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**UNINSURED CHILDREN IN THE SOUTH
Third Edition**



December 2007



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Uninsured Children in the South Third Edition

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TABLE OF CONTENTS

| | |
|--|----|
| ACKNOWLEDGEMENTS | ii |
| TABLE OF CONTENTS..... | vi |
| LIST OF APPENDICES..... | ix |
| LIST OF CHARTS AND TABLES | x |
| EXECUTIVE SUMMARY | xi |
| INTRODUCTION | 1 |
| First and Second Editions | 2 |
| Third Edition..... | 3 |
| Source of Estimates of Uninsured Children..... | 4 |
| Source of Estimates of Uninsured Pregnant Women..... | 4 |
| MEDICAID AND SCHIP POLICY AND ELIGIBILITY FOR CHILDREN IN THE SOUTHERN STATES..... | 4 |
| Determining Eligibility in the Enrollment Process..... | 7 |
| UNINSURED CHILDREN IN THE SOUTHERN STATES | 9 |
| Uninsured Children as a Percentage of the State Population Age 18 and Younger..... | 9 |
| Uninsured Children by Age and Income Levels..... | 10 |
| Change in Number of Uninsured Children from 1999 to 2006 | 13 |
| Uninsured Children within Medicaid/SCHIP Age and Income Eligibility Levels Who Are Not Covered..... | 15 |
| MEDICAID AND SCHIP ELIGIBILITY AND POLICY FOR PREGNANT WOMEN IN THE SOUTHERN STATES | 15 |
| Pregnancy Risk Assessment Monitoring System | 18 |
| Coverage for Adults..... | 19 |

DISCUSSION OF ISSUES THAT IMPEDE HEALTH COVERAGE OPPORTUNITIES FOR UNINSURED CHILDREN AND PREGNANT WOMEN IN THE SOUTHERN STATES.....20

Joint Application and Renewal Forms20

Aligning Eligibility Levels within Public Programs.....21

Medicaid and SCHIP Eligibility Levels21

Family-Friendly Applications, Renewal Forms and Notices.....21

Outstationed Eligibility Workers and Application Assisters.....22

Face-to-Face Interview Requirements23

Verification Requirements23

Asset Test.....23

Continuous Eligibility.....25

Child Support Enforcement27

Presumptive Eligibility: Coordination of Temporary and Regular Coverage28

ACTIONS SOUTHERN STATES CAN TAKE TO IMPROVE THE ELIGIBILITY PROCESS.....28

Design Income Eligibility Levels to Align Medicaid and SCHIP Coverage.....28

Increase Medicaid and SCHIP Eligibility Levels28

Design and Implement Outreach Programs to Target Unenrolled Children Most Likely to be Eligible for Medicaid and SCHIP28

Expand the Use of Outstationed Eligibility Workers and Application Assisters28

Utilize Joint Medicaid and SCHIP Renewal Applications and Forms29

Develop Family-Friendly Applications, Renewal Forms and Notices29

Eliminate the Face-to-Face Interview Requirement29

Reduce Verification Requirements29

Remove the Asset Test.....29

| | |
|---|----|
| Allow Continuous Eligibility | 29 |
| Adopt Presumptive Eligibility | 29 |
| CONCLUSION..... | 29 |
| STATE FACT SHEETS ON UNINSURED CHILDREN AND PREGNANT WOMEN..... | 30 |
| REFERENCES | 67 |
| APPENDICES | 72 |
| PROJECT STAFF..... | 84 |

LIST OF APPENDICES

| | | |
|-------------|--|----|
| APPENDIX 1: | Methodology | 73 |
| APPENDIX 2: | Federal Poverty Levels for a Family of Four, 2003-2007 | 76 |
| APPENDIX 3: | Total Medicaid Enrollment in the Southern States, 1997-2005 | 77 |
| APPENDIX 4: | Total State Children’s Health Insurance Program (SCHIP) Enrollment in the Southern States, 1997-2005 | 78 |
| APPENDIX 5: | Births Financed By Medicaid as a Percentage of Total Births, 2002 | 79 |
| APPENDIX 6: | Income Threshold for Parents Applying for Medicaid | 80 |
| APPENDIX 7: | Simplified Procedures in Medicaid in the Southern States for Parents with Comparisons to Children, 2006 | 81 |

LIST OF CHARTS AND TABLES

| | | |
|-----------|--|----|
| TABLE 1: | Federal Minimum Medicaid Age and Income Eligibility Levels, 2005 | 5 |
| TABLE 2: | Medicaid and SCHIP Eligibility Levels for Children in the South, July 2006..... | 7 |
| TABLE 3: | Medicaid Documentation Checklist..... | 8 |
| CHART 1: | Distribution of Uninsured Children in the United States, 2005-2006..... | 9 |
| TABLE 4: | Ranking by Percentage of Southern States' Uninsured Population Age 18 and Younger, 2005-2006 | 10 |
| TABLE 5: | Distribution of Uninsured Children in the Southern Region by Age, 2005-2006 | 11 |
| TABLE 6: | Distribution of Uninsured Children in the Southern Region by Family Income as Related to the Federal Poverty Level, 2005-2006 | 12 |
| TABLE 7: | Trends in Uninsured Children in the Southern Region, 1999-2004 | 14 |
| CHART 2: | Births Financed by Medicaid as a Percent of Total Births, 2002..... | 16 |
| TABLE 8: | Pregnant Women Eligibility Levels and Enrollment Policies for Medicaid and SCHIP, July 2006 | 18 |
| TABLE 9: | Method of Payment at Delivery: PRAMS & Vital Statistics Data, 2004 | 19 |
| TABLE 10: | Southern States Asset Testing for Children's Medicaid and Separate State SCHIP, Pregnant Women and Family Coverage as of July 2006..... | 25 |
| TABLE 11: | Southern States that have Adopted 12-Month Continuous Coverage for Medicaid and/or SCHIP as of July 2006..... | 27 |

Uninsured Children in the South
Third Edition
November 2007

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 coverage 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 parents¹ 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 children² (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.

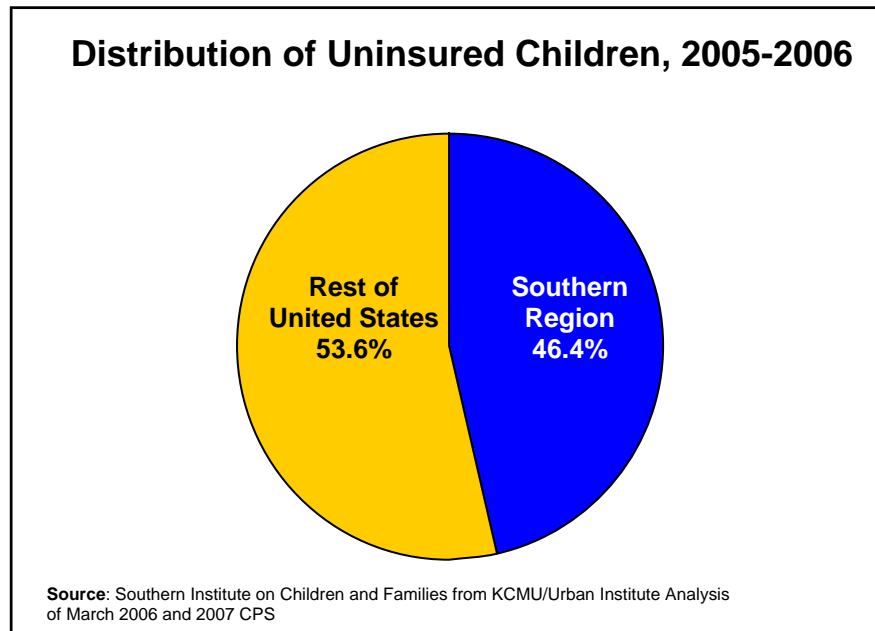
| Table 3 | | |
|--|--|---|
| Medicaid Documentation Checklist | | |
| Documentation Requirements for Applicants | Federal Requirements to Provide Documentation | State Option to Allow Self-Declaration |
| Immigration status for qualified aliens | X | |
| Citizenship | X | |
| Identity | X | |
| Income | | 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 difference⁴ 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

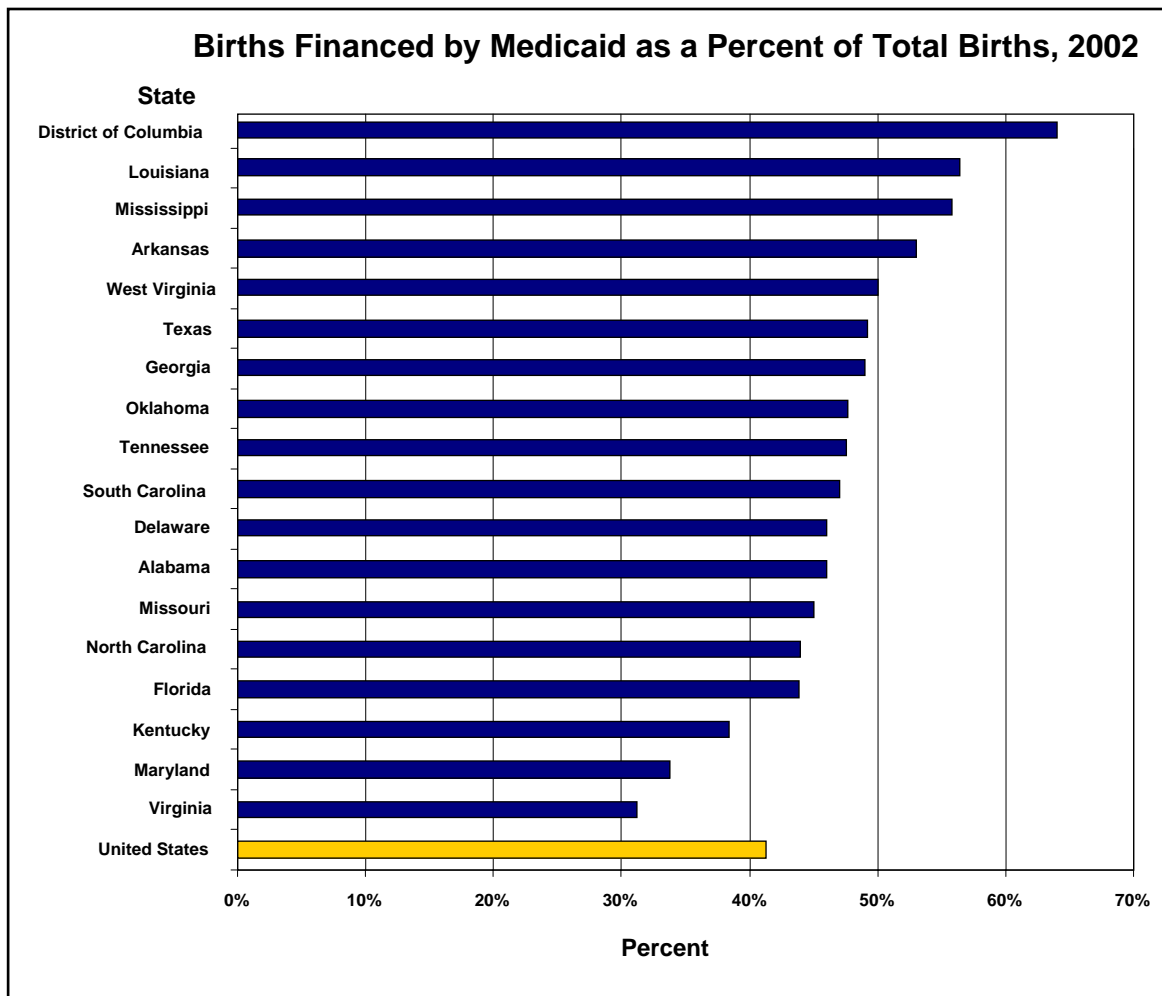
The health status of children is linked to the health status of their mothers prior to and during pregnancy. A large number of lower-income women have no health care coverage prior to pregnancy. That means many lower-income women may not be accessing health care prior to their pregnancies. Preconception 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 14 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 | 200% | \$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 | No | |
| Mississippi | 185% | No | No | |
| Missouri | 185% | No | Yes | |
| North Carolina | 185% | No | Yes | |
| Oklahoma | 185% | No | Yes | |
| South Carolina ² | 185% | \$30,000 | No | |
| Tennessee ³ | 185% | No | Yes | |
| Texas | 185% | No | Yes | Yes |
| Virginia ⁴ | 166% | No | No | |
| West Virginia | 150% | No | No | |
| Total Southern States | | 2 | 12 | 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.
- Three states (*Alabama, 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% |
| Georgia² | 56% | 44% | 13% | 3% | 9% |
| Maryland | 30% | 65% | 7% | | 0% |
| Missouri *** | 48% | 54% | 18% | | 2% |
| North Carolina | 54% | 48% | 21% | | 2% |
| Oklahoma³ | 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% | 45% | 17% | | 5% |

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

* Alabama, Florida and West Virginia data are from 2003.

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

***Missouri data are from 2005.

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

