



SPECIAL REPORT

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SCHIP REAUTHORIZATION

RHETORIC, REALITY, AND IMPLICATIONS FOR ILLINOIS

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OVERVIEW

On October 3, 2007, President Bush vetoed legislation that would reauthorize the State Children's Health Insurance Program (SCHIP). For several months, the Bush Administration has sharply criticized pending SCHIP reauthorization bills, claiming that Congress was considering a "massive expansion of government health care" that would create a "new entitlement program for higher income households" and would be a "step toward federalization of health care."

These characterizations of the SCHIP reauthorization bill are fundamentally misleading. The legislation would provide substantially more federal funding, but it does not amount to a "massive expansion" of the program. The bill would not mandate expanded eligibility to new groups, would not establish any new entitlements, and would not involve "federalization" of health care. The main thrust of the bill is to enroll more children who are *currently eligible* for SCHIP or Medicaid.

The struggle over SCHIP reauthorization involves very high stakes for Illinois. Since the late 1990s, Illinois has made significant progress in expanding health care coverage for children through both Medicaid and SCHIP. The state has also used SCHIP funds to gradually extend coverage for low-income parents. The SCHIP reauthorization bill would enable Illinois to continue this progress. If, however, federal funding remains at its current level or is set at the level proposed by the Bush Administration, these gains in health coverage for Illinois children and families could be in jeopardy.

The Significance of SCHIP

SCHIP has been part of a "quiet revolution" in health care coverage for children — a shift from welfare-based to income-based eligibility. Illinois was not among the early leaders in using SCHIP to expand health care coverage for low-income children, but the state has made substantial progress in recent years. Between 2001 and 2006, SCHIP enrollment in Illinois more than doubled.

SCHIP's role in the "quiet revolution" went beyond the expansion of eligibility for medical assistance. The implementation of SCHIP has also generated efforts to enroll eligible children through outreach activities and streamlined application procedures. As a result, SCHIP has had important spillover effects by facilitating enrollment of eligible children in Medicaid.

Expanded eligibility under both Medicaid and SCHIP has contributed to important gains in health insurance coverage for Illinois children. Data from the U.S. Census Bureau show that 18 percent of low-income children in Illinois were uninsured in 2004-2006, compared with 24 percent in 1997-1999. A substantial body of research indicates that expansion of health insurance coverage for children also leads to improvements in access to care and use of services. Children enrolled in Medicaid and SCHIP are more likely to have a usual source of care, more likely to receive preventive care, and less likely to experience unmet needs.

Illinois has also used SCHIP funds to expand coverage for low-income parents under the "FamilyCare" program. Nationwide, the uninsured rate for low-income parents is about twice the rate for low-income children. Lack of coverage can adversely affect both parental health and the financial stability of their families. There is also research evidence suggesting that health care coverage for parents represents sound *child health policy*. Medicaid and SCHIP coverage of low-income parents raises participation rates of eligible children, improves continuity of coverage for children, and increases the probability that children will have a regular source of care and will receive preventive services.

Reauthorization Issues

Federal funding levels: The baseline level for federal SCHIP funding is \$25 billion over five years, while the Bush administration has proposed an increase of \$4.8 billion. According to the Congressional Budget Office, simply maintaining current state programs would require increased appropriations of \$14 billion over five years. The reauthorization bill would provide \$34.9 billion beyond the current baseline. The CBO estimates that this level of funding would be enough to sustain enrollment under current state policies and to further boost SCHIP enrollment by 2.7 million and children's Medicaid enrollment by 1.9 million. More than 70 percent of new enrollees would be in existing eligibility groups.

State allotments: Under current law, federal SCHIP funds are allocated to states on the basis of number of children in low-income families and number of uninsured low-income children. This funding structure has yielded a mismatch between state allotments and actual spending needs. In FY 2007, a supplemental federal appropriation was enacted to cover projected shortfalls in 11 states, including Illinois. The reauthorization bill would establish new SCHIP allotment formulas based largely on actual and projected state spending of federal funds. Illinois's estimated FY 2008 allotment would be \$682 million, which is significantly larger than both its FY 2007 allotment (\$209.8 million) and its FY 2007 estimated spending of federal funds (\$425.6 million). This initial allotment, together with annual adjustments and the ability to use carryover funds for one year, would mean that the state would be much less likely to encounter federal funding shortfalls.

Bonus payments: The reauthorization bill would offer states "performance bonus payments" to offset additional costs resulting from increased enrollment of children who are already

Coverage of low-income parents: The SCHIP bill would prohibit additional federal waivers to cover parents of targeted low-income children. States with existing waivers, including Illinois, could opt for an automatic extension through FY 2009, after which federal matching rates would be gradually reduced.

Income eligibility limits for children: The SCHIP bill would put new restrictions on federal funding for children in families above 300 percent of the federal poverty level (FPL). For these families, states would receive federal funds at the Medicaid matching rate rather than the enhanced SCHIP matching rate. Beginning in FY 2011, there would be additional requirements to prevent crowd-out of private health insurance.

Conclusion

When SCHIP was enacted in 1997, it had broad bipartisan support in Congress. Greater programmatic flexibility and enhanced federal matching rates, as well as the focus on children, also made SCHIP politically attractive to state officials. Ten years later, however, reauthorization of the program has become highly controversial. The Bush Administration claims that the bill passed by Congress represents a “dramatic expansion” of SCHIP, establishment of a “new entitlement” for families with higher incomes, and a step toward “federalization” of health care.

In reality, the SCHIP reauthorization bill is designed to provide more federal support for existing state programs. The main thrust of the bill is to enroll more children who are currently eligible for SCHIP or Medicaid, and performance bonus payments are heavily weighted toward Medicaid. The legislation does not establish new entitlements for higher income households or anyone else. The bill limits new state efforts to expand income eligibility for children, and it rolls back federal funding for coverage of low-income parents.

The specter of “federalization” of health care through SCHIP is a rhetorical myth. SCHIP would remain a joint federal-state program that is administered by the states. There would still be wide variation across states in regard to program design, income eligibility, and service coverage. SCHIP would also remain a much smaller program than Medicaid.

The Bush Administration’s rhetoric about SCHIP has not been consistent with its actions. The President’s FY 2006 budget recommended early reauthorization of SCHIP but proposed flat funding over the next ten years. The Administration has approved numerous waivers for parental coverage under SCHIP, as well as coverage expansions for children with family incomes up to 300 percent of FPL. The Administration now wants to “refocus” SCHIP on its original target population and to give less policy discretion to the states.

Illinois has a great deal at stake in the struggle over SCHIP. Increased federal funding and a new allotment formula are essential to the financial viability of the state’s All Kids health insurance program. Health care coverage for low-income parents through FamilyCare is also at risk. If SCHIP were extended at the baseline appropriation level or at the level proposed by the Bush Administration, Illinois would encounter severe funding shortfalls. The state’s progress in expanding health care coverage for children and families would be in serious jeopardy.

SCHIP REAUTHORIZATION

RHETORIC, REALITY, AND IMPLICATIONS FOR ILLINOIS

Larry Joseph

On October 3, 2007, President George W. Bush vetoed a bill that would reauthorize the State Children's Health Insurance Program (SCHIP). The legislation had been passed by votes of 265-159 in the House of Representatives and 67-29 in the Senate. The President declared that the reauthorization bill would "move health care in this country in the wrong direction" and would "shift SCHIP away from its original purpose." For several months, the Bush Administration has sharply criticized pending SCHIP bills, claiming that Democratic leaders in Congress were considering a "massive expansion of government health care" through SCHIP and that expansion of SCHIP would be a "step toward federalization of health care." A recent White House press release asserted that the reauthorization bill "fails to focus on poor children, and instead creates a new entitlement program for higher income households."¹

This report will show that the Bush Administration's characterizations of the SCHIP reauthorization bill are fundamentally misleading. The legislation would provide substantially more federal funding, but it does not amount to a "massive expansion" of the program. The bill would not mandate expanded eligibility to new groups, would not establish any new entitlements, and would not involve "federalization" of health care. The stated purpose of the bill is:

"... to provide dependable and stable funding for children's health insurance under titles XXI and XIX of the Social Security Act [SCHIP and Medicaid] in order to enroll all six million uninsured children who are eligible, but not enrolled, for coverage today" through such titles."²

The struggle over SCHIP reauthorization involves very high stakes for Illinois. Since the late 1990s, Illinois has made significant progress in expanding health care coverage for low-income children through both Medicaid and SCHIP. The state has also used SCHIP funds to gradually extend coverage for low-income parents. The SCHIP reauthorization bill would enable Illinois to continue this progress. If, however, federal funding remains at its current level or is set at the level proposed by the Bush Administration, these gains in health coverage for Illinois children and families could be in jeopardy.

The report begins with a discussion of the significance of SCHIP and the evolution of health care coverage for low-income children in Illinois. It then turns to an analysis of the major features of the SCHIP reauthorization bill, especially those provisions with significant implications for Illinois. The report concludes with a brief assessment of some broader issues relating to federalism and health care policy.

¹ White House, 2007a, 2007b, 2007c, 2007d, 2007e, 2007f. See also Leavitt, 2007.

² U.S. House of Representatives, 2007, Sec. 2.

THE SIGNIFICANCE OF SCHIP

SCHIP has been part of a “quiet revolution” in health care coverage for children — a shift from welfare-based to income-based eligibility.³ From the inception of the Medicaid program in 1965, the principal basis for medical assistance eligibility for children was Aid to Families with Dependent Children (AFDC). Delinking medical assistance from the welfare system began in the late 1980s and early 1990s with a series of federal mandates for states to expand eligibility for children based on family income rather than on ties to the AFDC program. Federal legislation enacted in 1989 required states to offer Medicaid coverage to children under age 6 and pregnant women with family incomes below 133 percent of the federal poverty level (FPL). The following year, another federal law mandated incremental expansion of Medicaid coverage for older children (ages 6 through 18) in families with incomes up to 100 percent of FPL. This eligibility expansion began with children born after September 30, 1983, with one age cohort added each year, which meant that coverage would reach all 18-year-olds in October 2002.

The 1996 federal welfare reform law, which replaced AFDC with Temporary Assistance for Needy Families (TANF), completed the process of delinking medical assistance from family income assistance. In the short term, this made Medicaid eligibility for children considerably more complicated, and plummeting welfare caseloads in the mid-1990s were paralleled by declining Medicaid enrollment among both children and adults in low-income families. However, as states adjusted to delinking (with some prodding from the federal government), children’s enrollment began to recover.

The SCHIP program, established under the Balanced Budget Act of 1997, gave states new options for expanding health coverage for children. The program offers federal matching funds to provide coverage for children in families with incomes above a state’s Medicaid eligibility standards — primarily families at or below 200 percent of FPL. Like Medicaid, SCHIP is jointly financed by the federal government and the states, but states receive capped annual allotments rather than open-ended matching funds. In addition, the federal share of funding for SCHIP is higher than for Medicaid. In Illinois, the federal matching rates are 50 percent for Medicaid and 65 percent for SCHIP.

States have three basic options in their use of SCHIP funds: expanding Medicaid coverage (M-SCHIP), instituting a separate state child health program (S-SCHIP), or combining both approaches. Aside from higher income eligibility limits, M-SCHIP programs are subject to the same federal regulations as Medicaid. For example, children who meet the state’s eligibility criteria are entitled to benefits. Under S-SCHIP programs, however, states are allowed to offer more limited service coverage and to impose cost-sharing in the form of premiums and co-payments. In addition, S-SCHIP programs do not establish an entitlement, and states are allowed to set enrollment caps and establish waiting lists.

Illinois has used its SCHIP funds for both Medicaid expansion and a separate state program. In January 1998, the state expanded Medicaid to cover all children ages 6-18 with

³ For a more detailed discussion, see Joseph, 2004.

family incomes up to 133 percent of FPL. (By instituting M-SCHIP, the state was also accelerating the phase-in of poverty-based Medicaid eligibility for children up to 100 percent of FPL.) In October of that year, Illinois added a separate state program for children between 133 percent and 185 percent of FPL. This S-SCHIP component encompassed “KidCare Share” (which required co-payments from families and had an upper income limit of 150 percent of FPL) and “KidCare Premium” (which required both co-payments and monthly premiums).⁴

Illinois was not among the early leaders in using SCHIP to expand health care coverage for children. The state originally had a three-month waiting period for S-SCHIP eligibility, a provision that was eliminated in July 2002. By federal fiscal year (FY) 2002, three-fourths of the states had adopted SCHIP income eligibility limits of at least 200 percent of FPL. Illinois did not expand eligibility to that level until July 2003. In April 2004, the state instituted presumptive eligibility for children, which provides temporary coverage while their applications are being processed (see Tables 1 and 2).

Table 1: Evolution of SCHIP in Illinois

Jan. 1998:	Medicaid expansion (M-SCHIP) covers all children ages 6-18 in families with incomes up to 133% of FPL.
Oct. 1998:	Separate state program (S-SCHIP) covers children between 133% and 185% of FPL. S-SCHIP encompasses “KidCare Share” and “KidCare Premium.”
Feb. 2000:	State institutes 12-month continuous eligibility for Medicaid and SCHIP children, regardless of changes in family income or work status.
July 2002:	Elimination of three-month waiting period for S-SCHIP.
Oct. 2002:	Under a federal waiver, SCHIP funds are used to cover parents of Medicaid and SCHIP children (“FamilyCare”). Income eligibility limit is initially set at 49%. The same waiver allowed federal matching funds for “KidCare Rebate.”
July 2003:	Income eligibility limit for children is raised to 200% of FPL. Income eligibility limit for parents is raised to 90% of FPL.
April 2004:	State institutes presumptive eligibility for children, which provides temporary coverage while their applications are being processed.
Sept. 2004:	Income eligibility limit for FamilyCare is raised to 133% of FPL.
Jan. 2006:	Income eligibility limit for FamilyCare is raised to 185% of FPL.
July 2006:	Implementation of “All Kids.”

⁴ M-SCHIP, together with “regular” Medicaid, became known as “KidCare Assist.” Monthly premiums under S-SCHIP are currently \$15 for one child, \$25 for two children, and \$5 for each additional child— with a maximum of \$40 per family. Maximum copayments are \$100 per family per year.

Table 2: Medicaid and SCHIP Eligibility for Low-Income Children and Parents in Illinois

Children up to age 1

Medicaid: Family income up to 200% of FPL

Children over age 1 and under age 6

Medicaid: Family income up to 133% of FPL

S-SCHIP: Family income between 133% and 200% of FPL

Children ages 6-18

Medicaid: Family income up to 100% of FPL

M-SCHIP: Family income between 100% and 133% of FPL

S-SCHIP: Family income between 133% and 200% of FPL

Parents and other adult caretakers

Medicaid: Receipt of TANF or family income up to 37% of FPL

S-SCHIP: Family income between 37% and 185% of FPL

Pregnant women

Medicaid: Family income up to 200% of FPL

Note: Federal poverty level in 2007 is \$17,170 for a family of three, \$20,650 for a family of four, \$24,130 for a family of five.

Between September 2001 and September 2006, SCHIP enrollment in Illinois more than doubled (see Table 3). However, SCHIP's role in the "quiet revolution" went beyond the expansion of eligibility for medical assistance. SCHIP implementation generated efforts to enroll eligible children through outreach activities and streamlined application procedures. States are required to screen SCHIP applicants to determine whether they meet regular Medicaid eligibility standards, and SCHIP outreach efforts and simplified application procedures have facilitated enrollment of Medicaid-eligible children.⁵ Outreach activities in Illinois have included KidCare Application Agents — organizations such as hospitals, community health centers, local health departments, family service agencies, and community groups — that receive technical assistance payments of \$50 for each approved application. The state has also made an effort to reduce the stigma of public assistance by using a joint mail-in application for Medicaid and SCHIP and by offering a continuum of plans for families and children at different income levels.

SCHIP outreach in Illinois has had some important spillover effects on Medicaid enrollment. In December 2001, the state had about 64,000 children in SCHIP, but there were also some 97,000 Medicaid children who were enrolled through SCHIP outreach initiatives.⁶ Similarly, between September 2002 and September 2006, SCHIP enrollment increased by about 66,000 children, while Medicaid enrollment of children grew by well over 200,000 (see Table 3).

⁵ See, e.g., Ellwood, Merrill, and Conroy, 2003; Rosenbach et al., 2003; Rosenbach et al., 2007.

⁶ OAG, 2002.

**Table 3: Illinois Medicaid and SCHIP Enrollment of Children, 1997 to 2006
(in 1,000s, as of September 30 of each year)**

	Medicaid	SCHIP	Total
1997	777.4	-----	777.4
1998	747.7	23.5	771.3
1999	770.5	43.8	814.3
2000	830.7	60.0	890.7
2001	887.1	66.6	953.7
2002	891.4	69.6	961.0
2003	959.6	81.7	1,041.3
2004	1,025.8	90.1	1,115.9
2005	1,064.4	113.2	1,177.6
2006	1,132.2	136.2	1,268.4
Growth, 2002-2006	240.8	66.6	307.4

Source: Illinois Department of Healthcare and Family Services

Expanded eligibility under both Medicaid and SCHIP has contributed to important gains in health insurance coverage for children. Data from the U.S. Census Bureau show that 18 percent of low-income children in Illinois were uninsured in 2004-2006, compared with 24 percent in 1997-1999 (see Table 4). This decline parallels nationwide trends. A substantial body of research indicates that expansion of health insurance coverage for children also leads to improvements in access to care and use of services. Children enrolled in Medicaid and SCHIP are more likely to have a usual source of care, more likely to receive preventive care, and less likely to experience unmet needs.⁷

Table 4: Low-Income Uninsured Children in Illinois, Ages 0-18, Three-Year Moving Averages (in 1,000s)

	Low-income children	Number uninsured	Pct. uninsured
1996-1998	1,296	277	21.4%
1997-1999	1,239	295	23.8%
1998-2000	1,215	269	22.1%
1999-2001	1,098	223	20.3%
2000-2002	1,152	228	19.8%
2001-2003	1,202	235	19.6%
2002-2004	1,256	243	19.3%
2003-2005	1,233	230	18.7%
2004-2006	1,186	217	18.3%

Note: "Low-income" defined as family income at or below 200% of poverty level.

Source: U.S. Bureau of the Census

⁷ Kenney, Haley, and Tebay, 2003; Kenney and Yee, 2007.

SCHIP and All Kids

Illinois's "All Kids" health insurance program, which began operations in July 2006, offers coverage for uninsured children regardless of family income, health status, or immigration status. The benefit package is nearly identical to the services covered by Medicaid and SCHIP in Illinois. In its basic structure, All Kids is an extension of SCHIP. Families are responsible for monthly premiums and co-payments on a sliding scale based on household income.⁸

The first year of All Kids implementation indicates that the program is having spillover effects on both SCHIP and Medicaid, as well as enrolling of uninsured children who would not otherwise be eligible for public coverage. As of March 2007, about 54,000 children were participating in All Kids expansion (funded entirely with state revenue). Over the previous nine months since implementation of All Kids, SCHIP enrollment increased by 30,000 and Medicaid enrollment by 83,000.

SCHIP and FamilyCare

In August 2001, the Bush Administration announced the Health Insurance Flexibility and Accountability (HIFA) initiative, which was designed to make it easier and simpler for states to expand access to health care coverage through Medicaid and SCHIP. The following year, Illinois received approval for a HIFA waiver to use unexpended SCHIP funds to cover parents of low-income children.⁹ Beginning in October 2002, the state expanded its SCHIP coverage to low-income parents under the "FamilyCare" program. The income eligibility limit for parents was initially set at 49 percent of FPL and was gradually raised to 185 percent of FPL in January 2006.¹⁰

The income profile of parents covered by FamilyCare is quite different from children covered by SCHIP. In September 2006, Illinois had about 360,000 parents enrolled in regular Medicaid and 133,000 in FamilyCare. More than half of SCHIP-covered parents

⁸ The "KidCare" name has been subsumed under All Kids. For All Kids "expansion" (i.e., beyond Medicaid and SCHIP eligibility), children who enrolled during 2006 must have been uninsured since the first of that year; as of January 1, 2007, a 12-month "waiting period" has applied. Some groups are exempt from the waiting period: children with a parent who has lost employment that offered affordable dependent health insurance coverage, newborn children whose responsible relative does not have access to affordable private or employer-sponsored health insurance, and children who have lost Medicaid or SCHIP coverage within the previous year.

⁹ The same HIFA waiver allowed Illinois to receive federal SCHIP funds for "KidCare Rebate," which provides low-income families with subsidies for private health insurance coverage and was initially financed entirely with state funds.

¹⁰ In Illinois, adult TANF recipients are automatically covered by Medicaid, and those who leave TANF because of increased earnings are eligible for up to 12 months of transitional medical assistance. In addition, federal law specifies that parents can qualify for Medicaid if they would have been eligible for cash assistance under a state's old AFDC standards.

were below 100 percent of FPL, whereas all children from families with incomes below poverty are eligible for Medicaid.

Nationwide, the uninsured rate for low-income parents is about twice the rate for low-income children. Lack of coverage can adversely affect both parental health and the financial stability of their families. Nearly half of these uninsured parents have chronic health problems, and many of them delay or forego treatment because of costs. About one-third of low-income uninsured parents report that medical bills have had a major financial impact on the family.¹¹

There is also research evidence suggesting that health care coverage for parents represents sound *child health policy*. Medicaid and SCHIP coverage of low-income parents raises participation rates of eligible children, improves continuity of coverage for children, and increases the probability that children will have a regular source of care and will receive preventive services.¹²

Table 5: Illinois Medicaid and SCHIP Enrollment of Low-Income Parents, 1997 to 2006 (in 1,000s, as of September 30 of each year)

	Medicaid	SCHIP (FamilyCare)	Total
1997	277.5	-----	277.5
1998	258.3	-----	258.3
1999	252.9	-----	252.9
2000	252.6	-----	252.6
2001	260.5	-----	260.5
2002	264.1	-----	264.1
2003	289.0	41.0	330.0
2004	330.7	79.9	410.6
2005	355.6	109.1	464.7
2006	360.5	133.3	493.8
Growth, 2002-2006	96.4	133.3	229.7

Source: Illinois Department of Healthcare and Family Services

¹¹ Schwartz, 2007.

¹² Ku and Broaddus, 2006; Rosenbaum and Whittington, 2007; Artiga and Mann, 2007.

REAUTHORIZATION ISSUES

Federal Funding

The original SCHIP statute authorized \$40 billion in federal funding over ten years. For the first four years of SCHIP, annual state allotments were about \$4.3 billion. In order to meet overall federal budget targets, allotments were reduced to \$3.15 billion each year for FY 2002-2004. The appropriation level then rose to \$4.05 billion for FY 2005-2006 and \$5 billion for FY 2007.¹³

Under congressional budget rules, the funding level for the most recent fiscal year sets the “baseline” for SCHIP reauthorization. The Congressional Budget Office has determined that if SCHIP were reauthorized at the baseline level (\$25 billion over five years), 35 states would face shortfalls by 2012, and enrollment would have to be cut by about one-fourth. The Bush Administration has proposed an increase of \$4.8 billion over five years — but that amount would still not be enough to maintain current state programs, which would require increased appropriations of \$14 billion over five years (see Table 5). The \$14 billion level of funding would be enough to accommodate projected enrollment growth (8.6% over five years) and increased costs per enrollee, but with no changes in eligibility rules, service coverage, or outreach efforts.¹⁴

Table 6: Funding Levels for SCHIP Reauthorization, FY 2008-2012 (in \$ billions)

	New funding	Total funding
Baseline funding	-----	\$25.0
Bush Administration proposal	\$ 4.8	29.8
CBO (maintain current programs)	14.0	39.0
Reauthorization bill	34.9	59.9

Source: Congressional Budget Office

The reauthorization bill would provide \$34.9 billion beyond the current funding baseline, although only \$25 billion would reflect regular SCHIP payments to states. CBO cost projections also include bonus payments to states for increased enrollment in Medicaid and SCHIP (\$2.6 billion), estimated effects on federal Medicaid spending (\$3.8 billion), and various smaller amounts for purposes other than SCHIP benefits and administration (see Table 7).

The CBO estimates that the baseline funding level (\$25 billion over five years) would be enough to sustain SCHIP enrollment of 3.3 million in FY 2012. The reauthorization bill provides enough funding to maintain enrollment for another 1.7 million under current

¹³ Peterson, 2006.

¹⁴ CBO, 2007a, 2007b.

state programs. Additional funding would further boost SCHIP enrollment by 2.7 million and children's Medicaid enrollment by 1.9 million. More than 70 percent of new enrollees would be in *existing* eligibility groups. Expansion of SCHIP eligibility to new populations would increase enrollment by only 1.2 million (see Table 8).¹⁵

Table 7: Estimates of New Federal Spending under SCHIP Reauthorization Bill, FY 2008-2012 (in \$ billions)

SCHIP benefits and administrative costs	\$25.0
Child Enrollment Contingency Fund	0.6
Performance bonus payments	2.6
Outreach grants	0.3
Effects on federal Medicaid spending	3.8
Revise citizenship documentation requirement	1.4
Modify per capita income data for FMAPs*	0.5
Additional funding for Current Population Survey	0.1
Development of quality measures for child health	0.3
Other	0.3
Total	34.9

* FMAP = Federal Medical Assistance Percentage (federal matching rate)

Source: Congressional Budget Office, 2007c.

Table 8: Estimated Changes in SCHIP and Medicaid Enrollment of Children under Reauthorization Bill, FY 2012 (in millions)

	SCHIP	Medicaid	Total
Baseline projection	3.3	25.0	28.3
Effects of providing funding to maintain current SCHIP programs	1.7	-0.6	1.1
Effects of additional funding and other provisions			
Enrollment within existing eligibility groups	1.5	1.9	3.4
Expansion of eligibility to new groups	1.2	---	1.2
Total proposed changes	4.4	1.3	5.8
Total estimated enrollment	7.8	26.3	34.1

Source: Congressional Budget Office, 2007d.

¹⁵ For a more detailed discussion, see Park, 2007.

State Allotments

Under current law, federal SCHIP funds are allocated to states on the basis of their share of the number of children in low-income families, their share of the number of uninsured low-income children, and their wages in the health services sector relative to U.S. average. A state has three years to spend its annual allotment, and unexpended funds are then redistributed to other states. In a given fiscal year, a state's total available federal funds could include its regular allotment for that year, carryover funds from two previous years, and redistributed funds from other states.

The main problem with the current SCHIP funding structure is the mismatch between allotments and actual state spending needs. Some states have consistently used their entire allotments, while others have had unspent funds redistributed. As SCHIP enrollment grew over time, more states were spending their entire allotments. Between FY 2001 and FY 2006, the number of states eligible for redistributed funds grew from 12 to 40, while the pool of funds available for redistribution shrank from \$2 billion to \$173 million.¹⁶

From FY 1998 to FY 2003, Illinois spending of federal SCHIP funds was far below its annual allotments (see Table 9). In FY 2004 and 2005, the state's spending was covered by a combination of regular allotments, carryover funds from previous years, and redistributed funds. During FY 2006, Illinois — together with Massachusetts — had a projected SCHIP shortfall, part of which was covered by a supplemental federal appropriation. Both states also deferred some SCHIP claims until the next fiscal year.¹⁷

Table 9: Illinois SCHIP Allotments and Expenditures, FY 1998-2007 (in \$ millions)

	Federal allotments	Federal share of expenditures
1998	\$122.5	\$ 6.1
1999	121.9	14.7
2000	137.5	32.7
2001	159.8	39.1
2002	127.2	36.3
2003	132.2	59.4
2004	121.0	309.8
2005	164.9	320.2
2006	169.2	324.3
2007	209.8	425.6 (est.)
1998-2007	1,466.0	1,568.2 (est.)

Source: Congressional Research Service

¹⁶ Allen, 2007; Peterson, 2007.

¹⁷ Peterson, 2006.

In May 2007, the Congressional Budget Office projected that 11 states, including Illinois, would exhaust their available federal SCHIP funds by the end of the fiscal year. Illinois's expected spending of federal funds was \$449.2 million, while its available federal funds were estimated at \$268.2 million — which included its FY 2007 allotment (\$209.8 million), a small amount of carryover funds from FY 2006 (\$3.2 million), and the projected redistribution of unspent allotments from other states (\$55.2 million). At the end of May, Congress passed a supplemental appropriation (up to \$646 million) to cover projected state shortfalls; Illinois's share will be about \$180 million.

Even though Illinois had SCHIP funding shortfalls in the past several years, it came close to “breaking even” over ten years. From FY 1998 through FY 2007, the state's total estimated spending of federal funds was only 7 percent higher than its total annual allotments. Nonetheless, Illinois's “baseline” allotment is far below its recent spending.

The reauthorization bill would establish entirely new allotment formulas based largely on actual and projected state spending of federal funds. Allotments would be increased each year in proportion to state child population growth (plus one percentage point) and per capita national health expenditures growth. The bill would also reduce the availability of regular allotments from three years to two years.

Table 10: Overview of State Allotments under SCHIP Reauthorization Bill

FY 2008: State allotments based on 110% of the largest of the following amounts:

- FY 2007 annual allotment multiplied by allotment increase factor*
- Total federal payments for FY 2007 multiplied by allotment increase factor*
- Projected federal payments for FY 2008
- For states with projected shortfalls for FY 2007: estimated FY 2007 spending, as reported in November 2006, multiplied by allotment increase factor*

FY 2009: State allotments based on FY 2008 allotment, plus any payments from contingency fund, multiplied by allotment increase factor*

FY 2010: State allotments based on federal payments for FY 2009, plus contingency fund payments and redistributed funds in FY 2009, multiplied by allotment increase factor*

FY 2011: State allotments based on FY 2010 allotment, plus contingency fund payments in FY 2010, multiplied by allotment increase factor*

FY 2012: State allotments based on federal payments for FY 2011, plus contingency fund payments and redistributed funds in FY 2011, multiplied by allotment increase factor*

* Allotment increase factor = state child population growth (plus one percentage point) and per capita national health expenditures growth

According to the Congressional Research Service, aggregate state allotments for FY 2008 would be about 43 percent higher than estimated state spending of federal funds for FY 2007. Illinois's FY 2008 allotment would be \$682 million, which is significantly larger than both its FY 2007 allotment (\$209.8 million) and its FY 2007 estimated spending of federal funds (\$425.6 million). This initial allotment, together with annual adjustments and the ability to use carryover funds for one year, would mean that the state would be much less likely to encounter federal funding shortfalls in the future (see Table 11).

In addition to regular state allotments, the reauthorization bill would establish a child enrollment contingency fund to cover shortfalls resulting from increased enrollment of low-income children. The contingency fund would be capped at 20 percent of the annual national allotment. According to the CBO, the estimated cost of the contingency fund would be quite small — about \$600 million over five years.

Table 11: Projected SCHIP Allotments and Federal Payments for Illinois under the SCHIP Reauthorization Bill, FY 2008-2012 (in \$ millions)

	Allotment	Carryover funds	Total available federal funds	Federal funds spent
5% spending growth				
2008	682.0	0.0	682.0	465.2
2009	728.6	216.8	945.4	488.5
2010	522.7	456.9	979.6	512.9
2011	559.2	466.7	1,025.9	538.5
2012	576.2	487.4	1,063.6	565.5
10% spending growth				
2008	682.0	0.0	682.0	465.2
2009	728.6	216.8	945.4	511.7
2010	547.5	433.6	981.2	562.9
2011	585.9	418.3	1,004.2	619.2
2012	662.5	385.0	1,047.5	681.1

Bonus Payments

The reauthorization bill would offer states “performance bonus payments” to offset additional costs resulting from increased enrollment of children who are already eligible for SCHIP or Medicaid. Bonus payments would be based on percentages of per capita spending from state funds, with larger payments for Medicaid than for SCHIP. If Illinois's average monthly enrollment of children in FY 2008 was 5 percent above baseline for Medicaid and 10 percent above baseline for SCHIP, then it would receive about \$15

million in bonus payments. Over five years, the reauthorization bill would provide an estimated \$2.6 billion for bonus payments, as well as about \$300 million for grants to improve outreach and enrollment. The bonuses would also be contingent on state implementation of certain policies to facilitate enrollment and retention of children.¹⁸

	First tier	Second tier
Medicaid		
Enrollment above baseline	≤ 3%	> 3%
Bonus payments per enrollee (pct. of state per capita spending)	15%	60%
SCHIP		
Enrollment above baseline	≤ 7.5%	> 7.5%
Bonus payments per enrollee (pct. of state per capita spending)	10%	40%

Coverage of Low-Income Parents

In FY 2006, eleven states, including Illinois, had federal waivers allowing the use of SCHIP funds to cover parents or other adult caretakers of “targeted low-income children.” Nationwide enrollment of low-income parents was about 500,000, which represented 7 percent of total SCHIP enrollment. In Illinois, the FamilyCare program enrolled more than 200,000 parents.¹⁹ Although the Bush Administration approved eight of the waivers for parental coverage (including the Illinois waiver), it now wants to eliminate all SCHIP funding for parents (with the exception of pregnant women).

The reauthorization bill would prohibit additional federal waivers to cover parents of targeted low-income children, but states with existing waivers could opt for an automatic extension through FY 2009, after which there would be limits on federal reimbursement. For FY 2010-2012, funding for low-income parents would come from a block grant set aside from the state’s allotment. The set-aside would be equal to the federal share of 110 percent of a state’s projected expenditures for this population in each fiscal year. In FY 2010, the enhanced federal matching rate would apply only if a state meets one of several outreach or coverage benchmarks for children. Otherwise, the regular Medicaid matching rate would apply. In FY 2011 and 2012, meeting one of the

¹⁸ In order to receive bonus payments, a state would be required to implement at least four of the following: continuous eligibility, liberalization of asset requirements, elimination of in-person interview requirement, use of a joint application for Medicaid and SCHIP, automatic renewal, presumptive eligibility, and “express lane” eligibility.

¹⁹ Artiga and Mann, 2007.

benchmarks would allow a state to receive federal reimbursement halfway between its regular Medicaid match and its enhanced SCHIP match.

Under this provision of the bill, Illinois would get a two-year extension of its waiver for FamilyCare, but it is unclear whether the block grant set-aside would provide enough funding for the program. In FY 2006, the state received \$115.6 million in federal SCHIP funds for parental coverage; the corresponding figure for FY 2007 is likely to be twice that amount.²⁰ Beginning in FY 2010, federal matching rates would gradually decline to either 57.5 percent (the reduced enhanced match) or 50 percent (the regular Medicaid match). Illinois could lose almost one-fourth of its federal funding for FamilyCare.

If the transition period for parental coverage does not become law, the financial implications could be even worse. The FamilyCare waiver expired on September 30th. Illinois could request that low-income parents be transferred to Medicaid under a state plan amendment, which would mean that the federal matching rate would immediately drop from 65 percent to 50 percent. There is no guarantee, however, that the Bush Administration would approve the request.

Income Eligibility Limits for Children

The Bush Administration's FY 2008 budget documents called for refocusing SCHIP on its original target population — low-income, uninsured children below 200 percent of FPL.²¹ The budget narratives did not, however, specify how the refocusing would be accomplished. As of July 2007, SCHIP programs in 23 states had upper income limits of 200 percent of FPL. Lower thresholds were used in nine states and higher thresholds in 18 states. In FY 2006, there were about 586,000 SCHIP children in families above 200 percent of FPL. This group accounted for only 8 percent of total SCHIP enrollment.²²

The SCHIP reauthorization bill would put new restrictions on federal funding for children in families above 300 percent of FPL. For these families, states would receive federal funds at the Medicaid matching rate rather than the enhanced SCHIP matching rate. This restriction would not apply to states with approved SCHIP plan amendments or waivers (i.e., New Jersey) or to states that have enacted laws to submit a plan amendment (i.e., New York).²³

The bill would also direct the Government Accountability Office and the Institute of Medicine to submit reports on measures of crowd-out of private health insurance and

²⁰ Artiga and Mann, 2007; Graham, 2007.

²¹ OMB, 2007, p. 68; HHS, 2007, p. 65.

²² Peterson and Herz, 2007.

²³ Since 1999, New Jersey has had a SCHIP eligibility limit of 350 percent of FPL. New York enacted legislation to raise eligibility to 400 percent of FPL, but its state plan amendment was disapproved by the Bush Administration on September 7, 2007.

best practices for limiting crowd-out. Beginning in FY 2011, all states with income eligibility limits above 300 percent of FPL would be required to implement crowd-out prevention practices and to meet certain standards for coverage rates for low-income children. These provisions of the bill would essentially supersede the Bush Administration’s directive, issued through the Centers for Medicare and Medicaid Services (CMS) on August 17, 2007, that puts severe restrictions on states offering SCHIP coverage to children in families above 250 percent of FPL.²⁴

Illinois would not be immediately affected by the proposed restrictions on income eligibility in either the SCHIP reauthorization bill or the CMS directive. However, the outcome of the controversy will have implications for any future efforts to leverage additional federal funding for All Kids. The provisions of the reauthorization bill, including substantially higher allotments, would enable Illinois to raise its SCHIP income eligibility limit to 300 percent of FPL.

Although focusing on SCHIP’s original target population is a legitimate concern, there is little evidence that raising income eligibility is an impediment to enrolling children at lower income levels. Nine states currently have eligibility limits at or above 300 percent of FPL. In all but two of these states, the proportion of low-income children without health insurance is well below the national average. Moreover, an important benefit of state coverage expansions — including All Kids in Illinois — has been facilitating the enrollment of children who are already eligible for Medicaid or SCHIP.²⁵

Table 13: Low-Income Children without Health Insurance, Selected States

	SCHIP income eligibility limit (pct. of FPL)	Year implemented	Low-income children without health insurance: 2004-2006
Connecticut	300%	1998	13.4%
Hawaii	300%	2006	7.9%
Maryland	300%	2000	18.7%
Massachusetts	300%	2006	10.4%
Missouri	300%	1997	14.1%
New Hampshire	300%	1999	12.3%
New Jersey	350%	1999	22.0%
Pennsylvania	300%	2007	14.6%
Vermont	300%	1998	8.1%
U.S. average	-----	-----	18.1%

Sources: U.S. Department of Health and Human Services, U.S. Bureau of the Census

²⁴ The CMS directive imposes conditions that nearly all affected states would be unable to meet (see Mann and Odeh, 2007b). A number of states — including New Jersey, New York, and Illinois — are challenging the new requirements in federal court.

²⁵ Mann and Odeh, 2007a.

School-Based Outreach

The Bush Administration has repeatedly declared its support for enrolling eligible children in Medicaid and SCHIP. On August 31, 2007, however, CMS issued a proposed rule that would reverse longstanding Medicaid policy by eliminating federal reimbursement for certain administrative activities undertaken by school personnel, including Medicaid outreach and enrollment. The proposed rule is based on a determination by the Secretary of Health and Human Services that such school-based activities are necessary “for the proper and efficient administration” of a state Medicaid plan *only* if they are conducted by employees of a state Medicaid agency. This new policy would affect school-based outreach and enrollment program across the country, including the Children and Family Benefits Unit in the Chicago Public Schools.²⁶

The proposed rule has been published in the *Federal Register* and is open for public comment until November 6, 2007.²⁷ The SCHIP reauthorization bill includes a provision that would put a six-month moratorium on the new policy. Other pending legislation would establish specific guidelines for Medicaid reimbursement for school-based health services as well as for outreach and enrollment activities.²⁸

CONCLUSION

When SCHIP was enacted in 1997, it had broad bipartisan support in Congress and was signed into law by a Democratic president. The program was part of the “devolution revolution” of the 1990s and represented an approach to federalism that distinguished it from Medicaid. Greater programmatic flexibility and enhanced federal matching rates, as well as the focus on children, made SCHIP politically attractive to state officials.²⁹ Ten years later, however, reauthorization of the program has become highly controversial. The Bush Administration claims that the bill passed by Congress represents a “dramatic expansion” of SCHIP, establishment of a “new entitlement” for families with higher incomes, and a step toward “federalization” of health care.

In reality, the SCHIP reauthorization bill is designed to provide more federal support for existing state programs. The main thrust of the bill is to enroll more children who are currently eligible for SCHIP or Medicaid, and performance bonus payments are heavily weighted toward Medicaid. The legislation does not establish new entitlements for higher income households or anyone else. The bill limits new state efforts to expand income eligibility for children, and it rolls back federal funding for coverage of low-income parents. The Bush Administration, however, is trying to impose even tighter restrictions on state policy choices.

²⁶ Solomon and Ross, 2007.

²⁷ Centers for Medicare and Medicaid Services, 2007.

²⁸ The legislation is the “Protecting Children’s Health in Schools Act.” See NSBA, 2007.

²⁹ See Weil and Hill, 2003.

The specter of “federalization” of health care through SCHIP is a rhetorical myth. The reauthorization bill provides some new options for states, but the only new federal mandates involve requiring dental coverage and assuring parity for mental health services. Higher funding levels would enable states to enroll more children in current eligibility groups — but only if the states choose to do so. SCHIP would remain a joint federal-state program that is administered by the states. There would still be wide variation across states in regard to program design, income eligibility, and service coverage.

Under federal law, all states must make Medicaid available to children in families with incomes up to 100 percent of FPL. For children under age 6, the income eligibility limit is 133 percent of FPL. SCHIP does not have these kinds of uniform, minimum eligibility standards. The majority of states operate S-SCHIP programs — either alone or in combination with M-SCHIP — and the separate state programs do not have the entitlement status of Medicaid. The reauthorization bill would not change those realities. SCHIP would also remain a much smaller program than Medicaid. According to CBO projections, federal outlays in FY 2012 would be about \$284 billion for Medicaid and \$14 billion for SCHIP.

The Bush Administration’s rhetoric about SCHIP has not been consistent with its actions. The President’s FY 2006 budget recommended early reauthorization of SCHIP, citing the program’s “success at enrolling millions of low-income uninsured children.” At the same time, however, the budget proposed flat SCHIP funding over the next ten years. There were no new funds for projected SCHIP funding shortfalls in some states, rising health care costs, or enrollment growth.³⁰

The Bush Administration’s position on state “flexibility” has also been contradictory. The Administration has approved eight waivers for parental coverage under SCHIP. Similarly, in 2006 and 2007, three states were given approval for coverage expansions for children with family incomes up to 300 percent of FPL. In order to “refocus” SCHIP on its original target population, the Administration now wants to disavow those actions and to give less policy discretion to the states. Meanwhile, the concern for uninsured low-income children does not seem to apply to the nine states that still have income eligibility limits *below* 200% of FPL.³¹

Illinois has a great deal at stake in the struggle over SCHIP. Increased federal funding and a new allotment formula are essential to the financial viability of the All Kids health insurance program. Health care coverage for low-income parents through FamilyCare is also at risk. If SCHIP were extended at the baseline appropriation level or at the level proposed by the Bush Administration, Illinois would encounter severe funding shortfalls. The state’s progress in expanding health care coverage for children and families would be in serious jeopardy.

³⁰ Mann, 2005; Mann and Rudowitz, 2005.

³¹ The most restrictive eligibility standards are in North Dakota (140% of FPL), Montana (150%), and South Carolina (150%)

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About Voices for Illinois Children

Voices for Illinois Children works across issue areas to improve the lives of children of all ages throughout our state so they grow up healthy, happy, safe, loved, and well-educated. For 20 years, Voices has been helping opinion leaders and policymakers understand the issues facing children and families. The Voices network weaves through the state, involving community leaders and people who care passionately about children. Jerome Stermer is President of Voices for Illinois Children, and Craig R. Culbertson is Chair of the Board of Directors.

About the Budget & Tax Policy Initiative

The Budget & Tax Policy Initiative provides information and analysis to advocates and policymakers on a wide range of spending and revenue topics that have direct impact on the lives of children and families in Illinois. The Initiative helps Illinois policymakers and advocates set priorities and make wise fiscal decisions for the short term and for the long haul.

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