Requirements

Requiring families to have an in-person interview prior to enrollment or renewal can create significant barriers for families to enroll and retain Medicaid and SCHIP coverage. Lost wages and lack of transportation are the most cited barriers when a face-to-face interview is required for enrollment and renewal. Face-to-face interviews are not a federal requirement for enrollment or renewal (CMS, 2001) and 14 southern states and DC have eliminated face-to-face interviews, but Tennessee, Kentucky and Mississippi still require them when children apply for public coverage. States that do not require face-to-face interviews employ various procedures such as telephone interviews, permitting applicants and those renewing their coverage to meet with community-based representatives to satisfy the interview requirement, and allowing for mail-in application and renewal forms.

Verification Requirements

Reducing eligibility errors has often been cited as a major reason to require verification. However, a number of states have noted that reduced verification has not resulted in increasing the number of ineligible individuals getting health coverage. Requesting a long list of verification documents can be burdensome for families and eligibility staff, and can result in a denial or loss of coverage even though the family may be eligible. As of July 2006, five out of the nine states nationwide that do not require income documentation for eligibility determination were southern states.[8] Table 3 on page 8 displays a list of federal documentation requirements for Medicaid. It shows that many commonly requested verification documents are not required by the federal government.

Federal law does require that immigration status documentation be provided for non-citizens for enrollment in Medicaid and SCHIP (Ravenell, 2003). As part of the Deficit Reduction Act, July 2006 marked the date that states were to begin requesting citizenship and identity documentation for applications and renewals for children, parents and pregnant women as a requirement for Medicaid eligibility. These new requirements pose new challenges for states that have attempted to reduce verification requirements (Cohen Ross, Cox & Marks, 2007).

Asset Test

Since 1988, states have had the option of eliminating the asset test for lower-income children applying for Medicaid (Smith & Ellis, 2001). Having an asset test can contribute to the overall administrative burden and cost to state agencies. Almost all states (46) have taken advantage of this policy option and eliminated this barrier for enrollment of children in Medicaid and SCHIP. Twenty-one states have eliminated the asset tests for family coverage. Table 10 displays data on southern states that require asset testing for children's Medicaid and SCHIP (2 states), pregnant women (2 states) and family coverage eligibility (10 states).

Prior to 1996, only a few states had eliminated the asset test for adults for health care coverage. The passage of federal welfare reform in 1996 served as a catalyst for states to simplify the enrollment and renewal processes by eliminating the asset test for adult and

[8] Georgia has since changed its policy and now requires income documentation

family coverage categories under Medicaid. States can adopt eligibility methods under Section 1931 and Section 1902 (r)(2) [9] that are less restrictive than regular Medicaid and would allow the elimination of asset tests for lower-income family, children, and pregnant women categories (Smith & Ellis, 2001).

Research by the Kaiser Commission on Medicaid and the Uninsured showed that in addition to reducing verification burdens for families, the removal of the asset test has served to help eligibility staff save time and realize administrative savings. Further, of those states that participated in the study, "No state reported an increase in its Medicaid eligibility error rate due to the elimination of the asset test and no state anticipated any loss of federal matching funds as a result of doing so," (Smith & Ellis, 2001).

[9] Section 1902(r)(2) of the Social Security Act was enacted in the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360. Similar to Section 1921 authority for parents, Section 1902(r)(2) enables states to use "less restrictive" methodologies to count assets for poverty-level children and certain other eligibility categories, allowing a relaxation of the asset test or its elimination altogether.

Table 10				
Southern States Asset Testing for Children's Medicaid and Separate State SCHIP, Pregnant Women and Family Coverage as of July 2006				
State	**Children**[1]		**Pregnant Women**[2]	**Family**[1]
	Medicaid	**Separate SCHIP Program**		
Arkansas	Not Required	N/A	$3,100	$1,000
Florida	Not Required	Not Required	Not Required	$2,000
Georgia	Not Required	Not Required	Not Required	$1,000
Kentucky	Not Required	Not Required	Not Required	$2,000
Maryland	Not Required	Not Required	Not Required	$3,000
Missouri[3]	Not Required	Not Required	Not Required	Not Required
North Carolina	Not Required	Not Required	Not Required	$3,000
South Carolina	$30,000	N/A	$30,000	$2,000
Tennessee	Not Required	N/A	Not Required	$2,000
Texas[4]	$2,000	$5,000	Not Required	$2,000
West Virginia	Not Required	Not Required	Not Required	$1,000

N/A is for states that did not have a separate SCHIP program as of July 2006.

1. In states with asset limits, the limit noted is for a family of three.
2. With the exception of Arkansas, all states with an asset test for pregnancy coverage rely on a standard limit regardless of family size. In Arkansas, the asset limit shown is for a family of three.
3. In Missouri, children covered under the Section 1115 waiver expansion are subject to a "net worth" test of $250,000.
4. In Texas, the SCHIP asset test only applies to families with income above 150 % of the federal poverty line.

Source: Cohen Ross, Cox & Marks (January 2007).

Continuous Eligibility

The SCHIP legislation passed in 1997 changed Medicaid policy by allowing states the option to provide up to 12 months of guaranteed coverage to children enrolled in Medicaid. This policy option is referred to as "continuous eligibility." Continuous eligibility means that children and families remain eligible for a specified period regardless of changes in family circumstances. States can provide a continuous coverage period shorter than 12 months.

It should be noted that states could provide 12 months of Medicaid or SCHIP coverage without stipulating that it is continuous; this means the child can lose coverage during the 12-month period. If coverage is not continuous, families are responsible for reporting within 10 days a change in family circumstances, such as a change in income, so that eligibility can be reviewed. Requiring families to report changes in circumstances can result in a termination of benefits for children who may become eligible again shortly after being

terminated due to fluctuations in family income. The family will then have to reapply and go through the enrollment process for coverage. This practice of moving on and off of coverage is often referred to as "churning."[10] Table 11 shows the southern states that have adopted 12-month continuous coverage as a policy option for Medicaid and/or SCHIP.

Ensuring a 12-month period of guaranteed continuous health care coverage brings stability for both families and providers. This stability greatly enhances the child's continuity of health care, especially preventive and primary care.

[10] Churning also can be used to refer to those children who move between coverage under Medicaid and separate state SCHIP programs. If coordination is seamless, this movement between the two programs would not be apparent to the family. However, often eligible children lose coverage because of a lack of coordination.

Table 11 Southern States that have Adopted 12-Month Continuous Coverage For Medicaid and/or SCHIP as of July 2006		
State	**Medicaid**	**SCHIP**
Alabama	✓	✓
Arkansas[1]		N/A
Delaware		✓
District of Columbia		
Florida[2]		✓
Georgia		
Kentucky		
Louisiana	✓	N/A
Maryland		
Mississippi	✓	✓
Missouri		N/A
North Carolina	✓	✓
Oklahoma		N/A
South Carolina	✓	N/A
Tennessee		N/A
Texas		
Virginia[3]		✓
West Virginia	✓	✓

N/A is for states that do not have a separate SCHIP program.

1. In Arkansas, children who qualify under the Medicaid Section 1115 waiver category receive 12 months of continuous eligibility, as opposed to a 12 months renewal period in "regular" Medicaid.
2. In Florida's Medicaid program, children under age five receive 12 months of continuous eligibility and those ages five and older receive six months of continuous eligibility.
3. In Virginia, children covered under SCHIP receive 12 months of continuous coverage unless the family's income exceeds the program's income eligibility guideline or the family leaves the state.

Source: Cohen Ross, Cox & Marks (January 2007).

Child Support Enforcement

Child Support Enforcement procedures can pose barriers to child health coverage enrollment. Many eligibility agencies and custodial parents have misunderstood the policy that no child can be denied Medicaid coverage due to lack of cooperation on the part of an adult in paternity establishment (Shuptrine & McKenzie, 1998).

In December 2000, the Centers for Medicare & Medicaid Services (CMS) issued guidance in a "Dear State Medicaid Director Letter" stating that under federal law, a parent's cooperation in establishing paternity and providing third-party medical liability information cannot be required as a condition of eligibility on a child-only Medicaid application. Therefore, states are not required to ask about paternity or to seek cooperation in pursuing medical support when an application for Medicaid or a renewal is performed on behalf of a child. There are no Child Support Enforcement requirements for SCHIP (Westmoreland, 2000).

Presumptive Eligibility: Coordination of Temporary and Regular Coverage

"Presumptive eligibility can increase entry points into the children's health coverage system, speed enrollment and eliminate gaps in coverage" (Cohen Ross & Cox, 2002). Presumptive eligibility is a process that allows for "qualified entities" to enroll families and pregnant women in health care coverage temporarily while the formal application process is being completed. In 2000, Congress expanded the definition of "qualified entities" that are allowed to perform presumptive eligibility to include schools and eligibility determination agencies for Section 8 Housing, Medicaid, TANF and SCHIP (Fuentes, 2001).

The process for presumptive eligibility should be simple so children and pregnant women who obtain temporary coverage under this policy are immediately enrolled in regular coverage for the entire length of a state's allowed coverage period. States have reported that training of staff at qualified entities and effective tracking of presumptively approved applications are key issues if the process for presumptive eligibility is to be successful.

Actions Southern States Can Take to Improve the Eligibility Process

States can take a number of actions to improve the eligibility process and make the process more manageable for families as well for eligibility workers. These actions include strategies that affect program design and expand eligibility levels. Other actions stress simplifying the application and renewal process through a variety of means that will assist potentially eligible people in receiving and maintaining Medicaid and SCHIP coverage.

- ✓ **Design Income and Eligibility Levels to Align Medicaid and SCHIP Coverage** – Align age and income eligibility levels to eliminate the problem of children of different ages in the same family needing to enroll or renew in different programs.

- ✓ **Increase Medicaid and SCHIP Eligibility Levels** – Cover children up to 200% of the federal poverty level to reduce the number of uninsured children in lower-income families.

- ✓ **Design and Implement Outreach Programs to Target Unenrolled Children Most Likely to be Eligible for Medicaid and SCHIP** – Study state by state data in this report to identify children most likely to be uninsured and then design and implement outreach programs to reach these target populations.

- ✓ **Expand the Use of Outstationed Eligibility Workers and Application Assisters** – Increase the number of sites where families may go to apply for public coverage to make Medicaid and SCHIP coverage more accessible and to help families complete the application process.

- ✓ **Utilize Joint Medicaid and SCHIP Renewal Applications and Forms** – Utilize joint renewal forms for Medicaid and SCHIP to simplify the renewal process for both families and eligibility workers.

- ✓ **Develop Family-Friendly Applications, Renewal Forms and Notices** – Implement continuous testing on the readability of applications, forms and notices to make sure written communication is clear to family members enrolling in or renewing Medicaid and SCHIP eligibility.

- ✓ **Eliminate the Face-to-Face Interview Requirement** – Allow Medicaid and SCHIP mail-in or on-line application and renewal forms to improve access to public coverage, especially for working families.

- ✓ **Reduce Verification Requirements** – Reduce verification requirements and fully use available information from other programs to help in making eligibility determination decisions. For instance, some states are performing data matches with vital statistics to prove citizenship requirements.

- ✓ **Remove the Asset Test** – Eliminate the asset test to simplify the application and renewal process for families as well as eligibility agencies. This allows families to maintain resources that they can access during times of economic need.

- ✓ **Allow Continuous Eligibility** – Allow seamless continuing coverage to enhance continuity of health care.

- ✓ **Adopt Presumptive Eligibility** – Allow families to access covered services immediately to better promote early care for medical conditions.

Conclusion

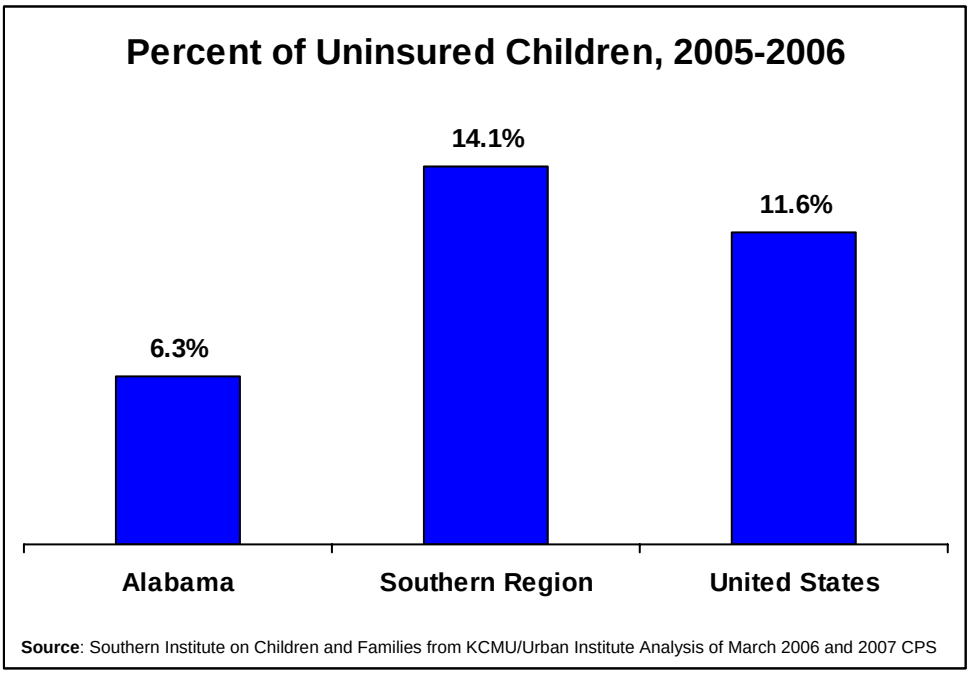
States in the southern region have made great strides in expanding Medicaid and SCHIP coverage for children and pregnant women, but continued leadership and action are needed to significantly reduce the number of children and pregnant women who are without health coverage. More than 4 million uninsured children reside in the southern region, and nationally, 12.9 million women of childbearing age are uninsured (March of Dimes, 2007). Reducing the number of uninsured children and pregnant women is a major public policy priority. Providing health coverage for lower-income children and pregnant women addresses several public goals, including improving access to preventive and primary care. Coverage for pregnant women assures a healthier start in life for their children. Supporting health coverage for lower-income families in the southern region will help maximize health and well-being throughout the South.

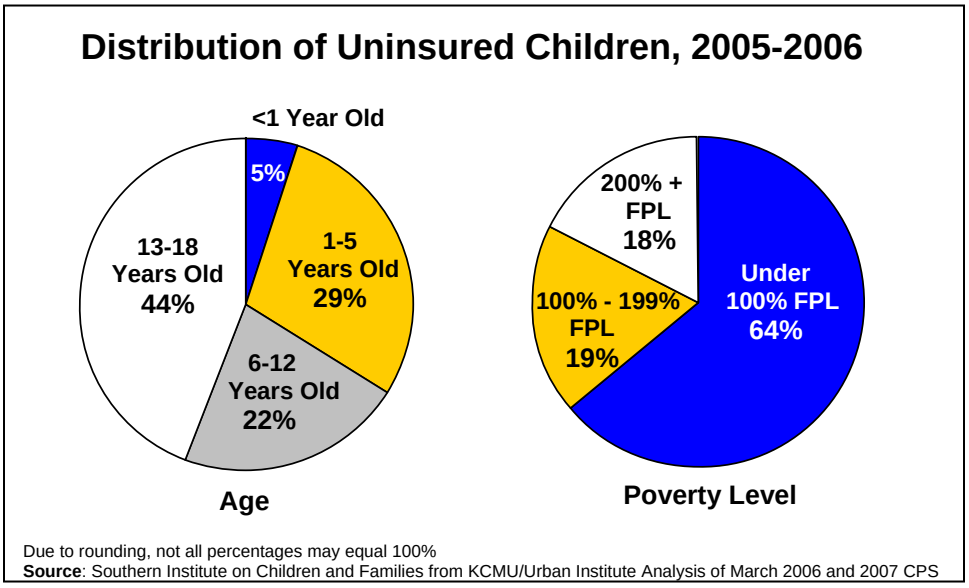
State Fact Sheets on Children and Pregnant Women

The following pages highlight state-specific fact sheets using information for the 17 southern states and the District of Columbia on children as well as on the state-specific information available from 12 of the 17 southern states concerning health coverage status of pregnant women. While CPS data on children's coverage is standardized for all states, the states collect and report some of their PRAMS data and Vital Records data differently; this is reflected in the charts for each state. For pregnant women, the years of available data ranged from 2000 to 2005, so data presented on pregnant women are not comparable state-to-state. The fact sheets include the following:

- Percentage of uninsured children in the state and the District of Columbia compared to the southern region as a whole and to the United States, 2005-2006.
- Distribution of uninsured children by age and income as a percent of the federal poverty level in 2005-2006.
- Medicaid and SCHIP eligibility levels for children in each state and the District of Columbia.
- Percentage of women covered by insurance (excluding Medicaid) prior to pregnancy.
- Percentage of women covered by Medicaid prior to pregnancy.
- Method of payment during pregnancy and at delivery.
- Medicaid and SCHIP eligibility levels for pregnant women in each state and the District of Columbia.

Alabama
Uninsured Children: 72,866



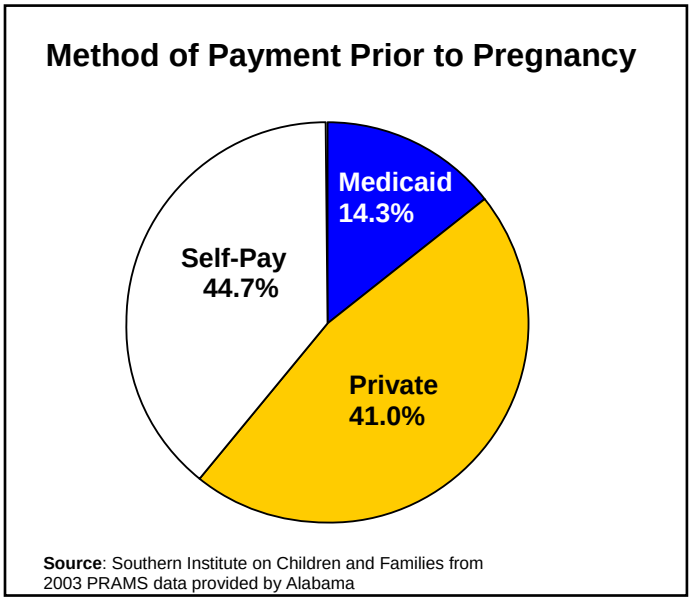


Medicaid/SCHIP Eligibility Levels for Children in Alabama, July 2006

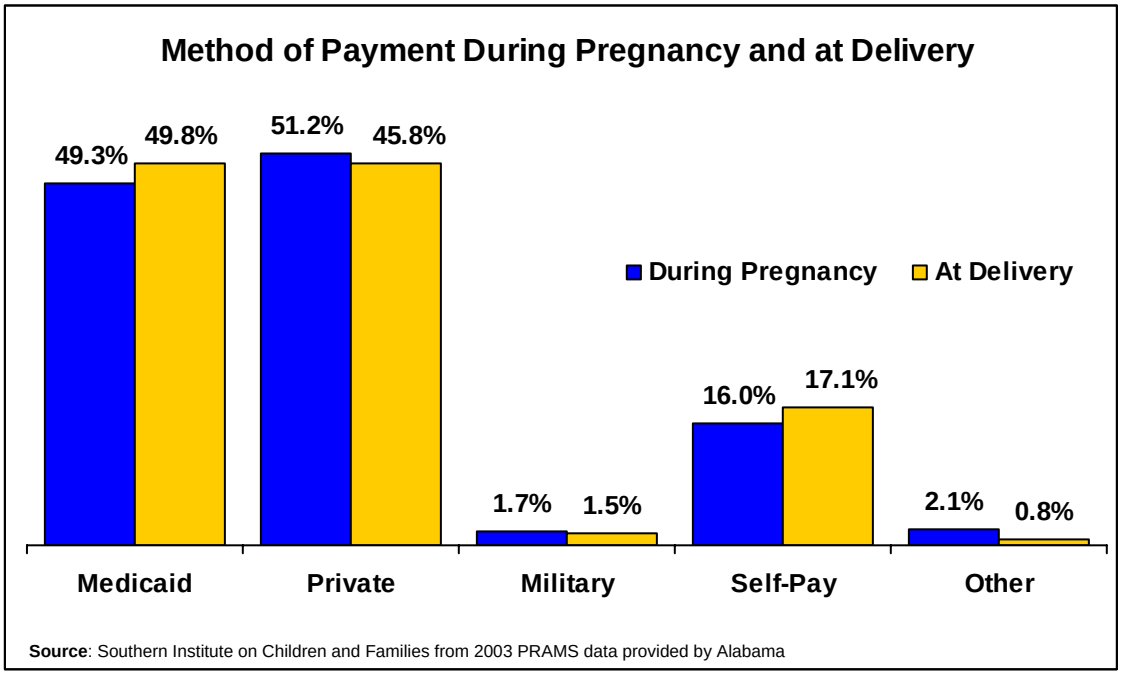
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	133%	133%	100%	200%
Annual Income	$26,600	$26,600	$20,000	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

Alabama
Pregnant Women



Source: Southern Institute on Children and Families from 2003 PRAMS data provided by Alabama

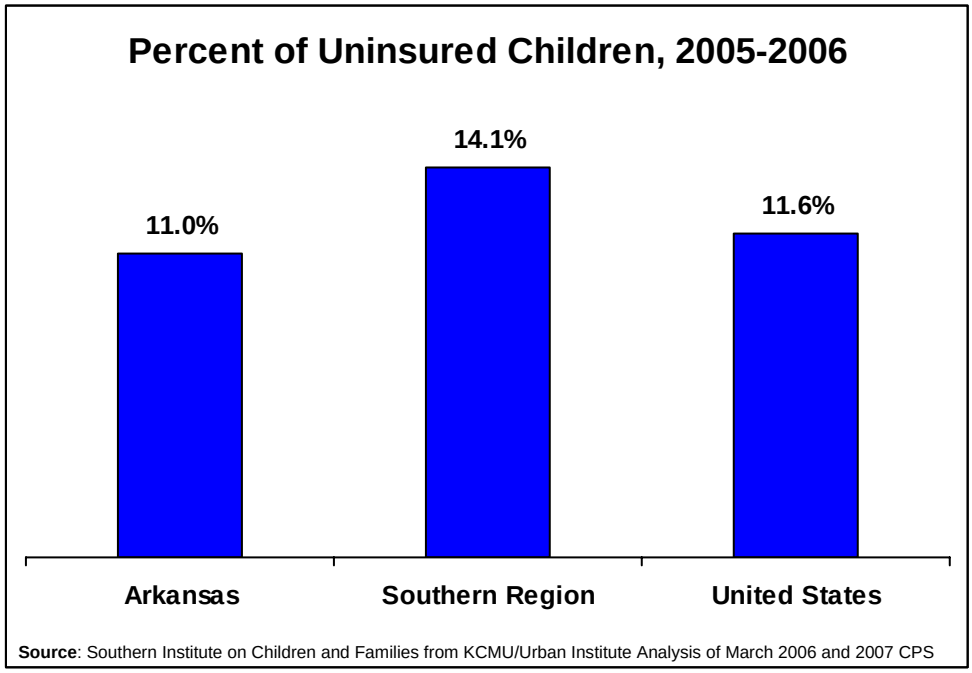


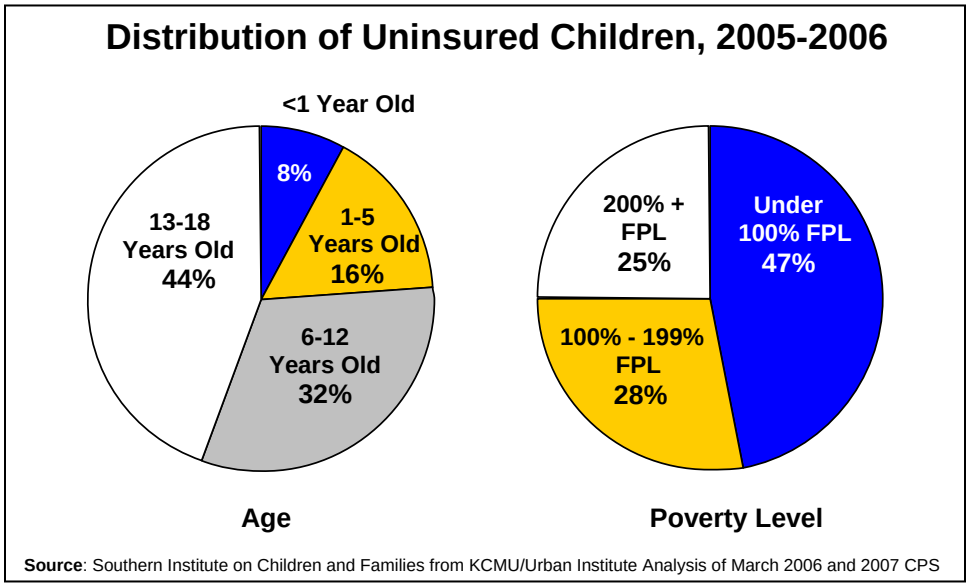
Source: Southern Institute on Children and Families from 2003 PRAMS data provided by Alabama

Medicaid/SCHIP Eligibility Levels for Pregnant Women in Alabama, July 2006	
	Medicaid
Federal Poverty Level	133%
Income	$26,600

Source**:** Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Arkansas
Uninsured Children: 78,845

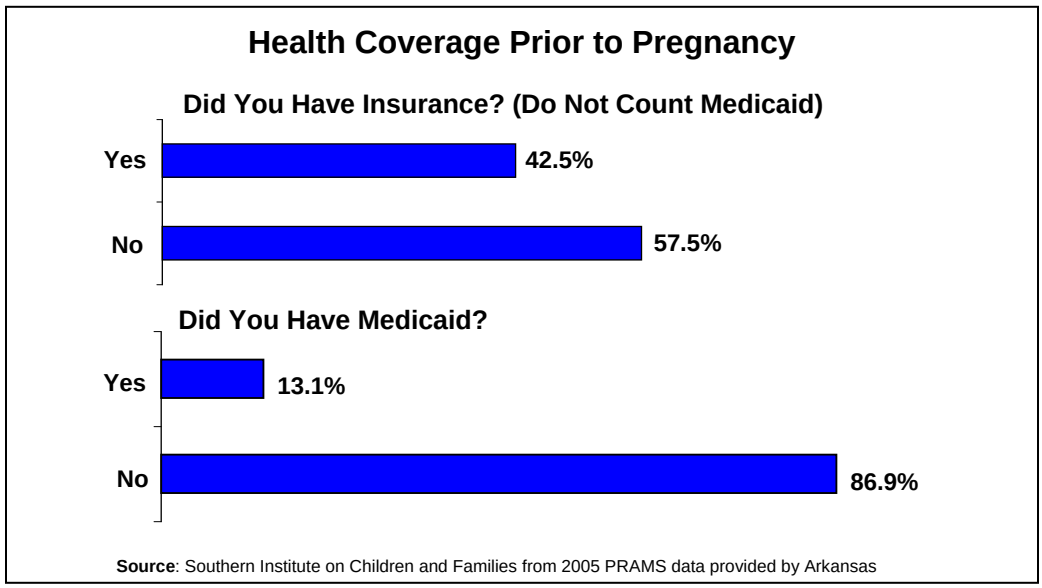




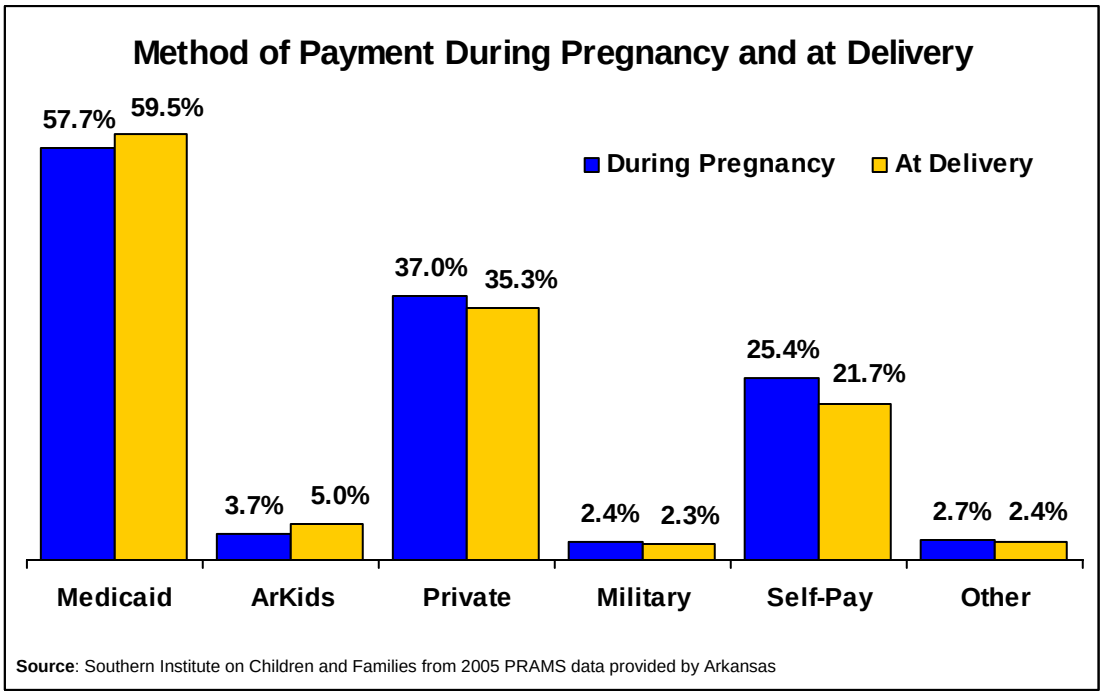
Medicaid/SCHIP Eligibility Levels for Children in Arkansas, July 2006				
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	200%	200%	200%	N/A
Annual Income	$40,000	$40,000	$40,000	N/A

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

Arkansas
Pregnant Women



Source: Southern Institute on Children and Families from 2005 PRAMS data provided by Arkansas

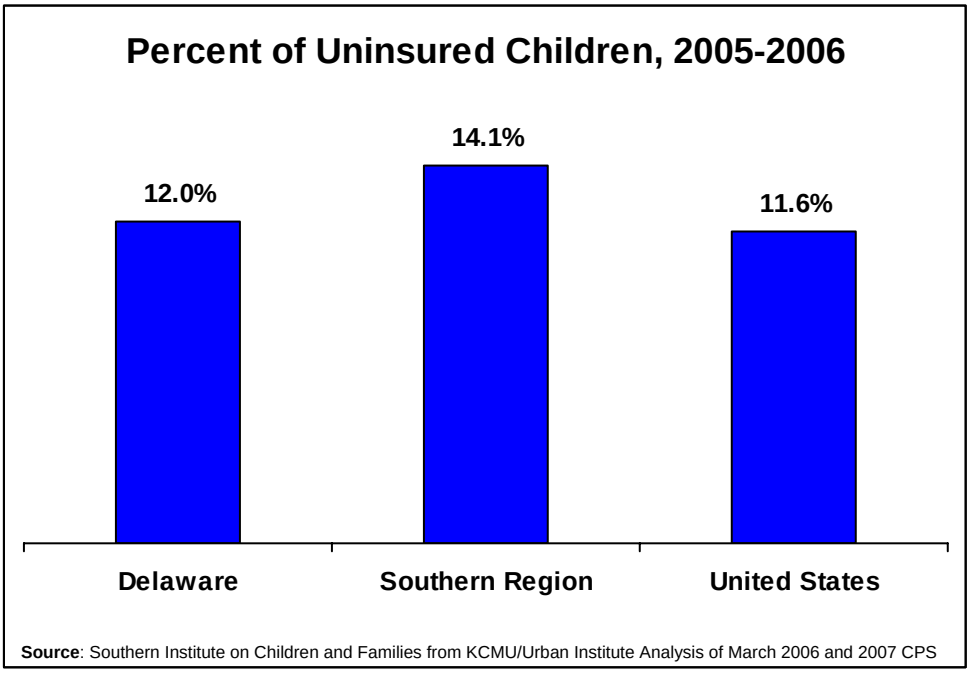


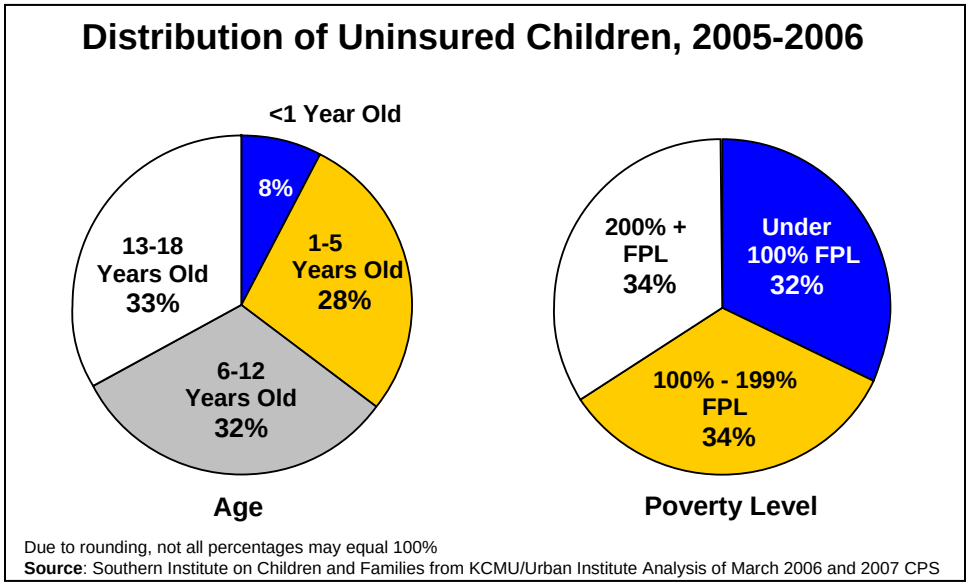
Source: Southern Institute on Children and Families from 2005 PRAMS data provided by Arkansas

Medicaid/SCHIP Eligibility Levels for Pregnant Women in Arkansas, July 2006	
	Medicaid
Federal Poverty Level (FPL)	200%
Annual Income	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Delaware
Uninsured Children: 25,666

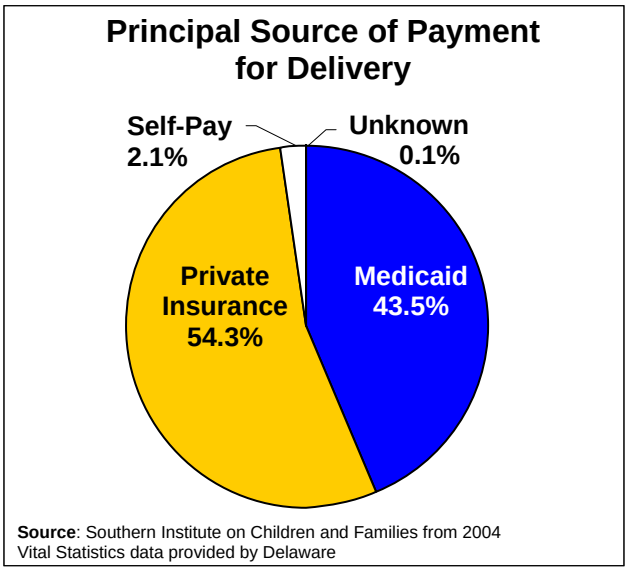




Medicaid/SCHIP Eligibility Levels for Children in Delaware, July 2006				
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	200%	133%	100%	200%
Annual Income	$40,000	$26,600	$20,000	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

Delaware
Pregnant Women

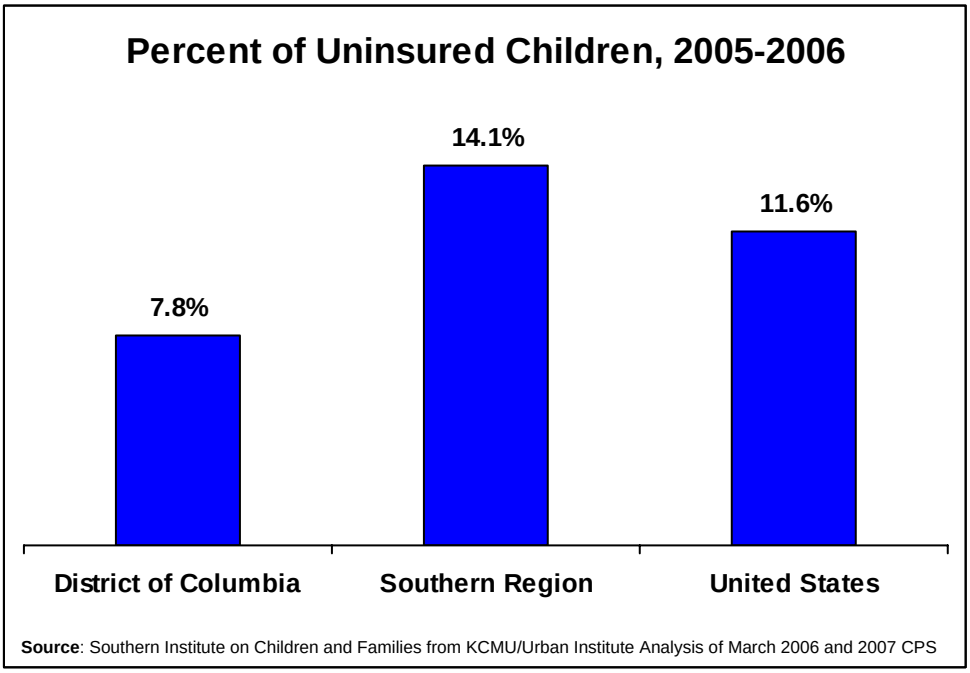


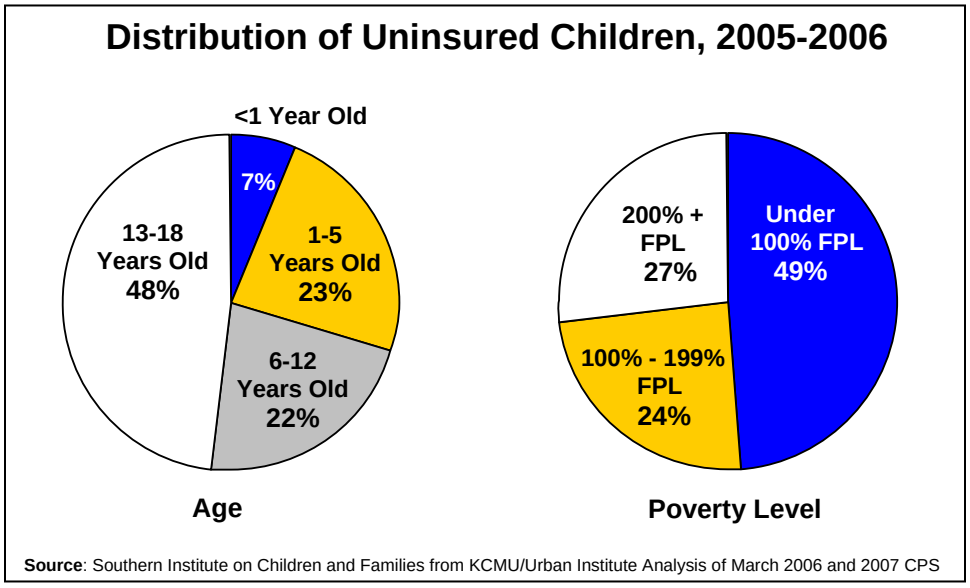
Source: Southern Institute on Children and Families from 2004 Vital Statistics data provided by Delaware

Medicaid/SCHIP Eligibility Levels for Pregnant Women in Delaware, July 2006	
	Medicaid
Federal Poverty Level (FPL)	200%
Annual Income	$40,000

Source**:** Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

District of Columbia
Uninsured Children: 9,221





Medicaid/SCHIP Eligibility Levels for Children in District of Columbia, July 2006				
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	200%	200%	200%	N/A
Annual Income	$40,000	$40,000	$40,000	N/A

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

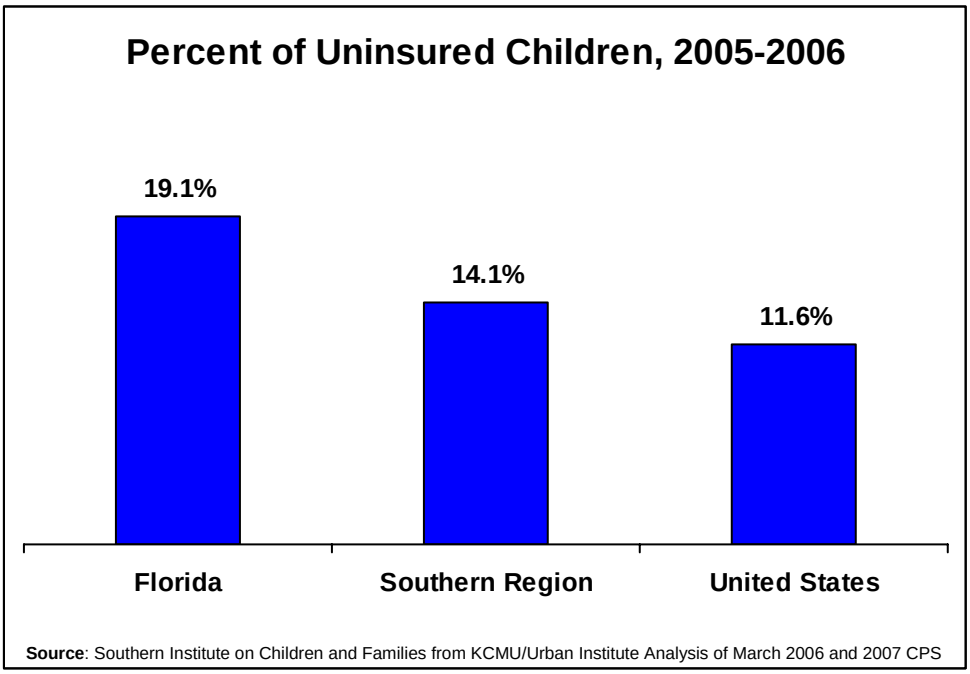
District of Columbia
Pregnant Women

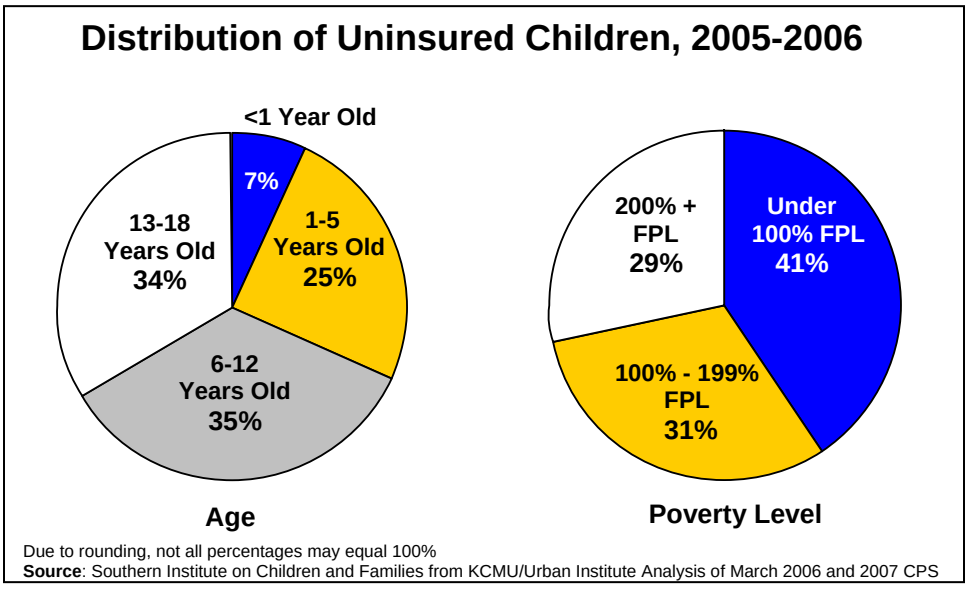
Medicaid/SCHIP Eligibility Levels for Pregnant Women in District of Columbia, July 2006	
	Medicaid
Federal Poverty Level (FPL)	200%
Annual Income	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Data for pregnant women not available for recent years.

Florida
Uninsured Children: 816,979

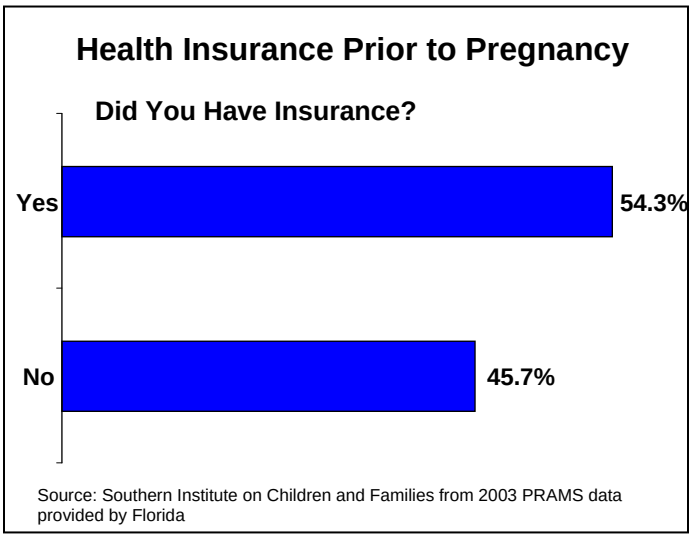


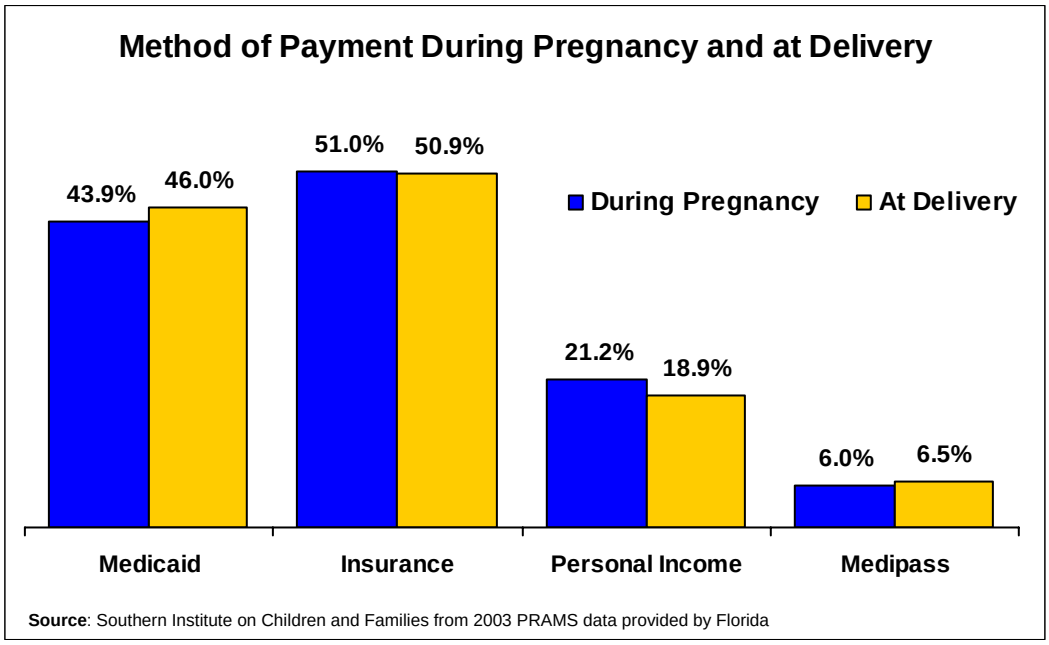


Medicaid/SCHIP Eligibility Levels for Children in Florida, July 2006				
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	200%	133%	100%	200%
Annual Income	$40,000	$26,600	$20,000	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

Florida
Pregnant Women

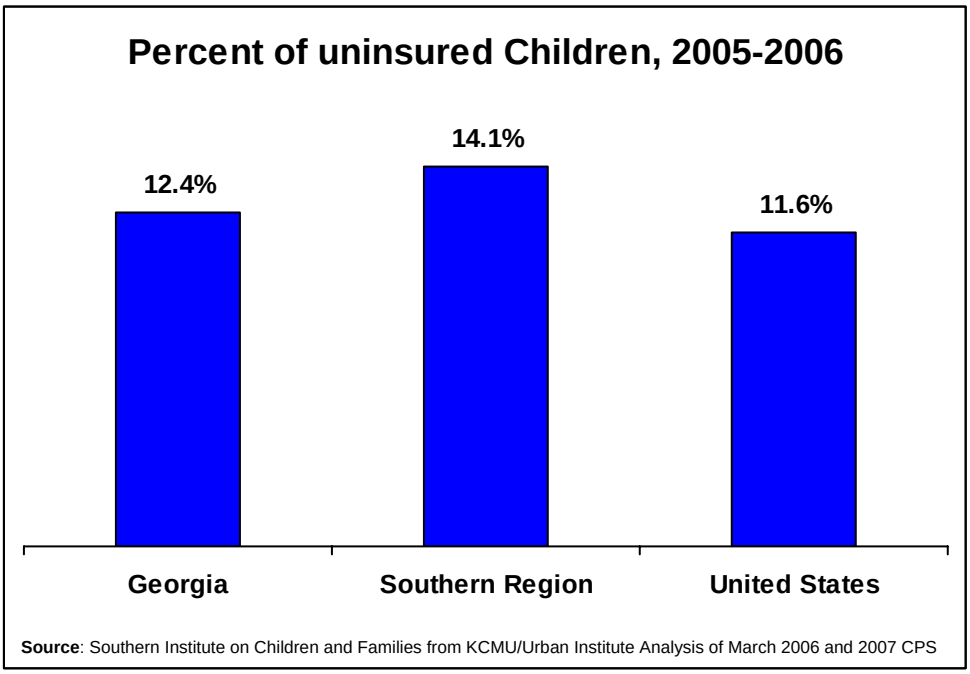


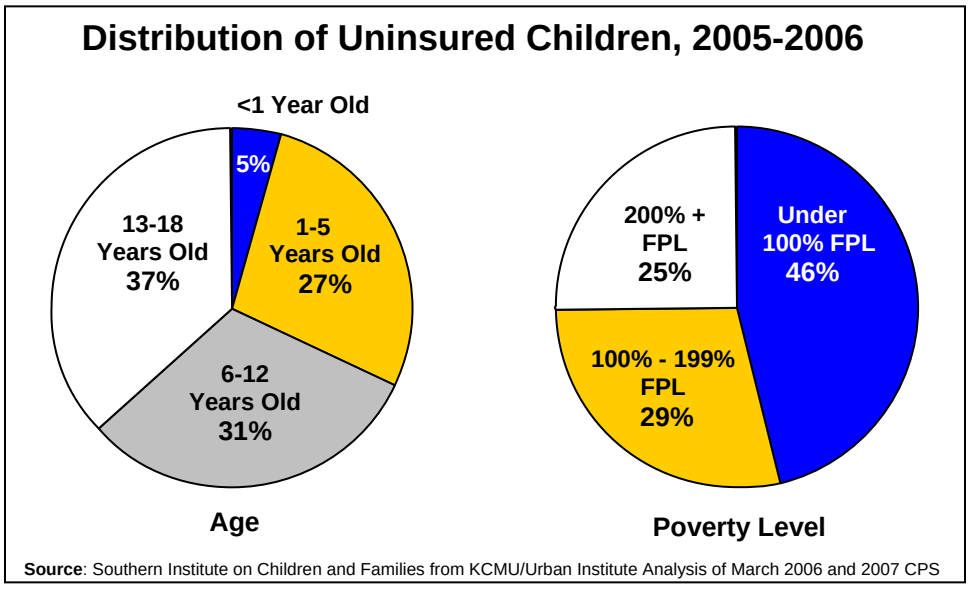


Medicaid/SCHIP Eligibility Levels for Pregnant Women in Florida, July 2006	
	Medicaid
Federal Poverty Level (FPL)	185%
Annual Income	$37,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Georgia
Uninsured Children: 313,465

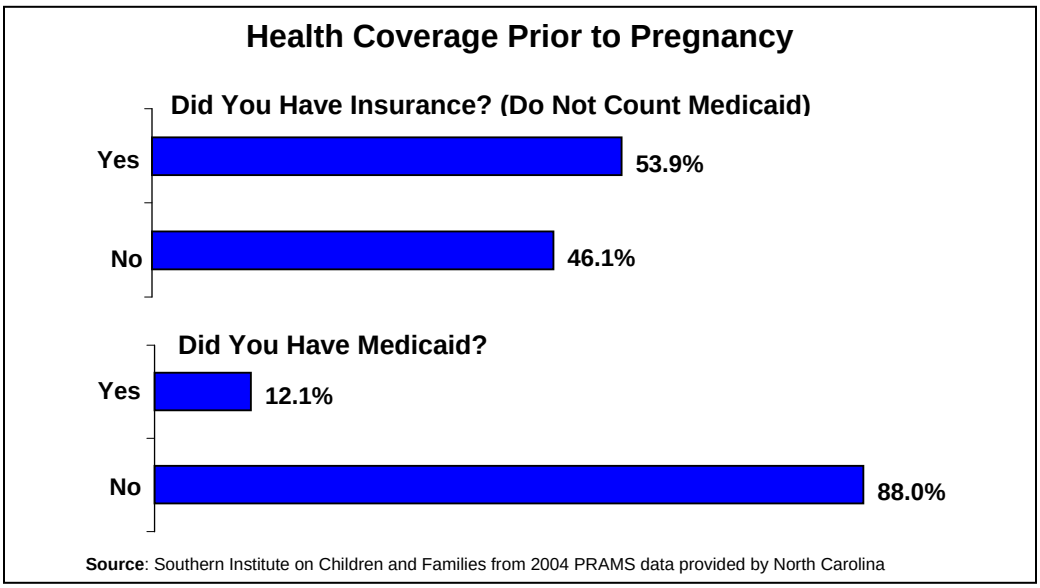




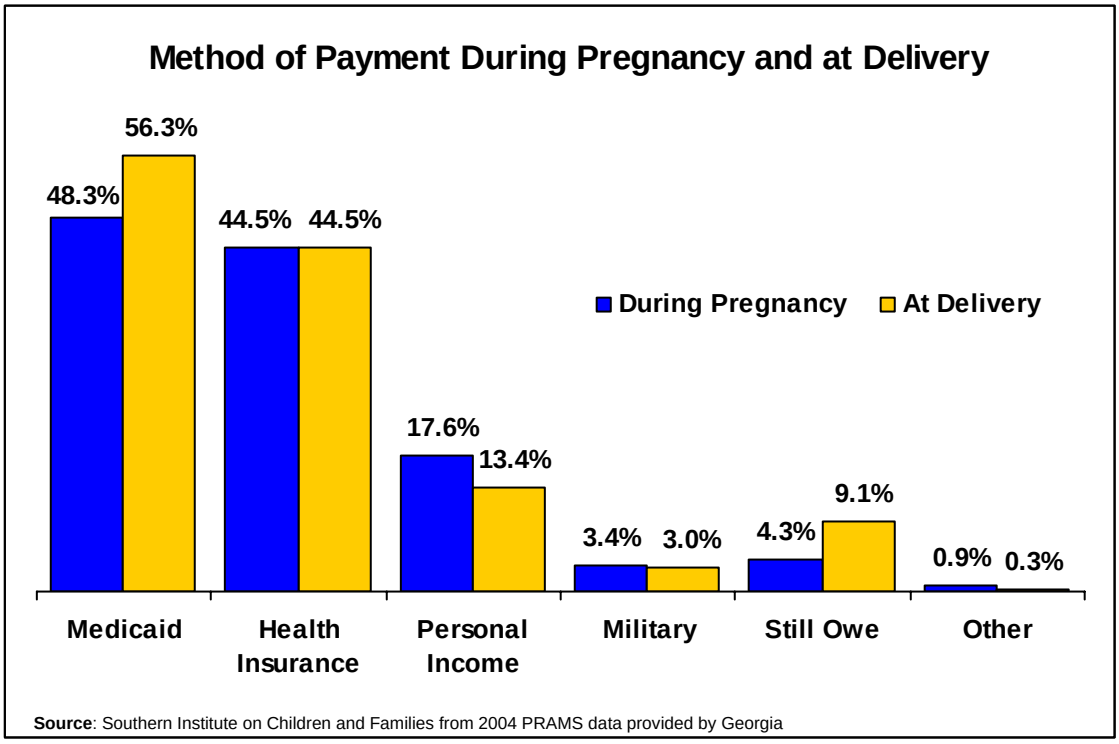
Medicaid/SCHIP Eligibility Levels for Children in Georgia, July 2006				
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	200%	133%	100%	235%
Annual Income	$40,000	$26,600	$20,000	$47,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

Georgia
Pregnant Women



Source: Southern Institute on Children and Families from 2004 PRAMS data provided by North Carolina

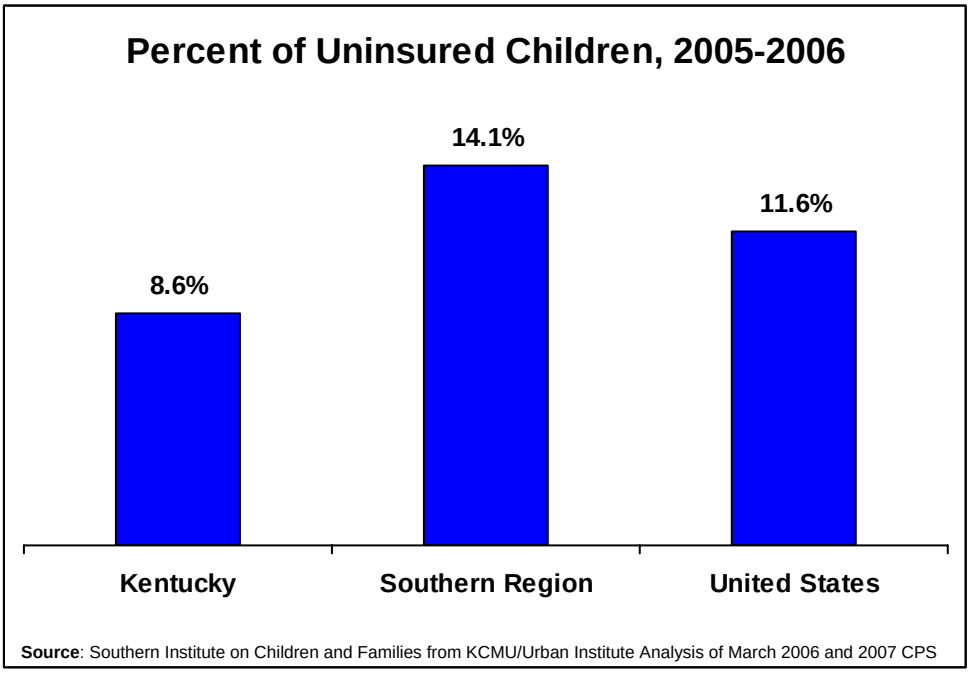


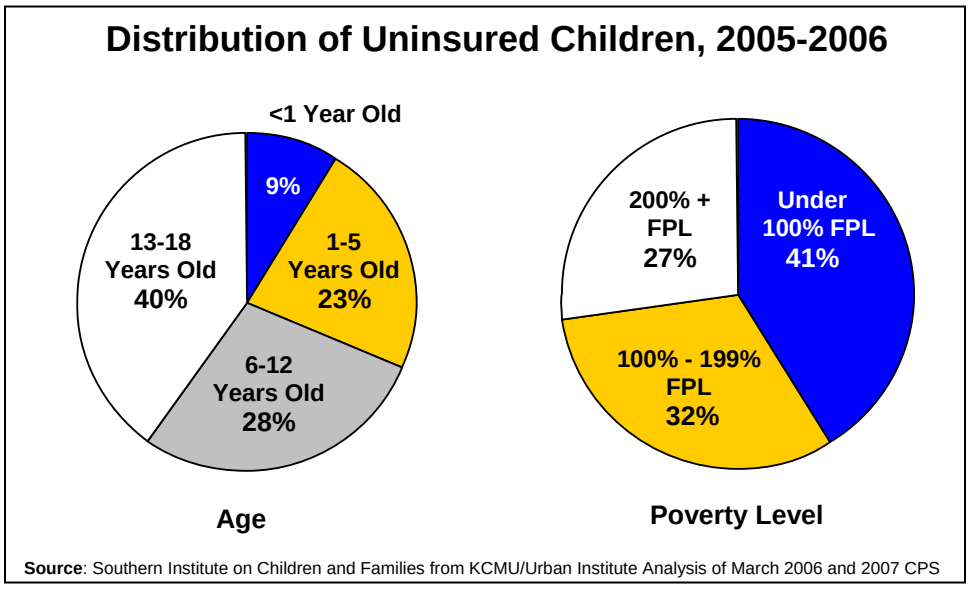
Source: Southern Institute on Children and Families from 2004 PRAMS data provided by Georgia

Medicaid/SCHIP Eligibility Levels for Pregnant Women in Georgia, July 2006	
	Medicaid
Federal Poverty Level (FPL)	200%
Annual Income	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Kentucky
Uninsured Children: 90,496





Medicaid/SCHIP Eligibility Levels for Children in Kentucky, July 2006				
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	185%	150%	150%	200%
Annual Income	$37,000	$30,000	$30,000	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

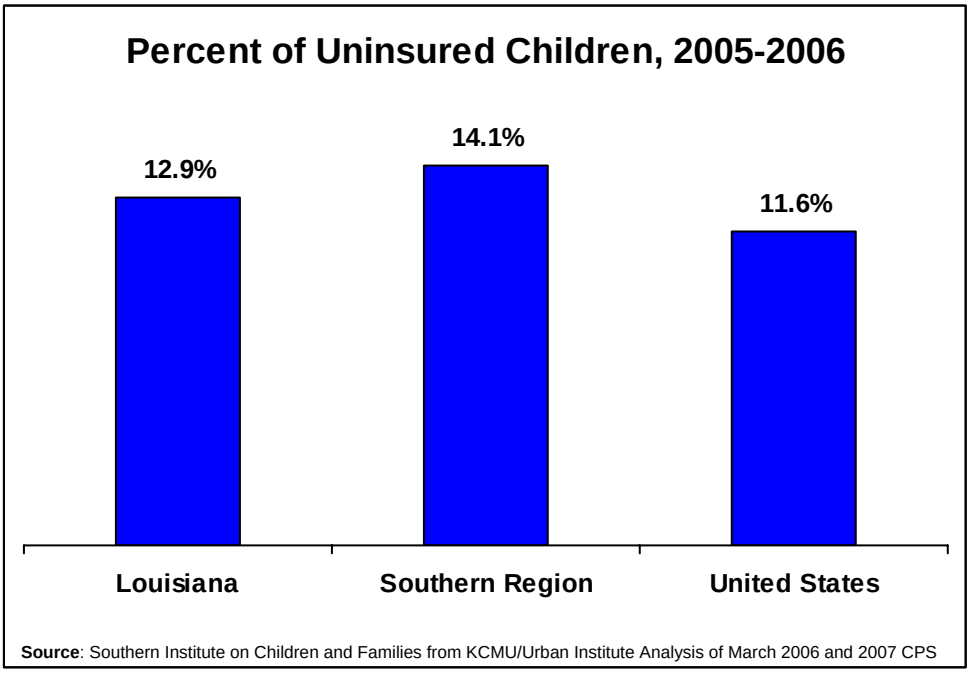
Kentucky
Pregnant Women

Medicaid/SCHIP Eligibility Levels for Pregnant Women in Kentucky, July 2006	
	Medicaid
Federal Poverty Level (FPL)	185%
Annual Income	$37,000

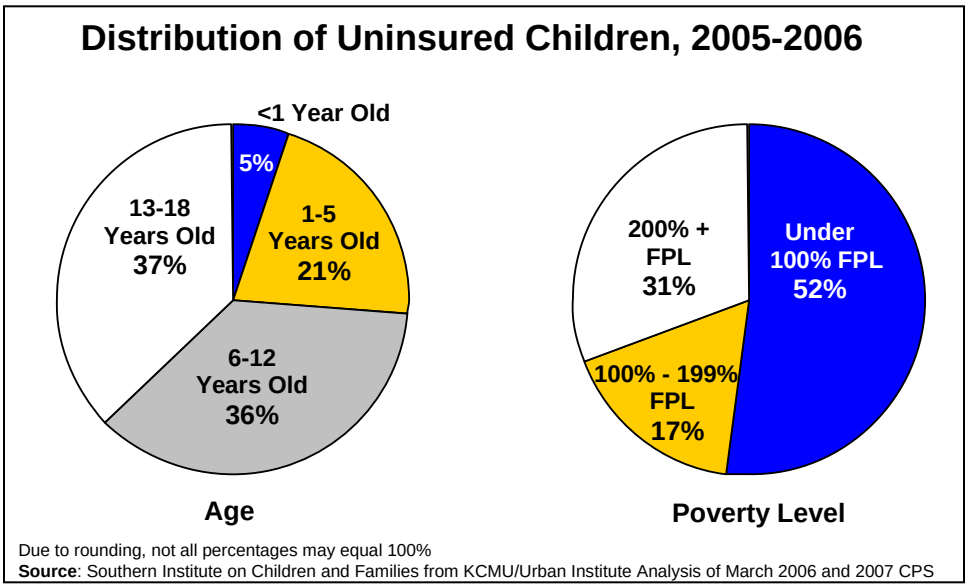
Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Data for pregnant women not available for recent years.

Louisiana
Uninsured Children: 145,259



Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS



Due to rounding, not all percentages may equal 100%
Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS

Medicaid/SCHIP Eligibility Levels for Children in Louisiana, July 2006

	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	200%	200%	200%	N/A
Annual Income	$40,000	$40,000	$40,000	N/A

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

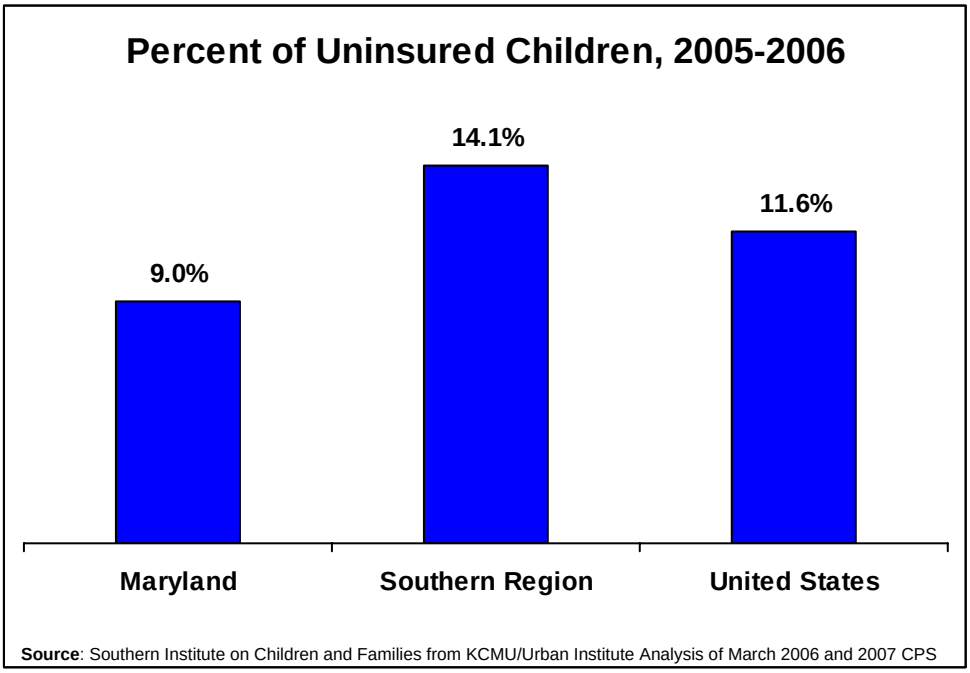
Louisiana
Pregnant Women

Medicaid/SCHIP Eligibility Levels for Pregnant Women in Louisiana, July 2006	
	Medicaid
Federal Poverty Level (FPL)	200%
Annual Income	$40,000

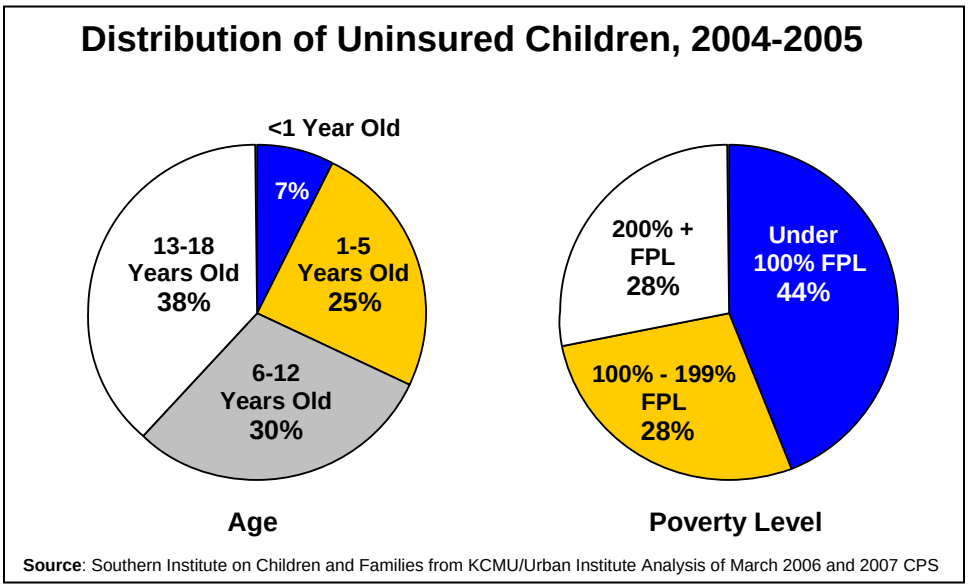
Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Data for pregnant women not available for recent years.

Maryland
Uninsured Children: 131,086



Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS



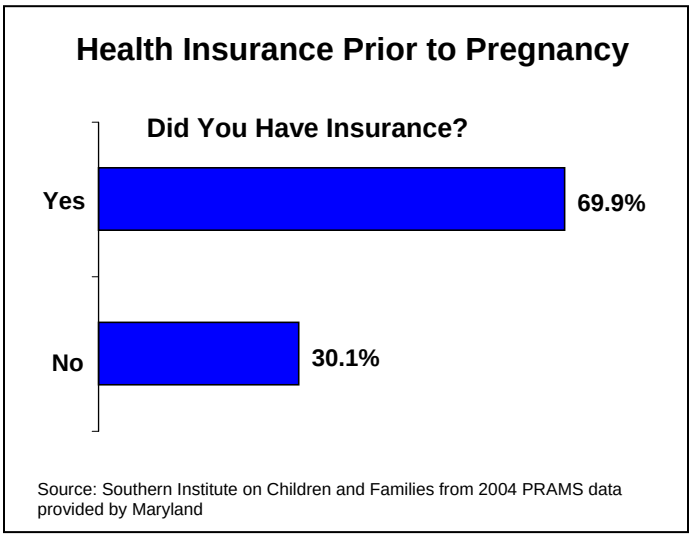
Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS

Medicaid/SCHIP Eligibility Levels for Children in Maryland, July 2006

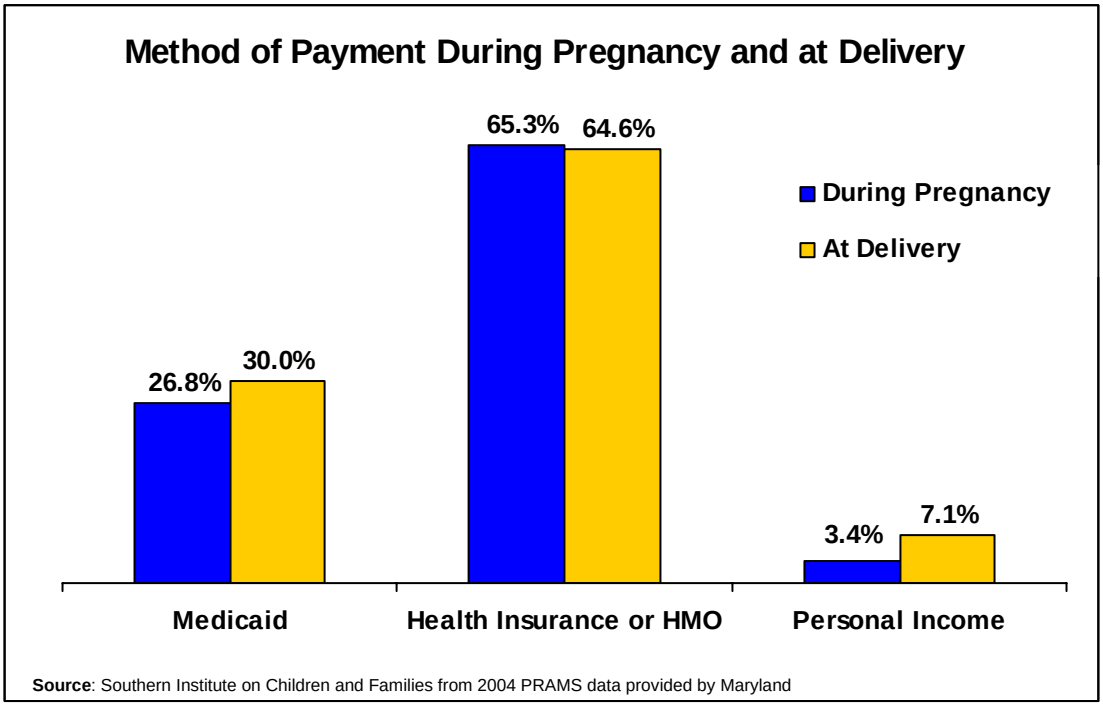
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	200%	200%	200%	300%
Annual Income	$40,000	$40,000	$40,000	$60,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

Maryland
Pregnant Women



Source: Southern Institute on Children and Families from 2004 PRAMS data provided by Maryland

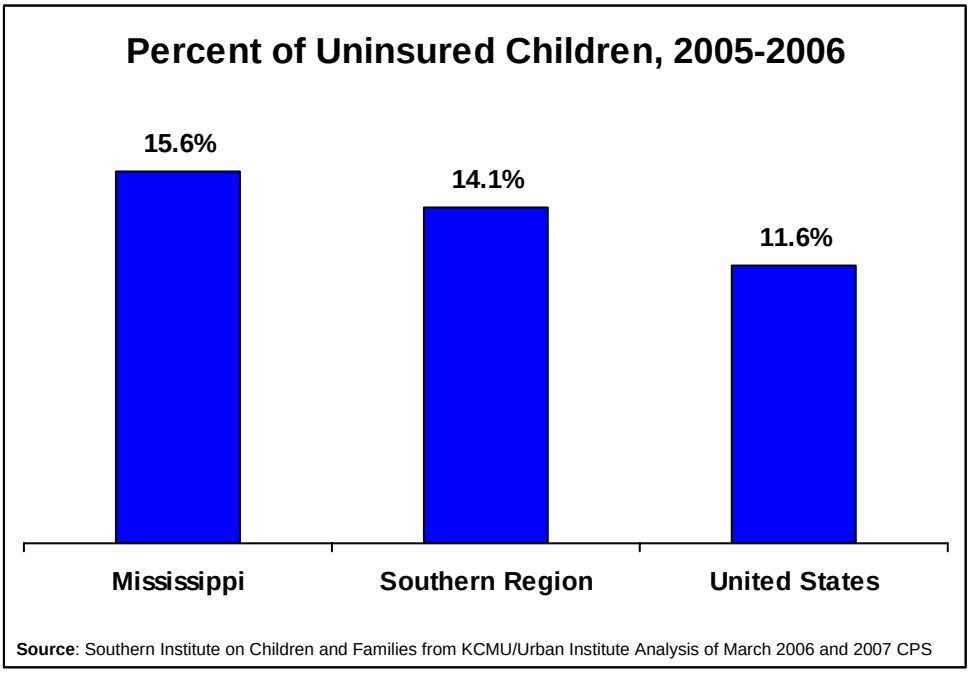


Source: Southern Institute on Children and Families from 2004 PRAMS data provided by Maryland

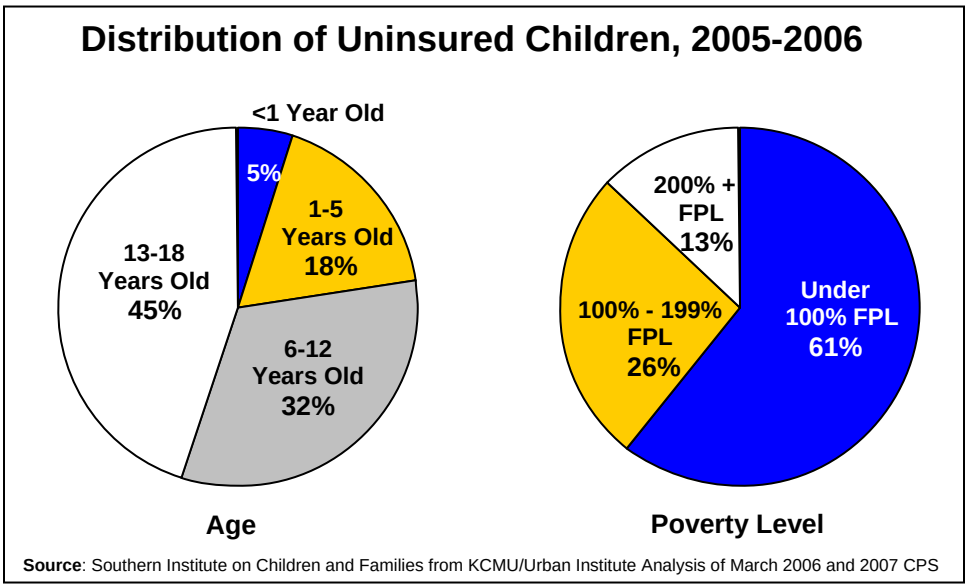
Medicaid/SCHIP Eligibility Levels for Pregnant Women in Maryland, July 2006	
	Medicaid
Federal Poverty Level (FPL)	250%
Annual Income	$50,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Mississippi
Uninsured Children: 127,822



Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS



Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS

Medicaid/SCHIP Eligibility Levels for Children in Mississippi, July 2006

	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	185%	133%	100%	200%
Annual Income	$37,000	$26,600	$20,000	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

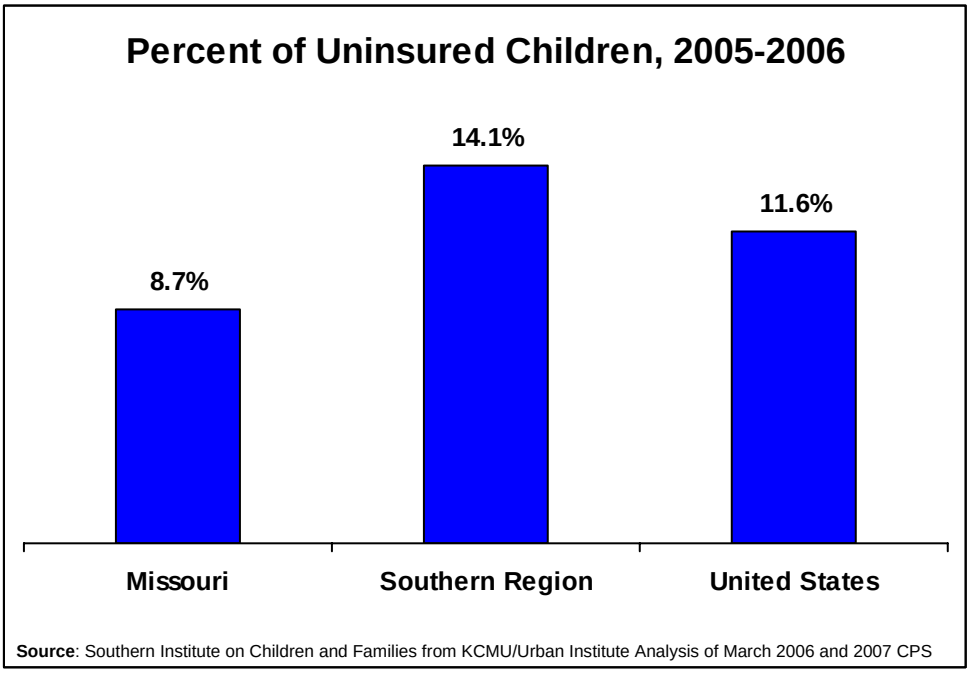
Mississippi
Pregnant Women

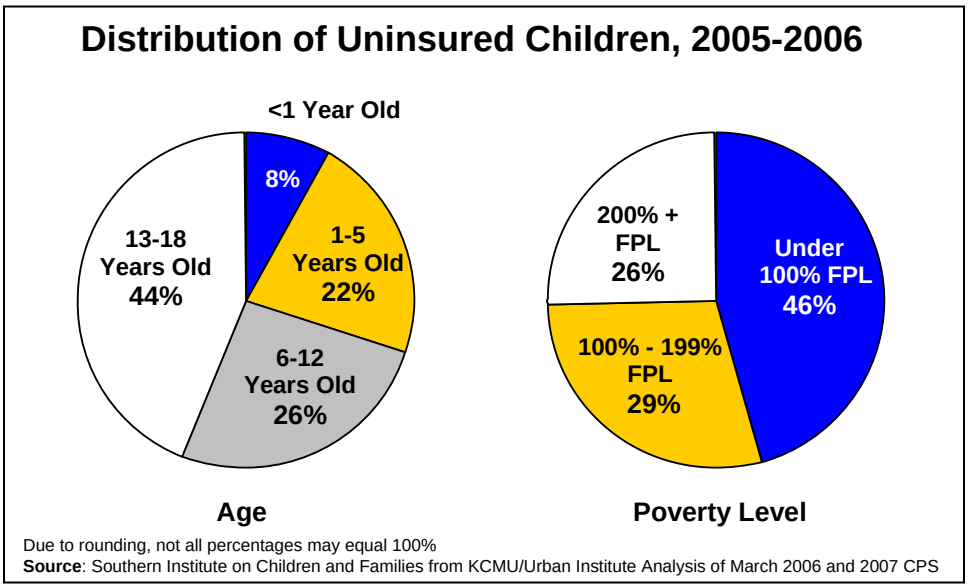
Medicaid/SCHIP Eligibility Levels for Pregnant Women in Mississippi, July 2006	
	Medicaid
Federal Poverty Level (FPL)	185%
Annual Income	$37,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Data for pregnant women not available for recent years.

Missouri
Uninsured Children: 127,484



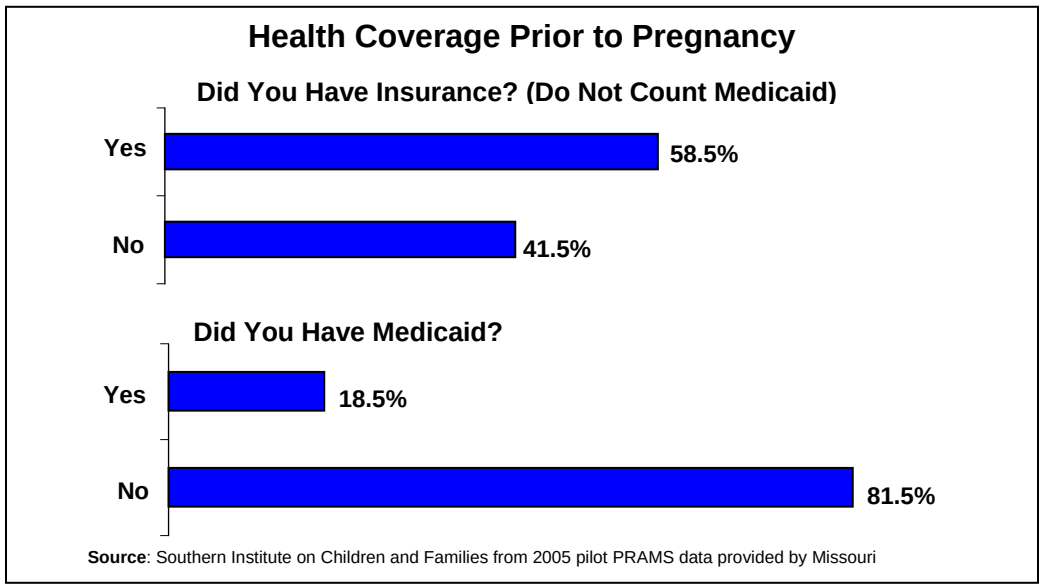


Medicaid/SCHIP Eligibility Levels for Children in Missouri, July 2006

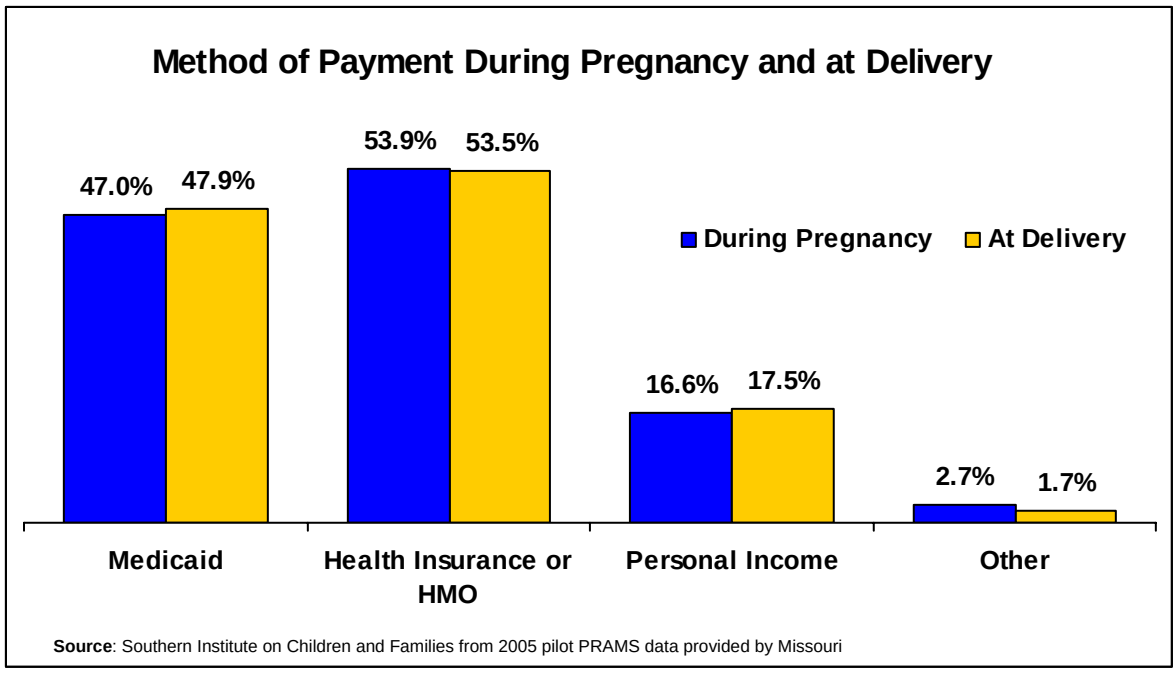
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	300%	300%	300%	N/A
Annual Income	$60,000	$60,000	$60,000	N/A

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

Missouri
Pregnant Women



Source: Southern Institute on Children and Families from 2005 pilot PRAMS data provided by Missouri

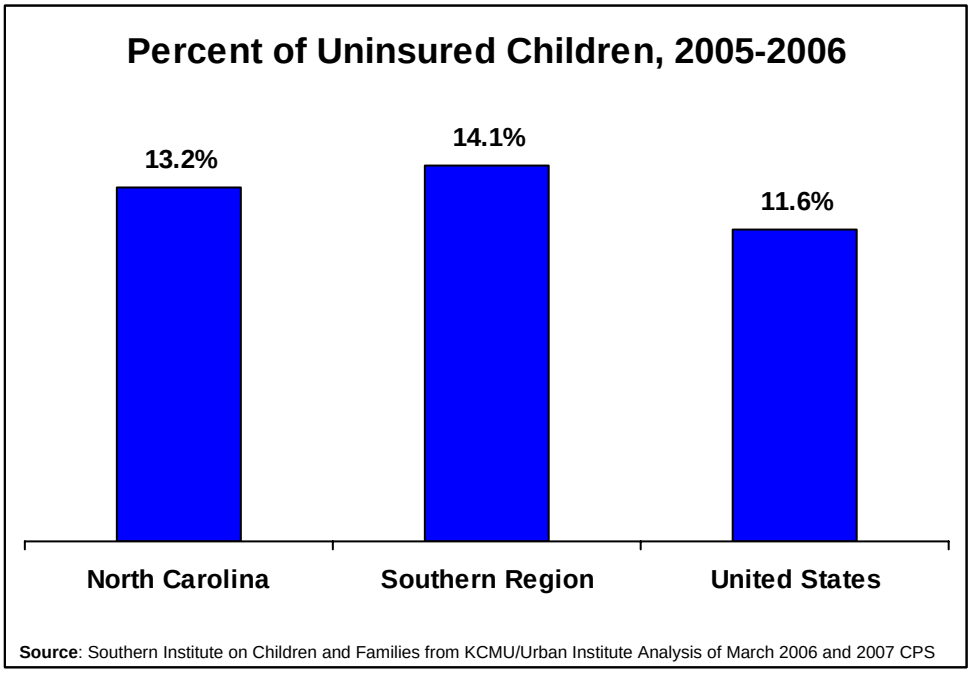


Source: Southern Institute on Children and Families from 2005 pilot PRAMS data provided by Missouri

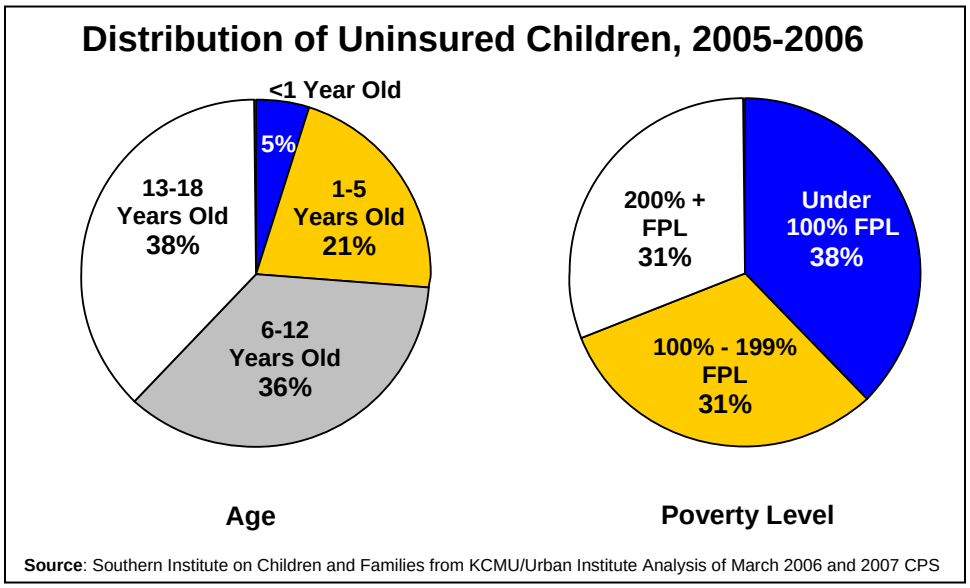
Medicaid/SCHIP Eligibility Levels for Pregnant Women in Missouri, July 2006	
	Medicaid
Federal Poverty Level (FPL)	185%
Annual Income	$37,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

North Carolina
Uninsured Children: 305,690



Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS



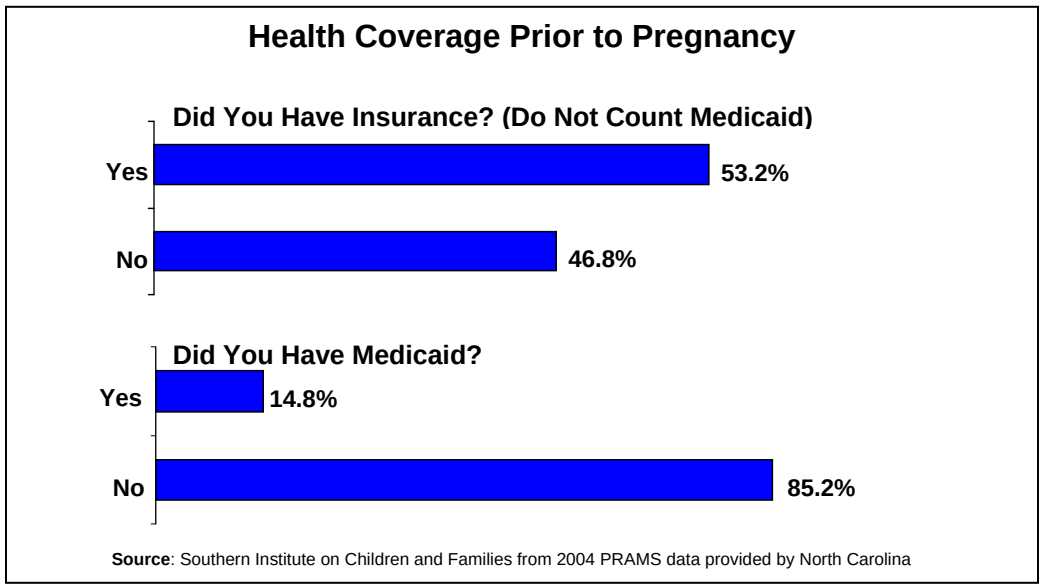
Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS

Medicaid/SCHIP Eligibility Levels for Children in North Carolina, July 2006

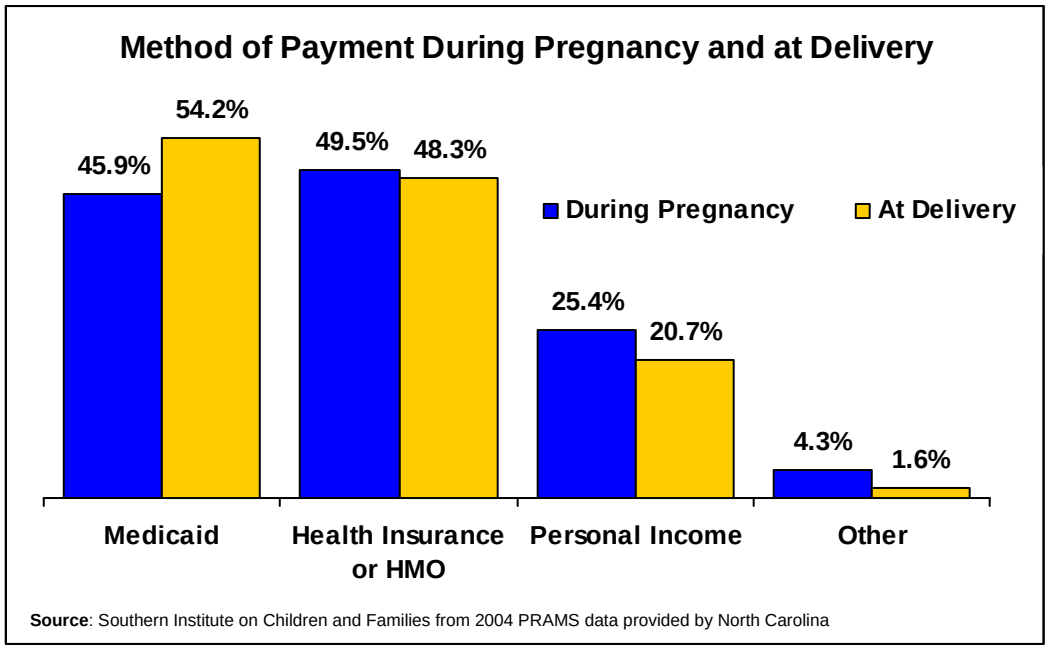
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	200%	200%	100%	200%
Annual Income	$40,000	$40,000	$20,000	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

North Carolina
Pregnant Women



Source: Southern Institute on Children and Families from 2004 PRAMS data provided by North Carolina

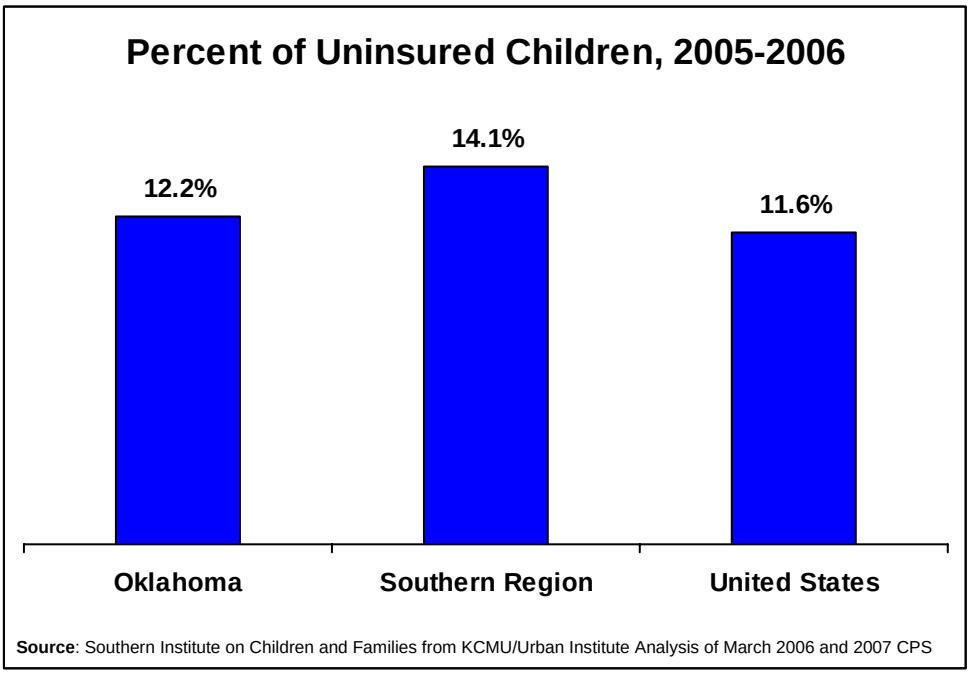


Source: Southern Institute on Children and Families from 2004 PRAMS data provided by North Carolina

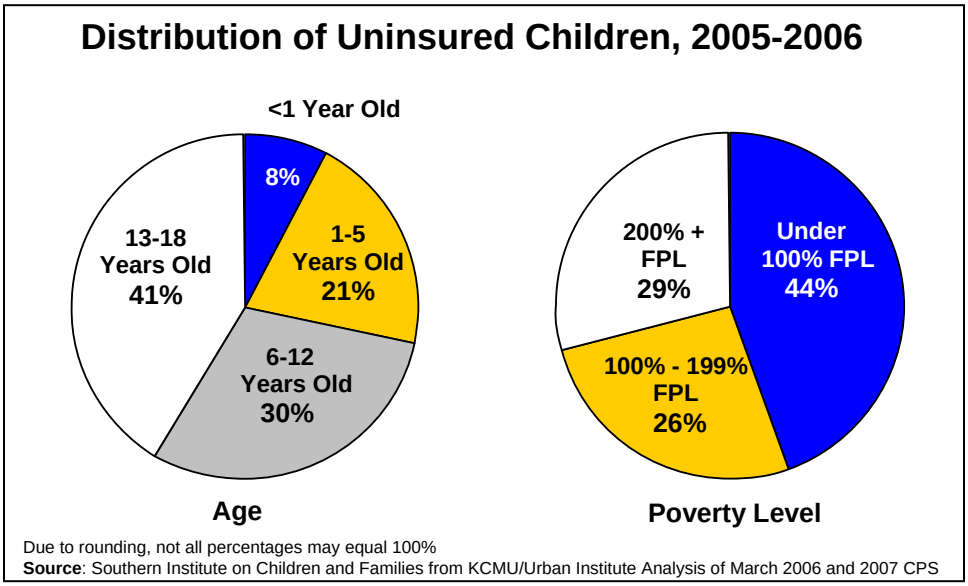
Medicaid/SCHIP Eligibility Levels for Pregnant Women in North Carolina, July 2006	
	Medicaid
Federal Poverty Level (FPL)	185%
Annual Income	$37,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Oklahoma
Uninsured Children: 113,735



Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS

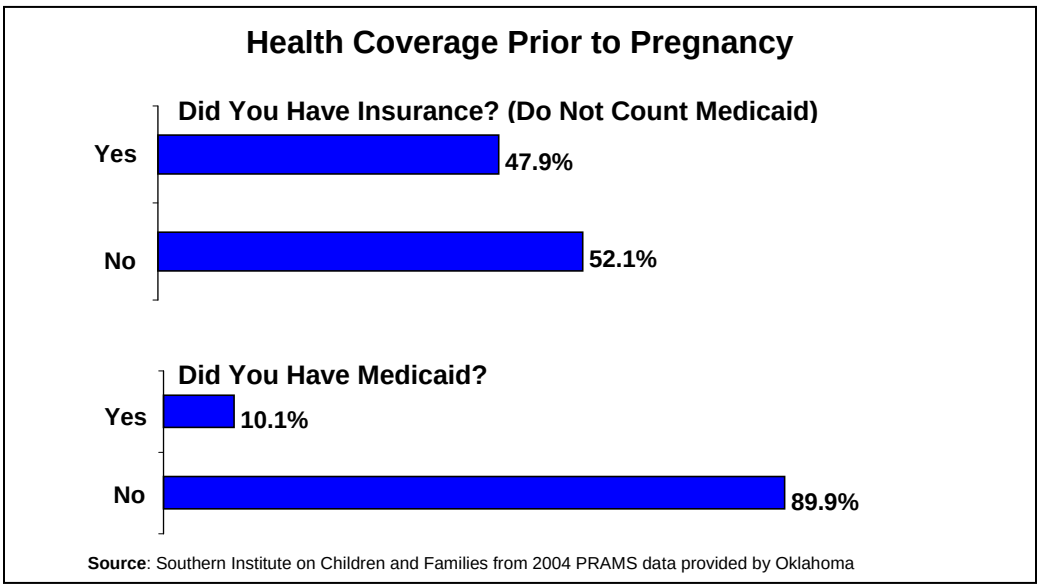


Due to rounding, not all percentages may equal 100%
Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS

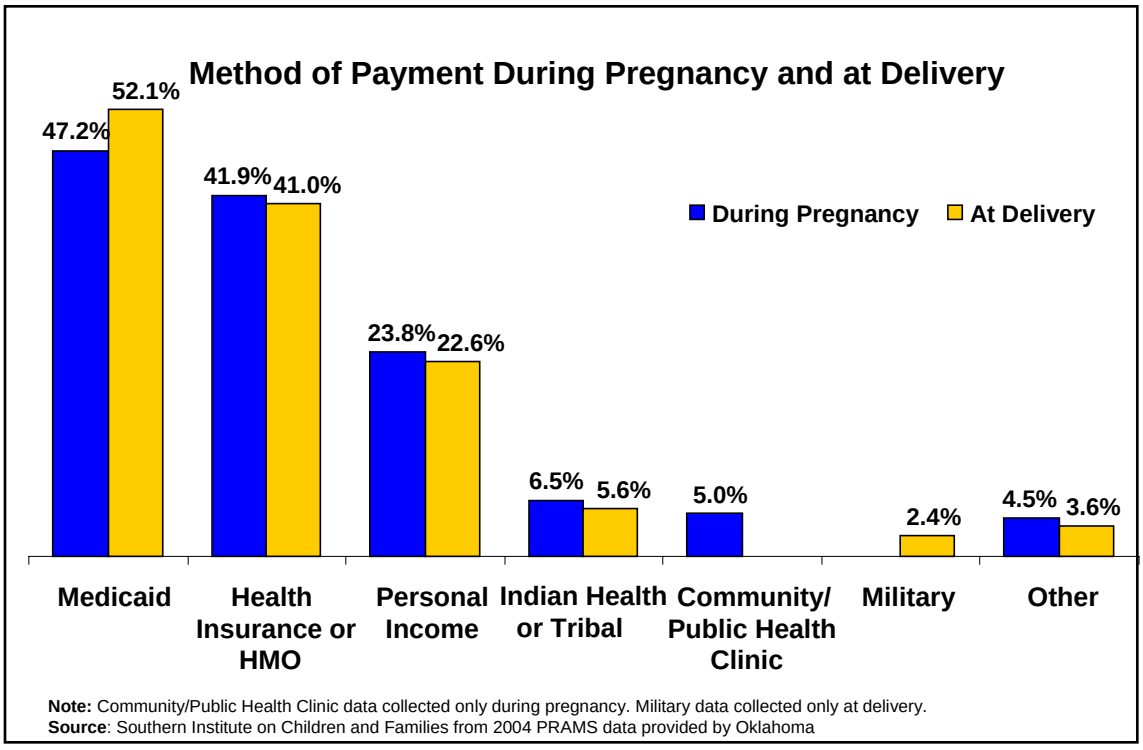
Medicaid/SCHIP Eligibility Levels for Children in Oklahoma, July 2006				
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	185%	185%	185%	N/A
Annual Income	$37,000	$37,000	$37,000	N/A

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

Oklahoma
Pregnant Women



Source: Southern Institute on Children and Families from 2004 PRAMS data provided by Oklahoma

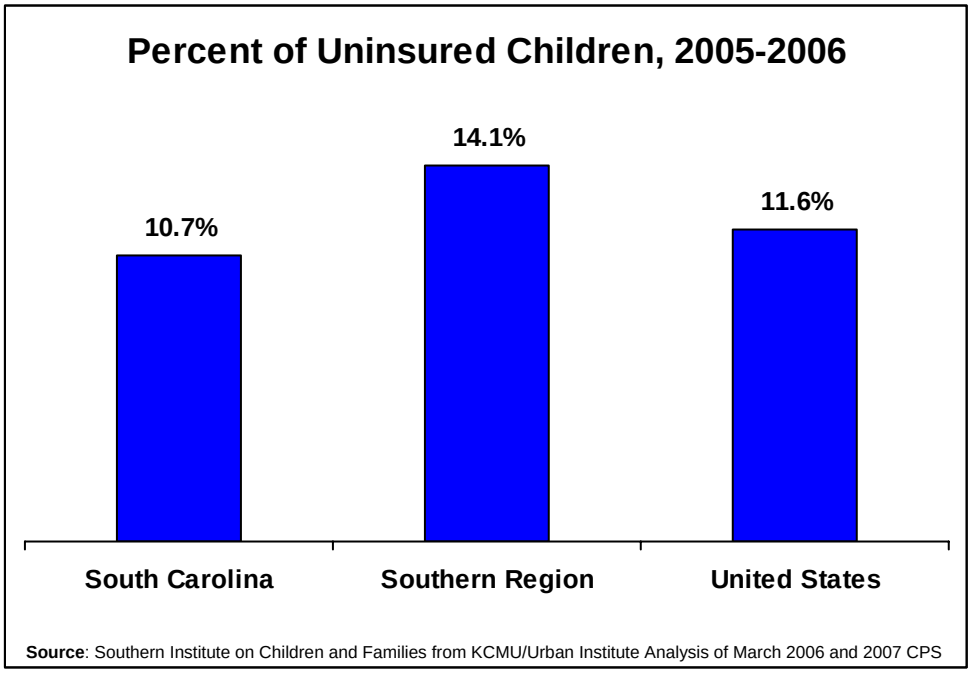


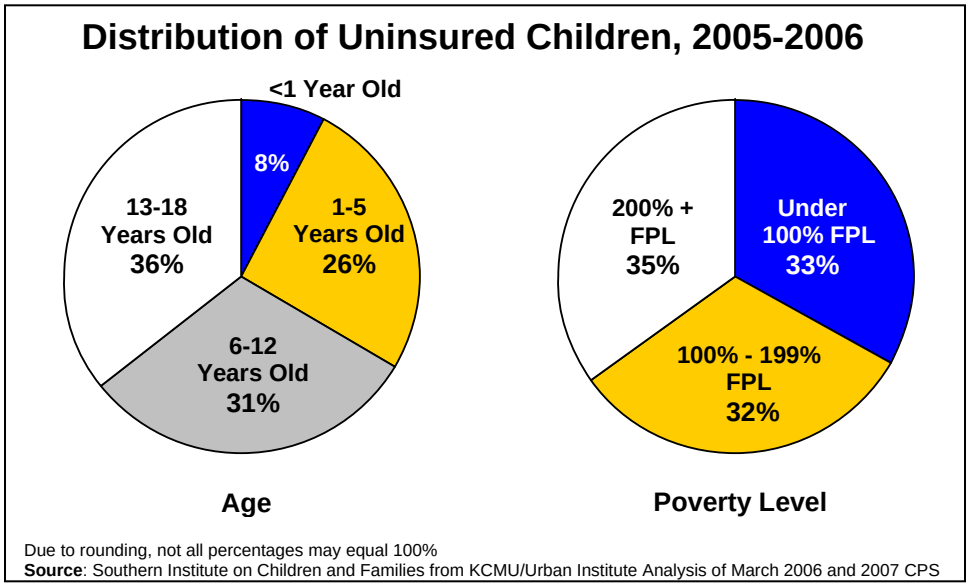
Note: Community/Public Health Clinic data collected only during pregnancy. Military data collected only at delivery.
Source: Southern Institute on Children and Families from 2004 PRAMS data provided by Oklahoma

Medicaid/SCHIP Eligibility Levels for Pregnant Women in Oklahoma, July 2006	
	Medicaid
Federal Poverty Level (FPL)	185%
Annual Income	$37,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

South Carolina
Uninsured Children: 115,115



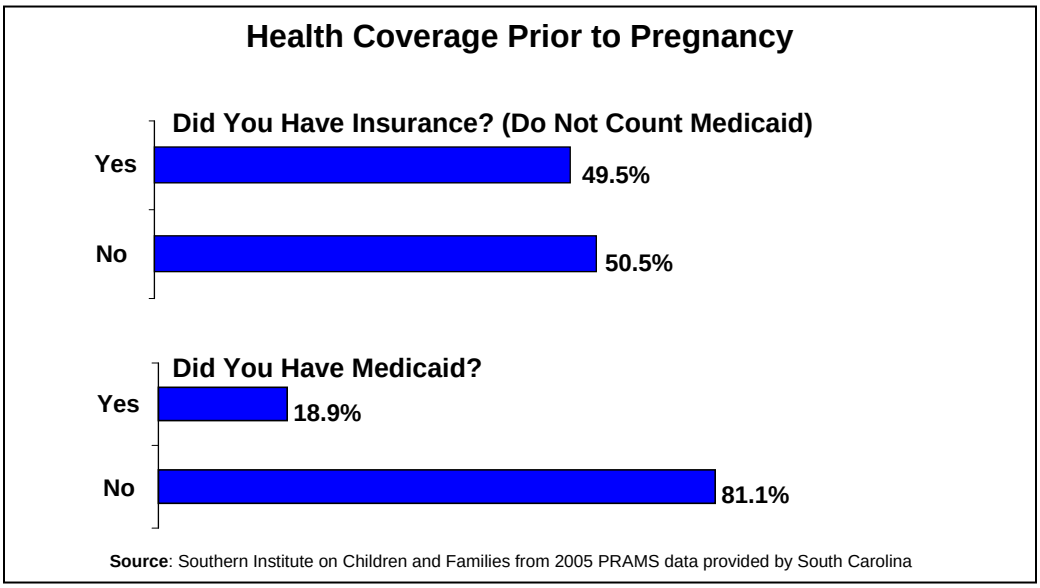


Medicaid/SCHIP Eligibility Levels for Children in South Carolina, July 2006

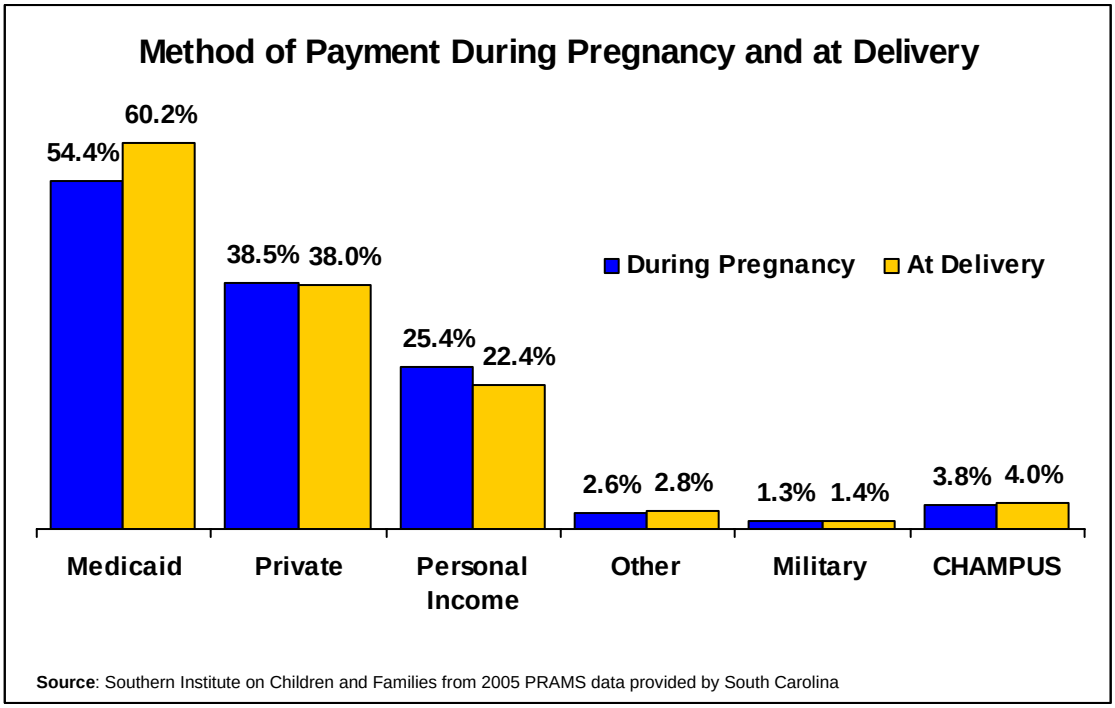
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	185%	150%	150%	N/A
Annual Income	$37,000	$30,000	$30,000	N/A

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

South Carolina
Pregnant Women



Source: Southern Institute on Children and Families from 2005 PRAMS data provided by South Carolina

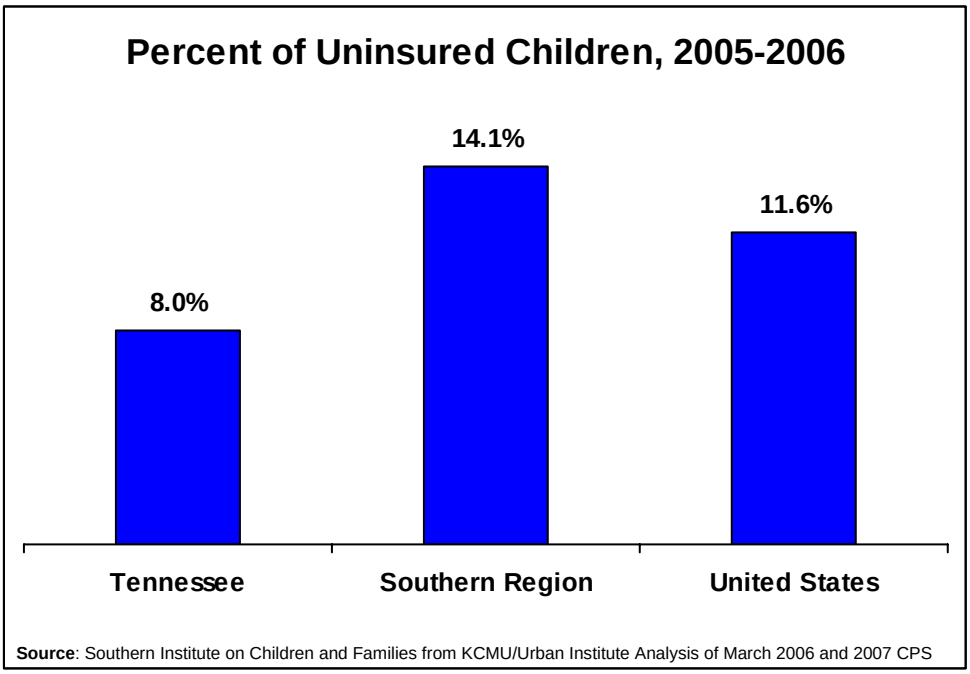


Source: Southern Institute on Children and Families from 2005 PRAMS data provided by South Carolina

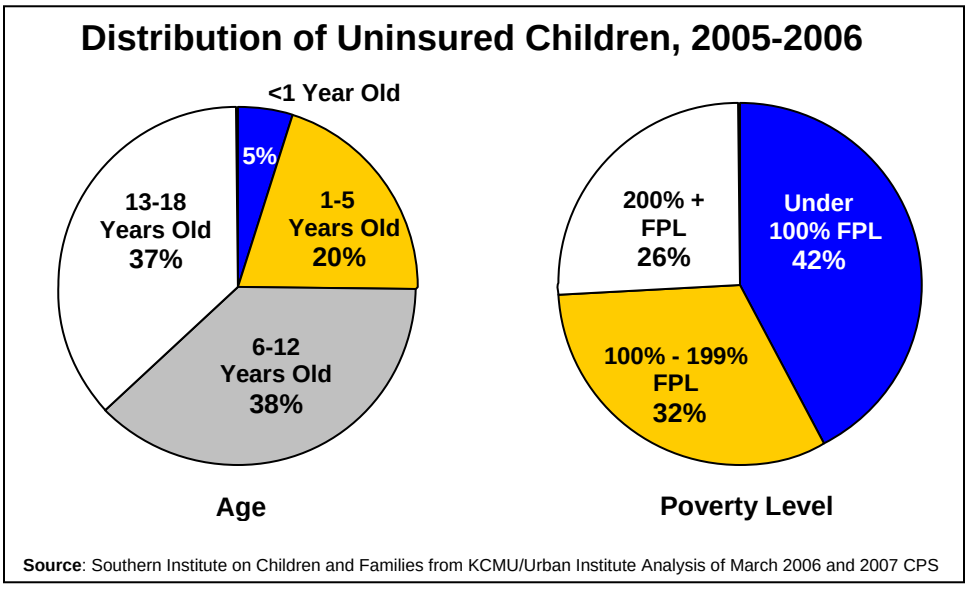
Medicaid/SCHIP Eligibility Levels for Pregnant Women in South Carolina, July 2006	
	Medicaid
Federal Poverty Level (FPL)	185%
Annual Income	$37,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Tennessee
Uninsured Children: 121,456



Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS



Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS

Medicaid/SCHIP Eligibility Levels for Children in Tennessee, July 2006

	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	185%	133%	100%	N/A
Annual Income	$37,000	$26,600	$20,000	N/A

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

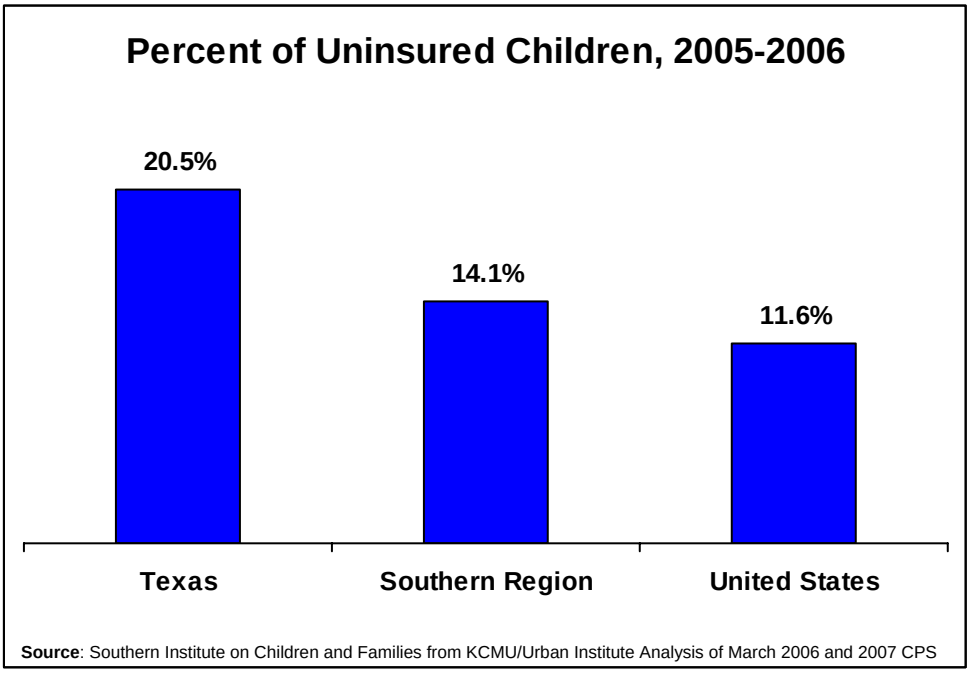
Tennessee
Pregnant Women

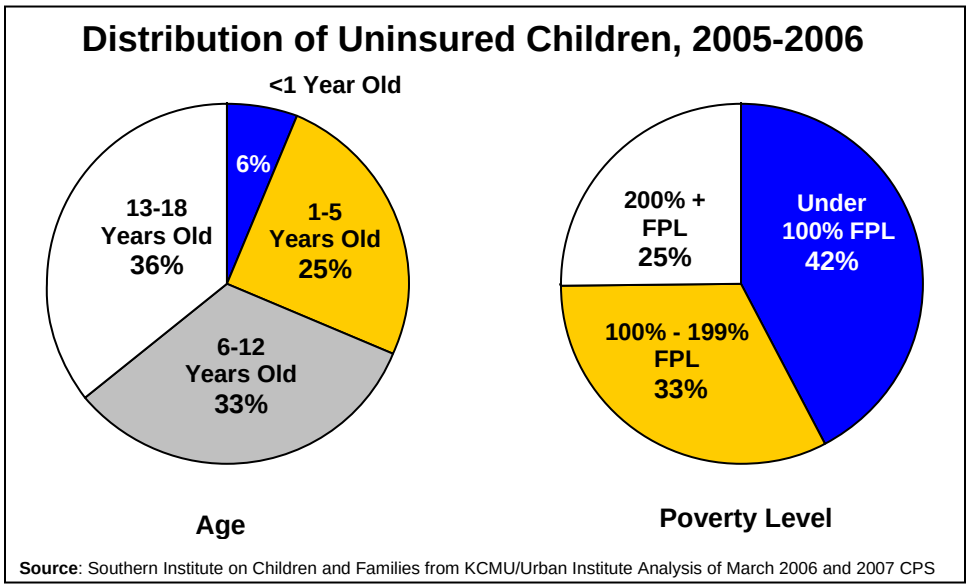
Medicaid/SCHIP Eligibility Levels for Pregnant Women in Tennessee, July 2006	
	Medicaid
Federal Poverty Level (FPL)	185%
Annual Income	$37,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Data for pregnant women not available for recent years.

Texas
Uninsured Children: 1,405,819

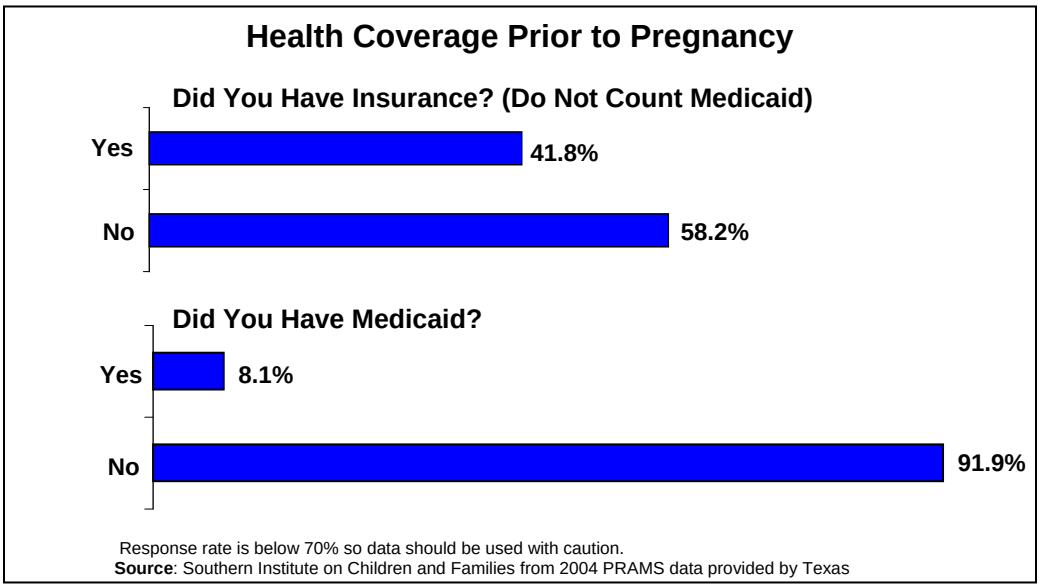




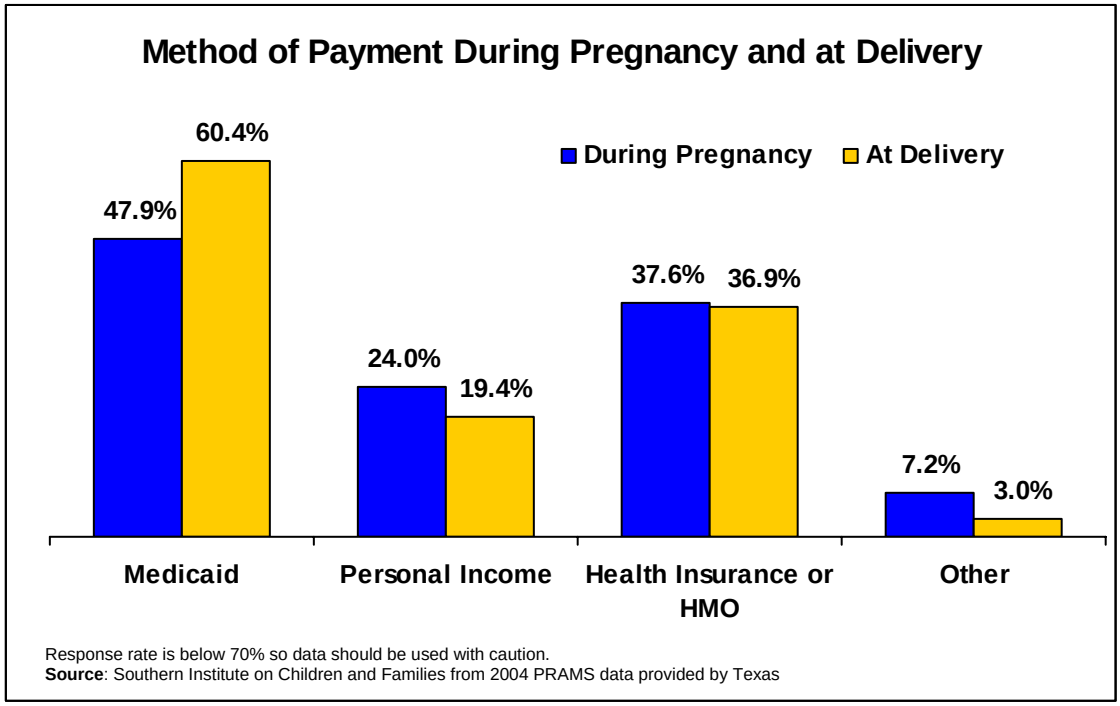
Medicaid/SCHIP Eligibility Levels for Children in Texas, July 2006				
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	185%	133%	100%	200%
Annual Income	$37,000	$26,600	$20,000	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

Texas
Pregnant Women



Response rate is below 70% so data should be used with caution.
Source: Southern Institute on Children and Families from 2004 PRAMS data provided by Texas

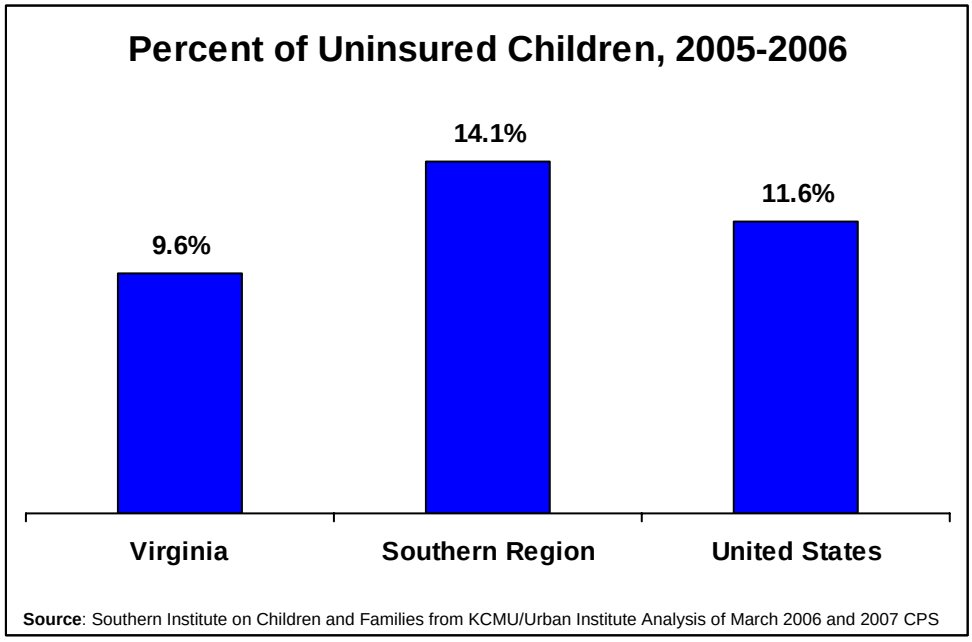


Response rate is below 70% so data should be used with caution.
Source: Southern Institute on Children and Families from 2004 PRAMS data provided by Texas

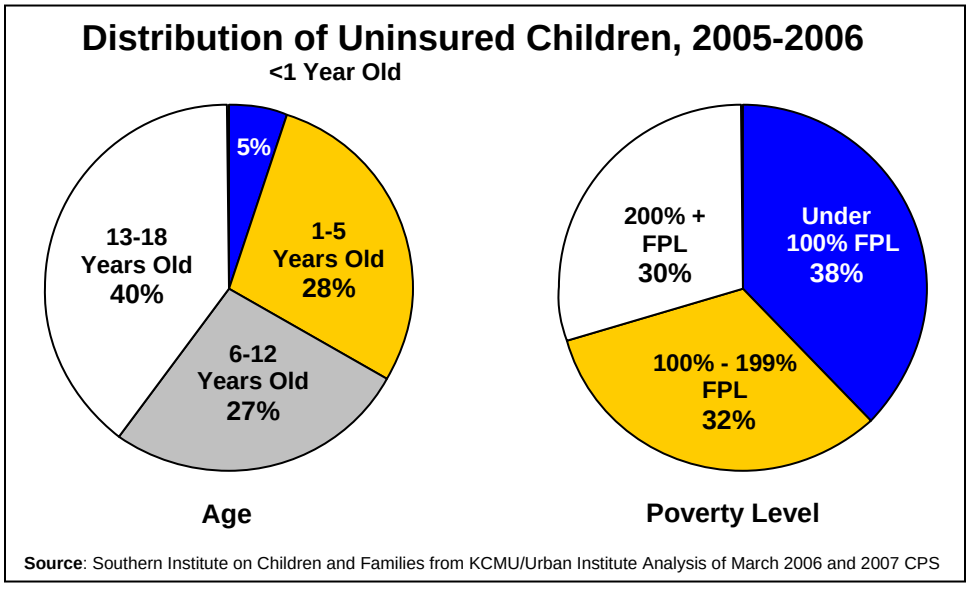
Medicaid/SCHIP Eligibility Levels for Pregnant Women in Texas, July 2006	
	Medicaid
Federal Poverty Level (FPL)	185%
Annual Income	$37,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

Virginia
Uninsured Children: 185,020



Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS

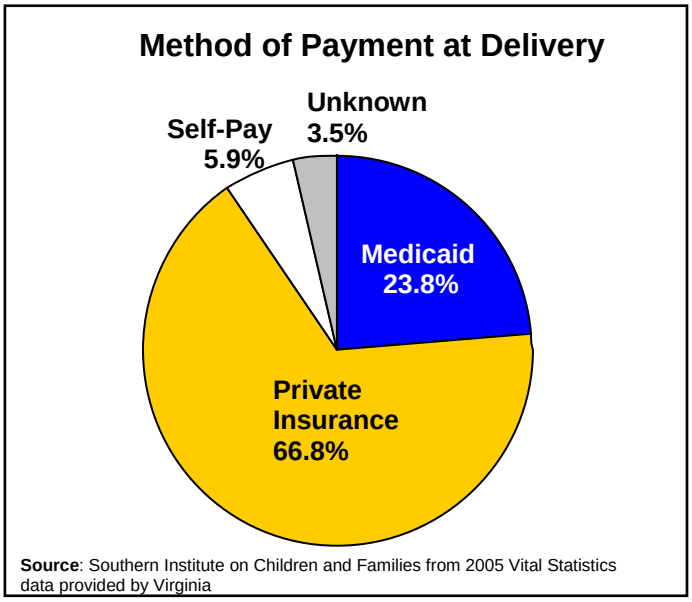


Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS

Medicaid/SCHIP Eligibility Levels for Children in Virginia, July 2006				
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level (FPL)	133%	133%	133%	200%
Annual Income	$26,600	$26,600	$26,600	$40,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

Virginia
Pregnant Women

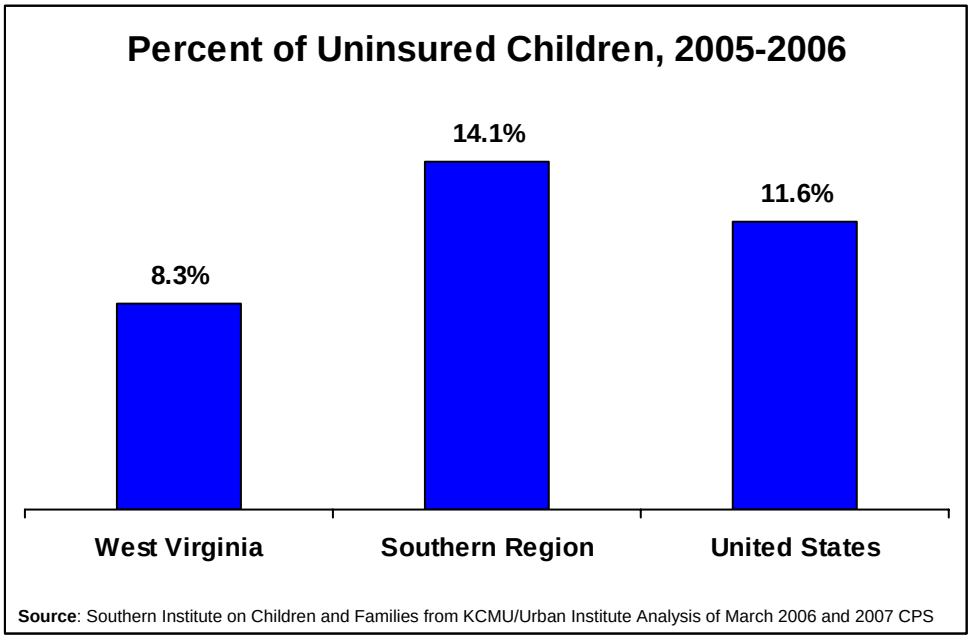


Source: Southern Institute on Children and Families from 2005 Vital Statistics data provided by Virginia

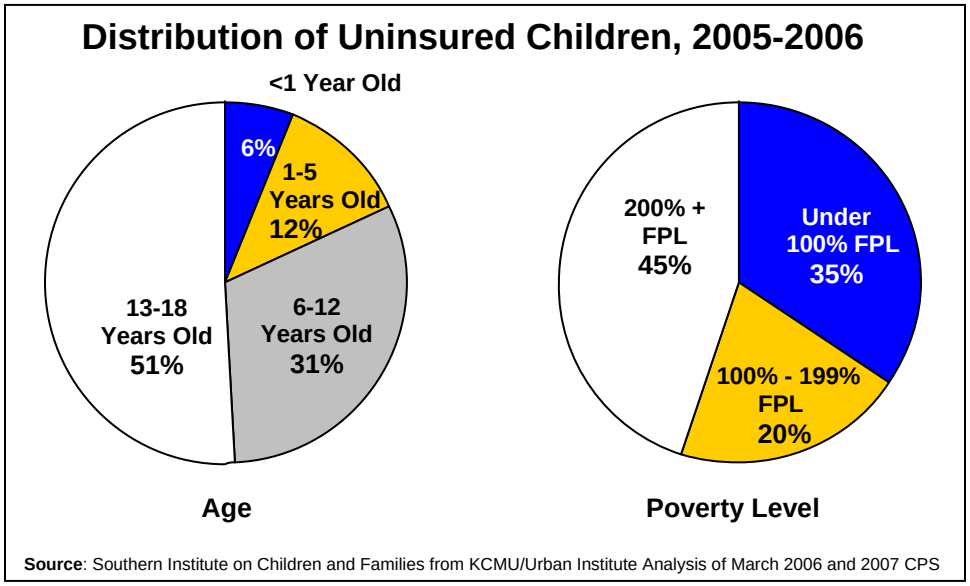
Medicaid/SCHIP Eligibility Levels for Pregnant Women in Virginia, July 2006	
	Medicaid
Federal Poverty Level (FPL)	166%
Annual Income	$33,200

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

West Virginia
Uninsured Children: 34,451



Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS



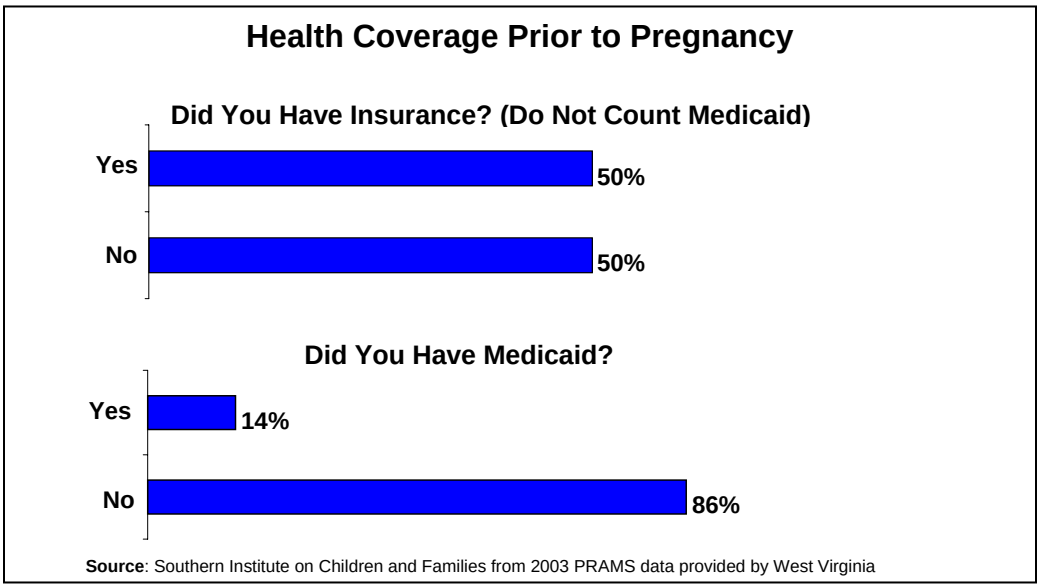
Source: Southern Institute on Children and Families from KCMU/Urban Institute Analysis of March 2006 and 2007 CPS

Medicaid/SCHIP Eligibility Levels for Children in West Virginia, July 2006

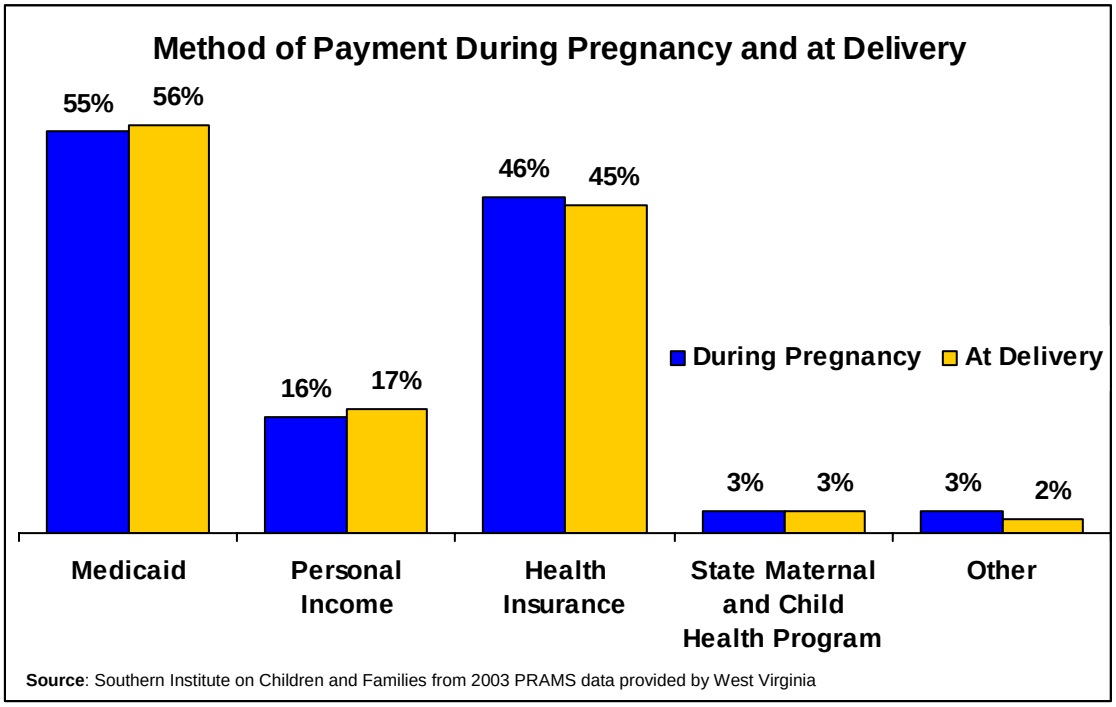
	Medicaid			Separate SCHIP Program
	Birth-Age 1	Ages 1-5	Ages 6-19	Ages 0-19
Federal Poverty Level	150%	133%	100%	220%
Annual Income	$30,000	$26,600	$20,000	$44,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income levels based on family of four.

West Virginia
Pregnant Women



Source: Southern Institute on Children and Families from 2003 PRAMS data provided by West Virginia



Source: Southern Institute on Children and Families from 2003 PRAMS data provided by West Virginia

Medicaid/SCHIP Eligibility Levels for Pregnant Women in West Virginia, July 2006	
	Medicaid
Federal Poverty Level (FPL)	150%
Annual Income	$30,000

Source: Southern Institute on Children and Families, adapted from Cohen Ross, Cox & Marks, January 2007. Annual income level based on family of four.

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APPENDICES

APPENDIX 1

Methodology

Source of Estimates of Uninsured Children

The source of the estimates of uninsured children is based on the national Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS) for 2005-2006. In addition, ASEC data for 1999 and 2004 were used for trend analysis. The ASEC is the most commonly cited estimate of the number of uninsured children in the United States (Lewis, Ellwood & Czajka, 1998). The numbers in this report are calculated from the ASEC-CPS to include all children from birth through age 18 in the southern region.

The CPS is a monthly survey of a household sample of the civilian non-institutionalized population that is conducted by the US Census Bureau. The ASEC is conducted on a random sample of households from an address listing file that is updated continuously by the Census Bureau. The data are collected via in-person interviews and telephone surveys. The response rate is generally high and was 84% in 2003 (SHADAC & Urban Institute, 2005). The ASEC focuses on the employment status of household members for the prior year, and thus information on insurance status is collected. For sampled households, respondents are asked to identify which forms of health coverage each person in the household had at any time during the preceding calendar year.

Respondents are asked if household members had the following types of coverage in the prior year:

- Employer-based coverage
- Private insurance not employer-based
- Medicaid
- Medicare
- State specific health insurance, including SCHIP
- CHAMPUS/VA/Military Health Care

If a respondent answers “no” to all of the above categories for any household member, then a follow-up question is asked to confirm that the household member(s) was not covered by any health plan at any time during the preceding year. Uninsured in this data set means the lack of any health insurance for an entire year.

The most recent ASEC-CPS 2007 estimates for the 2006 calendar year were released in August 2007, and these data along with some data from previous years were used for this edition.

There is debate over whether the ASEC-CPS insurance estimates actually cover an entire year; many believe it more accurately depicts a point-in-time estimate of coverage when the question was asked (SHADAC & Urban Institute, 2005; Lewis, Ellwood & Czajka, 1998). There also is a concern that undercounting public coverage leads to overestimates of the uninsured (SHADAC & Urban Institute, 2005). However, no matter which data set is used to derive uninsured estimates, most experts agree that the overall trends hold true across various estimates and the total numbers indicate that the US has a sizeable number of uninsured children (SHADAC & Urban Institute, 2005).

The Henry J. Kaiser Family Foundation with the Urban Institute analyzed most of the CPS figures used in this report in 2007, aggregating CPS data for 2005 and 2006 to ensure a large enough sample size to make stable estimates at the state level. They also provided estimates that included all children in the southern region up through age 18. In addition, the Southern Institute on Children and Families accessed CPS data directly, analyzed these data, and created many of the tables and all of the graphs and charts for this report.

Source of Estimates of Uninsured Pregnant Women

The source of the estimates of pregnant women is the Pregnancy Risk Assessment Monitoring System (PRAMS) for the ten states (Alabama, Arkansas, Florida, Georgia, Maryland, North Carolina, Oklahoma, South Carolina, Texas and West Virginia) that had PRAMS data available for recent years. One state (Missouri) had data from a pilot project modeled after the PRAMS survey. Two states (Delaware and Virginia) that did not have PRAMS data provided Vital Statistics birth record data.

Pregnancy Risk Assessment Monitoring System

The Pregnancy Risk Assessment Monitoring System, known as PRAMS, is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments initiated in 1987. State participation in PRAMS is voluntary. State-specific data are gathered for PRAMS on maternal attitudes and experiences before, during, and shortly after pregnancy.

PRAMS provides data to state health officials and policymakers to use for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health. The goal of the PRAMS project is to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity and maternal morbidity.

The population-based survey samples all women in a state who recently had a live birth. Low birth weight (under 2500 grams) and very low birth weight (under 1800 grams) are oversampled in the data set to allow a large enough sample of these adverse birth outcomes. This stratified data is then weighted in analyses to allow findings to be applied to the state's entire population of women who have recently delivered a live-born infant.

Participating states randomly identify a stratified systematic sample of 100-250 new mothers monthly, based on birth certificate information (Melvin *et al*, 2000). Most states mail a questionnaire to respondents with telephone and in-person interview follow-ups if

the mailed questionnaire is not returned in a timely manner. Response rates vary, and the CDC strongly cautions against relying on state PRAMS data when the state has lower than a 70% response rate in any given year.

While there are certain core questions asked in all states that conduct PRAMS surveys, states also have the option of asking state-specific questions. States also report different aspects of data and disseminate data differently. Some states in the southern region have online access to their data, other states will entertain requests for special data runs, and still others periodically publish reports from which data can be culled. Some states require research proposals in order to access any data.

The specific questions from the survey used for this edition of the report for developing profiles and estimating uninsurance among pregnant women in the southern states included:

- Just before you got pregnant, did you have health insurance? Do not count Medicaid.
- Just before you got pregnant, were you on Medicaid?
- How was your prenatal care paid for? Check all that apply.
- How was your delivery paid for? Check all that apply.

Not all the southern states participate in PRAMS, and some of those that do participate were unable to provide the data within our requested time frame. Vital statistics data on method of payment for delivery were collected when available in cases where states were unable to provide PRAMS data.

Vital Statistics Birth Records

All states collect data on births though birth certificates. This is considered a census of all births in a state for a given year. These records do not include information on health insurance coverage prior to pregnancy, and not all states collect or report data on the method of payment during pregnancy or at delivery.

APPENDIX 2

Federal Poverty Guidelines for a Family of Four, 2004-2007				
Percentage of HHS Federal Poverty Guidelines	**Annual Income 2004**	**Annual Income 2005**	**Annual Income 2006**	**Annual Income 2007**
100%	$18,850.00	$19,350.00	$20,000.00	$20,650.00
120%	$22,620.00	$23,220.00	$24,000.00	$24,780.00
133%	$25,070.50	$25,735.50	$26,600.00	$27,464.50
135%	$25,447.50	$26,122.50	$27,000.00	$27,877.50
150%	$28,275.00	$29,025.00	$30,000.00	$30,975.00
175%	$32,987.50	$33,862.50	$35,000.00	$36,137.50
185%	$34,872.50	$35,797.50	$37,000.00	$38,202.50
200%	$37,700.00	$38,700.00	$40,000.00	$41,300.00
250%	$47,125.00	$48,375.00	$50,000.00	$51,625.00

Source: http://aspe.hhs.gov/poverty/figures-fed-reg.shtml

APPENDIX 3

Total Medicaid Enrollment in the Southern States and the District of Columbia (June 1997 to June 2005)
Monthly Enrollment in Thousands

State	Jun-97	Jun-98	Jun-99	Jun-00	Jun-01	Jun-02	Jun-03	Jun-04	Jun-05
Alabama	497.4	504.5	526.4	542.8	579.4	622.4	651.7	678.2	687.3
Arkansas	273.3	298.0	315.0	329.8	372.6	415.9	410.6	438.0	458.4
DC	132.0	127.1	135.1	117.9	131.0	131.4	131.8	135.4	137.3
Delaware	80.8	81.0	91.0	98.2	108.1	116.2	125.3	135.1	140.5
Florida	1,454.9	1,403.5	1,438.1	1,582.7	1,741.3	1,901.2	1,982.2	2,091.7	2,201.2
Georgia	946.6	926.0	927.4	912.0	996.9	1,125.0	1,254.0	1,325.5	1,379.8
Kentucky	542.4	533.3	536.4	563.3	597.9	613.3	653.0	656.7	671.9
Louisiana	542.2	532.0	561.4	634.7	715.5	814.6	882.8	945.1	990.6
Maryland	438.9	413.6	399.7	412.0	434.9	456.5	467.1	495.6	506.7
Mississippi	409.3	382.5	401.5	445.8	545.4	576.1	584.8	579.2	593.3
Missouri	572.2	567.9	621.7	670.8	745.1	789.9	847.7	871.6	877.4
North Carolina	828.5	815.4	828.5	872.6	971.9	1,023.6	1,074.6	1,112.3	1,137.5
Oklahoma	282.5	310.5	329.8	369.1	404.4	437.0	450.7	472.4	486.7
South Carolina	393.6	443.0	452.6	535.0	631.7	664.5	678.1	656.6	654.1
Tennessee	1,188.6	1,266.4	1,296.3	1,282.8	1,416.6	1,410.8	1,304.8	1,345.1	1,350.4
Texas	1,944.1	1,803.5	1,749.3	1,761.4	1,849.3	2,200.1	2,554.8	2,683.6	2,782.9
Virginia	522.1	498.6	491.7	480.7	480.3	502.2	540.3	596.3	628.0
West Virginia	300.3	308.9	266.8	259.1	262.4	279.1	289.1	296.0	299.7
Total	**11,349.7**	**11,215.7**	**11,368.7**	**11,870.7**	**12,984.7**	**14,079.8**	**14,883.4**	**15,514.4**	**15,983.7**

This state-provided enrollment data are "point-in-time" counts of enrollment, reflecting the number of children and adults enrolled in Medicaid in each state in the indicated month as reported in the referenced report. "Point-in-time" data differ from an "ever-enrolled, for any length of time" count of enrollees, such as in reports issued by the federal Centers for Medicare & Medicaid Services (CMS).

Source: Ellis, Smith, Rousseau & Schwartz, December 2006.

APPENDIX 4

Total Monthly SCHIP Enrollment in the Southern States and the District of Columbia (December 1998 to June 2005)									
	Program Type*	***Dec-98***	***Dec-99***	***Dec-00***	***Dec-01***	***Dec-02***	***Dec-03***	***Dec-04***	***Jun-05***
Alabama	S	22,102	33,638	32,915	46,971	55,423	58,696	62,817	64,342
Arkansas	M	341	1,021	1,498	1,686	-	-	-	61,102
Delaware	C	-	2,510	3,823	3,502	4,515	4,751	4,413	4,360
DC	M	569	2,187	3,178	2,554	3,786	3,720	4,379	4,573
Florida	C	56,265	124,763	188,364	221,388	283,079	319,477	271,946	203,983
Georgia	S	213	56,116	106,574	150,330	171,702	196,615	211,857	228,801
Kentucky	C	5,188	28,068	52,653	50,486	50,340	51,381	49,638	49,377
Louisiana	M	3,741	26,649	40,551	69,906	81,077	94,799	106,091	107,914
Maryland	C	35,757	62,893	82,065	96,581	109,827	89,574	90,852	95,018
Mississippi	S	8,276	11,191	30,827	49,608	53,937	61,159	67,015	68,068
Missouri	M	23,998	54,306	70,888	77,811	81,707	89,811	94,457	93,730
North Carolina	S	17,887	55,723	72,024	64,815	89,446	104,923	122,613	130,467
Oklahoma	M	15,523	32,503	37,000	40,707	43,217	46,110	54,905	54,427
South Carolina	M	38,006	43,773	44,392	47,680	42,395	45,534	51,469	52,561
Tennessee	-	13,603	16,805	12,873	6,320	-	-	-	-
Texas	S	35,477	28,513	200,290	492,803	500,567	438,164	335,751	326,473
Virginia	C	1,420	19,569	29,967	36,091	46,611	56,258	68,524	73,187
West Virginia	S	329	8,935	15,653	20,593	21,348	22,790	24,283	24,515
Total		**278,695**	**609,163**	**1,025,535**	**1,479,832**	**1,638,977**	**1,683,762**	**1,621,010**	**1,642,898**

* SCHIP program classification is as of June 2005. M = Medicaid Expansion Program S = Separate Program C = Combined Program
This state-provided enrollment data are "point-in-time" counts of enrollment, reflecting the number of children and adults enrolled in SCHIP programs in each state in the indicated month as reported in SCHIP enrollment reports for 2004 and 2005 referenced below. "Point-in-time" data differ from an "ever-enrolled, for any length of time" count of enrollees, such as in reports issued by the federal Centers for Medicare & Medicaid Services (CMS).

Source: Smith, Rousseau & O'Malley, July 2004; Smith & Rousseau, September 2005; Smith, Rousseau & Marks, December 2006.

APPENDIX 5

Births Financed by Medicaid as a Percentage of Total Births, 2002		
Rank	**State**	**As Percent of State Births**
1	District of Columbia	64.0%
2	Louisiana	56.4%
3	Mississippi	55.8%
4	Arkansas	53.0%
5	West Virginia	50.0%
6	Texas	49.2%
7	Georgia	49.0%
8	Oklahoma	47.7%
9	Tennessee[1]	47.6%
10	South Carolina	47.0%
11	Alabama	46.0%
12	Delaware	46.0%
13	Missouri	44.9%
14	North Carolina	44.0%
15	Florida	43.9%
16	Kentucky	38.4%
17	Maryland	33.8%
18	Virginia[2]	31.2%
	United States[3]	**41.3%**

1. Tennessee figures include both Medicaid and Expansion population.
2. Virginia data is based on the state fiscal year.
3. The total number of births to all US pregnant women in 2002 was 4,019,280. Centers for Disease Control and Prevention (CDC). National Vital Statistics Reports, Vol. 51, No. 11, June 25, 2003.

Source: Kaiser Family Foundation, 2002. http://www.statehealthfacts.org

APPENDIX 6

Income Threshold for Parents Applying for Medicaid[1] (Based on a Family of Three as of July 2006)						
	Income Threshold for Non-Working Parents			Income Threshold for Working Parents		
State	Monthly Dollar Amount	Annual Dollar Amount	As a Percent of Poverty Line	Monthly Dollar Amount	Annual Dollar Amount	As a Percent of Poverty Line
Alabama	$164	$1,968	12%	$366	$4,391	26%
Arkansas[2]	$204	$2,448	15%	$255	$3,060	18%
Delaware	$1,383	$16,600	100%	$1,473	$17,680	107%
DC	$2,767	$33,200	200%	$2,867	$34,400	207%
Florida	$303	$3,636	22%	$806	$9,672	58%
Georgia	$424	$5,088	31%	$756	$9,068	55%
Kentucky	$526	$6,312	38%	$909	$10,903	66%
Louisiana	$190	$2,280	14%	$280	$3,360	20%
Maryland	$434	$5,208	31%	$524	$6,288	38%
Mississippi	$368	$4,416	27%	$458	$5,496	33%
Missouri	$292	$3,504	21%	$556	$6,670	40%
North Carolina	$544	$6,528	39%	$750	$9,004	54%
Oklahoma[3/4]	$471 / $2,559	$5,652 / $30,710	34% / 185%	$591 / $2,559	$7,092 / $30,710	43% / 185%
South Carolina	$670	$8,040	48%	$1,340	$16,080	97%
Tennessee	$963	$11,556	70%	$1,113	$13,356	80%
Texas	$188	$2,256	14%	$402	$4,822	29%
Virginia	$337	$4,044	24%	$427	$5,124	31%
West Virginia	$253	$3,036	18%	$499	$5,992	36%
US Median[5]	$583	$6,996	42%	$904	$10,849	65%

Table presents rules in effect as of July 2006, unless noted otherwise.

1. This table takes earnings disregards, when applicable, into account when determining income thresholds for working parents. Computations are based on a family of three with one earner. In some cases, earnings disregards may be time limited. States may use additional disregards in determining eligibility. In some states, the income eligibility guidelines vary by region. In this situation, the income guideline in the most populous region of the state is used.

2. Arkansas had planned to implement waiver coverage, which would only be available to parents and childless adults employed by a participating employer, in January 2007.

3. When two thresholds are noted, the first is for "regular" Medicaid programs that provide comprehensive coverage that meets federal Medicaid guidelines and the second refers to coverage established through waivers. The coverage offered through these waivers generally provides fewer benefits and has higher cost-sharing than allowed in Medicaid.

4. Oklahoma obtained a waiver to create a health plan for employees of small employers and other individuals. Coverage for employees of participating employers is currently available. The state had planned to open enrollment to other individuals by the end of 2006.

5. The median threshold was computed using the income threshold for each state at which parents can obtain comprehensive coverage that meets federal Medicaid guidelines.

Source: Cohen Ross, Cox & Marks, January 2007.

APPENDIX 7

Enrollment: Selected Simplified Procedures in Medicaid for Parents with Comparisons to Children July 2006				
Program		**Family Application**[1]	**Face-to-Face Interview**	**Asset Test (or limit for family of 3)**
Total	Aligned Medicaid for Children and Separate SCHIP*	7	3	2
	Total Medicaid for Parents (18)**		6	10
Alabama[2]	Medicaid for Children	Yes	No	No
	Separate SCHIP		No	No
	Medicaid for Parents		No	No
Arkansas[3]	Medicaid for Children	No	No	No
	Medicaid for Parents		Yes	($1,000)
Delaware	Medicaid for Children	Yes	No	No
	Separate SCHIP		No	No
	Medicaid for Parents		No	No
	Expanded Medicaid for Parents		No	No
DC	Medicaid for Children	Yes	No	No
	Medicaid for Parents		No	No
	Expanded Medicaid for Parents		No	No
Florida[4]	Medicaid for Children	No	No	No
	Separate SCHIP		No	No
	Medicaid for Parents		No	($2,000)
Georgia[5]	Medicaid for Children	No	No	No
	Separate SCHIP		No	No
	Medicaid for Parents		No	($1,000)
Kentucky	Medicaid for Children	Yes	Yes	No
	Separate SCHIP		Yes	No
	Medicaid for Parents		Yes	($2,000)
Louisiana	Medicaid for Children	No	No	No
	Medicaid for Parents		No	No
Maryland	Medicaid for Children	No	No	No
	Separate SCHIP		No	No
	Medicaid for Parents		Yes	($3,000)
Mississippi	Medicaid for Children	Yes	Yes	No
	Separate SCHIP		Yes	No
	Medicaid for Parents		Yes	No
Missouri[6]	Medicaid for Children	Yes	No	No
	Medicaid for Parents		No	No

	Program	Family Application[1]	Face-to-Face Interview	Asset Test (or limit for family of 3)
North Carolina[5]	Medicaid for Children	No	No	No
	Separate SCHIP		No	No
	Medicaid for Parents		No	($3,000)
Oklahoma[5]	Medicaid for Children	No	No	No
	Medicaid for Parents		No	No
	Expanded Medicaid for Parents		No	No
South Carolina[5]	Medicaid for Children –	No	No	($30,000)
	Medicaid for Parents –		No	($30,000)
Tennessee[7]	Medicaid for Children	Yes	Yes	No
	Medicaid for Parents		Yes	($2,000)
Texas[8]	Medicaid for Children	No	No	($2,000)
	Separate SCHIP		No	($5,000)
	Medicaid for Parents +		No	($2,000)
Virginia	Medicaid for Children	No	No	No
	Separate SCHIP		No	No
	Medicaid for Parents		No	No
West Virginia	Medicaid for Children	No	No	No
	Separate SCHIP		No	No
	Medicaid for Parents		Yes	($1,000)

* “Aligned Medicaid for Children and Separate SCHIP” indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children’s Medicaid and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered “aligned” if the simplified procedure applies to children in the “regular” Medicaid program and the SCHIP-funded Medicaid expansion program. "Regular" Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children.

** “Total Medicaid for Parents” indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both pre-expansion Medicaid for parents and expanded coverage for parents, if the state has expanded coverage for parents. All 17 southern states and the District of Columbia operate a Medicaid program for parents. Two states and the District of Columbia have expanded Medicaid coverage for parents up to 100 percent of the federal poverty line or higher.

"+" Indicates that a state has simplified one or more of its procedures for parents between July 2005 and July 2006.

"–" Indicates that a state has rescinded one or more simplified procedures for parents between July 2005 and July 2006.

1. The Family Application column indicates whether the simplest application that can be used to apply for children's coverage can also be used to apply for coverage for parents. In states with “family” applications, parents are not required to complete additional forms or provide additional information to obtain coverage for themselves and the family application can be used to apply for all parents and children, whether they are eligible for Medicaid or a separate SCHIP program.

2. In Alabama, a telephone interview is required in children's Medicaid.

3. In Arkansas, county offices have the option of requiring either a face-to-face or telephone interview for Medicaid. Applicants that have had an active Medicaid case within the past year are not required to do an interview. The joint Medicaid/SCHIP application in Arkansas has a place for parents to indicate they are interested in health coverage for themselves. Parents who indicate an interest in coverage for themselves are required to complete a separate Medicaid application.

4. In Florida, families who submit applications that do not appear to be prone to error or fraud, known as “green track” applications, are not required to do an interview.

5. In Georgia, North Carolina, Oklahoma and South Carolina the same simplified application can be used to apply for coverage for children and parents. However, parents must complete additional forms or take additional steps (such as to provide information on assets or absent parents) prior to an eligibility determination for themselves.

6. In Missouri, children covered under the Section 1115 waiver expansion are subject to a "net worth" test of $250,000.

7. In Tennessee, a face-to-face or telephone interview is required.

8. In Texas, the SCHIP asset test only applies to families with income above 150 percent of the federal poverty line.

Source: Cohen Ross, Cox & Marks, January 2007.

PROJECT STAFF

Kathryn J. Luchok, PhD, MA
Director, Policy and Research Center

Beth Shine, MMC
Director, Communications

Glenn Mainwaring
Manager, Business Administration

Michael Stafford
Assistant, Policy and Research Center

Nicole Ravenell, MPP
President and CEO

Southern Institute
ON CHILDREN & FAMILIES
Knowledge - Leadership - Action

500 Taylor Street, Suite 202
Columbia, SC 29201

T 803.779.2607
F 803.254.6301
www.thesoutherninstitute.org