

## **Simplification of Eligibility Requirements for PeachCare for Kids: Increasing Health Insurance Coverage for Georgia's Children**

### **Executive Summary:**

PeachCare for Kids (PCK) provides free or low-cost health coverage for children residing in Georgia and is part of the federal State Children's Health Insurance Program (SCHIP). PCK is supported by federal and state funds and administered by the Georgia Department of Community Health (DCH). Federal funding challenges for SCHIP have resulted in recent fiscal shortfalls for PCK. In response, the Georgia DCH froze enrollment. After Congress appropriated further funds for SCHIP, the DCH lifted the freeze but increased documentation requirements for proof of income, citizenship, and identity. This policy change seems unfounded because DCH officials stated that increased regulatory measures were not instituted in response to abuses of the program by ineligible individuals.<sup>i</sup>

As case studies of procedural barriers in other states suggest, increased administrative hurdles regarding eligibility for PCK will result in lower rates of coverage of eligible children in Georgia, greater administrative costs, and decreased health outcomes for children overall. These restrictive measures increased the amount of required documentation for enrollment in PCK, resulting in a twenty-two percent decrease (60,736 children) in enrollment from 2007 to 2008.<sup>ii</sup> Various nationwide studies have found that increasing required documentation for enrollment in SCHIP has mostly resulted in coverage gaps and denials for eligible children.<sup>iii</sup>

Because access to health care is linked to better health outcomes, especially among children, the Georgia DCH should reinstate simplified verification methods to determine proof of income. Such methods would include self-attestation, citizenship confirmation through the use of social security numbers, administrative verification of income, and presumptive eligibility

(where qualified institutions identify children likely eligible for temporary coverage to determine citizenship and identity).<sup>iv</sup> Furthermore, the cost of insuring children is relatively modest when compared to state and federal spending on Medicaid. State officials have a moral responsibility to ensure that all children eligible for PCK benefits receive health coverage. The basic goal of PCK is to provide health insurance for low-income children in order to improve health outcomes. Increasing enrollment of uninsured children already eligible for PCK will help Georgia reach this goal.

**Background:**

Health insurance increases children's access to primary care and helps them lead healthier lives. Studies have found that children with health insurance coverage have higher rates of access to preventive care, which may reduce the need for future medical attention and increased treatment costs.<sup>v</sup> Recognizing the need to increase children's access to care, the U.S. Congress enacted Title XXI of the Social Security Act in 1997 to create the State Children's Health Insurance Program (SCHIP). This program provides health coverage for uninsured children up to age 19 in low-income families whose incomes are too high to qualify for Medicaid.<sup>vi</sup> As outlined by the Balanced Budget Act of 1997, H.R. 2015, SCHIP is jointly financed by the federal government and state governments. States administer the program under general federal guidelines. These guidelines require states to submit plans for outreach activities and eligibility requirements to the federal government. Because requirements are determined state-by-state, eligibility requirements vary across the nation.

Section 49-5-273 of the Official Code of Georgia created PeachCare for Kids (PCK) in 1999 using SCHIP funds. PCK provides health care for uninsured children in Georgia families with incomes below 235 percent of the federal poverty level.<sup>vii</sup> The Division of Medical Assistance within the Georgia Department of Community Health (DCH) administers PeachCare

for Kids and Medicaid and develops policy that establishes eligibility and other requirements. The DCH also includes a Board of Community Health made up of nine individuals appointed by the Governor and confirmed by the state Senate who possess policy-making authority.<sup>viii</sup> Federal funds account for 73 percent of funding for PCK, and benefits include primary, dental, vision, and other forms of more specialized care. However, PCK recently began to suffer from federal funding cutbacks, leaving the state \$131 million dollars short of essential funding by February 2007.<sup>ix</sup> The Georgia DCH instituted an enrollment freeze for PCK on March 11, 2007 in response to the shortfall.<sup>x</sup>

After Congress passed legislation appropriating funds for states experiencing SCHIP shortfalls, the DCH lifted the enrollment freeze in July 2007.<sup>xi,xii</sup> However, the DCH also increased eligibility requirements for enrollment in PCK. For example, the DCH began to require original documentation for proof of income and citizenship, eliminating the use of self-attestation and administrative verification.<sup>xiii</sup> In traditional administrative verification, state officials utilize state databases and case records to confirm reported income. New applicants for PCK send proof of income through various forms such as pay stubs, unemployment checks, letters from employers, Social Security Administration award letters, or other documented work statements. In order to maintain eligibility, recipients must provide verification of income every year.

The Medicaid Citizenship Documentation Requirement, a provision of the 2005 Deficit Reduction Act (DRA), S. 1932, complicates enrollment procedures for eligible children.<sup>xiv</sup> U.S. citizenship has been a requirement for Medicaid in the past, but applicants could self-attest to their status. The DRA altered this system to require proof of citizenship through the presentation of original documentation. Although the citizenship documentation requirement does not

directly apply to SCHIP, some states, such as Georgia after the enrollment freeze, have applied the same enrollment procedures for both Medicaid and SCHIP.<sup>xv</sup>

Citizenship and identity documentation are organized into three levels. Applicants for PCK can send documentation confirming citizenship and identity with first level documents such as passports, certificates of citizenship, or certificates of naturalization. If applicants lack these documents, they must submit one document from the second level to prove citizenship (birth certificates, extracts of hospital records on hospital letterhead, or other birth or adoption records) and one document from the third level to prove identity (an identification card issued by federal, state, or local governments, school records, or other similar documents).<sup>xvi</sup> The change from self-attestation and administrative verification has contributed to a twenty-two percent enrollment decrease, coverage gaps for children, and increased administrative costs because of the complications involved in obtaining original documentation.<sup>xvii,xviii</sup>

The original intent of the DRA was to “ensure that Medicaid beneficiaries are citizens without imposing undue burdens on them or the states.”<sup>xix</sup> However, the Administrator of the Centers for Medicare and Medicaid Services, Mark McClellan, stated that “The [Inspector General’s] report does not find particular problems regarding false allegations of citizenship, nor are we aware of any” when the DRA was passed, undermining the legitimacy and necessity for such a measure.<sup>xx</sup> In fact, the measures enacted by the bill have reduced health coverage for eligible U.S. citizens because of the difficulty of obtaining necessary documentation.<sup>xxi</sup>

Enrollment in SCHIP and Medicaid is sensitive to changes in administrative procedures. National surveys have reported declines in enrollment after the application of stringent enrollment procedures; thirteen states have reported a significant negative impact on enrollment while another twenty-four report a modest impact.<sup>xxii</sup> Furthermore, sixteen states have reported

that thousands of people who appear to be eligible U.S. citizens (having provided citizenship documentation but not a second form confirming identity) have lost benefits from SCHIP or had them delayed.<sup>xxiii</sup> These states include Connecticut and Wisconsin, which experienced declines in enrollment in their SCHIP programs after enacting documentation requirements for income and citizenship.<sup>xxiv</sup>

A recent report by the DCH states that PCK enrollment decreased twenty-two percent between July 2007 and June 2008 after eligibility rules increasing required original documentation went into effect.<sup>xxv</sup> Case studies and nationwide analyses demonstrate that this phenomenon is largely the result of complicated eligibility and enrollment procedures and will lead to lower health outcomes. Overly stringent eligibility requirements create inefficiencies and threaten child health. According to recent studies, 8.66 million American children, or 11.7 percent of all American children under age 18, remain uninsured.<sup>xxvi</sup> More than 70 percent of these children are eligible for public health coverage, and covering these eligible children would result in health care coverage for up to 95 percent of American children.<sup>xxvii</sup> Over 300,000 children in Georgia, or 12.5 percent of Georgia children, are uninsured, a percentage that is higher than the national average.<sup>xxviii</sup> According to the National Conference of State Legislatures, a non-governmental organization that provides research for policymakers regarding state issues, an estimated 100,000 children are eligible for PCK but not enrolled.<sup>xxix</sup> This figure may underestimate the number of non-enrolled eligible children because Georgia lacks effective methods for identifying such cases.

Inefficiencies involved in the determination of eligibility for PCK exist at various levels throughout the application process. These inefficiencies may be detrimental to child health in Georgia. The hassle and difficulty of obtaining documents for the PCK application may

discourage families from beginning or continuing the application process. After families provide the necessary documentation, program administrators must also spend time verifying and monitoring these documents. PCK cannot provide health insurance for all of Georgia's children, but simplification of procedural requirements regarding documentation would significantly increase coverage for eligible children residing in Georgia.

### **Simplifying Eligibility Requirements for PCK:**

The Georgia Department of Community Health should adopt simplified verification methods such as a combined Medicaid and PCK application, determination of proof of income through self-declaration and administrative verification of income, utilization of presumptive eligibility to deliver needed care immediately, and acceptance of social security numbers to establish citizenship and identity. These measures will increase coverage for eligible children and promote administrative efficiency.

#### *A Single Application for PCK and Medicaid*

State officials of the DCH should simplify the overall application processes for Medicaid and PCK by providing a single application for both programs. The DCH administers both PCK and Medicaid in Georgia, and a combined application would not require drastic bureaucratic restructuring. A single application allows families to provide necessary information once, and program administrators can determine whether the child is eligible for Medicaid or PCK. Indiana reported that the use of a joint application for its children's Medicaid and SCHIP program, Hoosier Healthwise, has halved the time that state workers spend verifying information provided by applicants and has saved on printing costs.<sup>xxx</sup> Instead of applying for one program, being rejected, and applying for another through additional applications and forms, parents could

apply for both programs at once, increasing the likelihood of their children receiving coverage in an efficient manner.

### *Self-Attestation and Administrative Verification of Income*

Self-declaration of income has been the historical method of determining eligibility for SCHIP-funded programs. Under this process, applicants provide information on their incomes and are under penalty of perjury if they provide false information. States use existing administrative records to verify applicants' incomes and supplement verification with random audits. Increased utilization of information already obtained by government agencies will facilitate eligibility evaluation through administrative verification without extensive effort from applying families. In order to ensure the accuracy of the information about family incomes, states often employ post-eligibility measures by consulting resources such as state databases, state departments of labor, and available case records and conducting third-party checks before determining final eligibility.

If families are rejected from this application due to lack of available records or information, an alternative application process involving the current requirements of original documentation should still be available. Through these verification methods, the enrollment process is simplified while the program's selection process is still effective. Administrators must confirm eligibility whether documentation is required or not, and administrative verification reduces paperwork that families must complete. This practice also accelerates enrollment, leading to greater numbers of applicant children receiving coverage. Several studies have shown that enrollment increases in states that institute simplified procedures such as administrative verification.<sup>xxx</sup>

### *Use of Social Security Numbers to Determine Citizenship and Identity*

Many states, including Georgia, have interpreted the Medicaid Citizenship Documentation Requirement in the 2005 Deficit Reduction Act to apply to both Medicaid and SCHIP. Presentation of original documents to prove citizenship and identity has resulted in substantial enrollment declines in states, and these declines continue even when states strive to obtain birth records from various agencies in order to cover more applicants. The Georgia DCH should allow families to use their children's social security numbers as proof of qualification for PCK. Families already must present proof of legal immigration status or citizenship to the Social Security Administration in order to obtain social security numbers for their children. The Social Security Administration confirms the submitted documents through the same methods used by SCHIP-sponsored programs such as PCK through the Department of Homeland Security and U.S. Citizenship and Immigration Services.<sup>xxxii</sup> If a family applies for PCK and the child lacks a social security number, the family must then provide proper documentation based on the existing framework outlined by the Georgia DCH and the DRA.

#### *Presumptive Eligibility*

The Georgia DCH should also adopt presumptive eligibility to temporarily enroll children who appear eligible for PCK benefits. Insurance providers began using presumptive eligibility in the 1980s to determine whether an individual was likely eligible for Medicaid.<sup>xxxiii</sup> Presumptive eligibility allows clinics, hospitals, schools, and other qualified entities to determine temporary eligibility for some public benefits. Under these measures, children who appear eligible for PCK or Medicaid benefits are provided with temporary coverage while their families complete the necessary steps to apply for continued coverage, allowing children to access necessary medical care immediately. The DCH will set a time frame for temporary coverage lasting the average duration of application processing; however, this precaution may be

unnecessary since decreased documentation places the application processing time under state officials' control. PCK will reimburse providers for delivering care during this period, even if the child is later found to be ineligible for such coverage.<sup>xxxiv</sup> Presumptive eligibility thus prevents substantial delays in coverage while still providing a time limit to avert abuses of the program. Ten states have adopted presumptive eligibility procedures for either Medicaid or SCHIP potential eligibility determination. Numerous studies have shown that both self-declaration of income and presumptive eligibility increase enrollment numbers considerably. Rampant abuses have not been documented as a result of these measures.<sup>xxxv</sup>

Simplification of citizenship confirmation increases the efficiency of enrolling eligible U.S. children. More efficient enrollment of eligible children will also lead to higher rates of coverage for U.S. children. By eliminating documentation requirements while maintaining verification of information through efficient and effective methods, the Georgia DCH will reduce procedural obstacles that waste state resources and complicate enrollment while maintaining the integrity of PCK.

#### **Benefits of Simplified Enrollment Procedures for PCK:**

Reducing documentation requirements increases health insurance enrollment. Health insurance carries many benefits for children and their families. Children with health insurance have better access to preventive and primary health care and also tend to have better school attendance, participation, and performance.<sup>xxxvi</sup> One California study surveyed parents and found that children enrolled in SCHIP or other public insurance programs demonstrated a 68 percent improvement in paying attention during school and keeping up with assignments and activities.<sup>xxxvii</sup> Enrollees in PCK and other SCHIP programs are more likely than uninsured

children to receive office visits for primary care, preventive care, dental care, and are less likely to have emergency room visits.

Reducing the amount of documentation required to determine PCK eligibility will decrease costs from a long-term perspective. As stated earlier, enrollment in New York's SCHIP program (CHPlus) resulted in increased primary care visits by forty-two percent and lowered hospitalizations by 36 percent.<sup>xxxviii</sup> Fewer hospitalizations result in lower costs incurred from uncompensated care. Parents can take their insured children to receive primary care in the early stages of illness rather than waiting on serious health problems to arise before seeking care in emergency rooms.

Substantial costs result from administrative hurdles as well. One New York study found that up to eighty percent of the \$280 it costs to enroll a child in a public health insurance program is associated with the complicated calculations and rules concerning eligibility determinations. Sixty-one percent of the total cost of enrollment was spent on application completion and documentation gathering. The study also estimated that a simplified system requiring fewer documents would reduce enrollment costs by forty percent.<sup>xxxix</sup> Covering more children will require increased funding in the short-term but will lead to decreased spending overall due to reduced costs of uncompensated care and lower administrative costs.

From a public health perspective, healthy children create a healthier society as a whole. Children participate in many activities in which they are in close contact with others, such as attending day care programs and schools. Providing children with health care and its associated benefits, such as immunization and primary care, not only decreases the burden on taxpayers by reducing incidences of less cost-effective uncompensated care for preventable diseases but also protects the health of all children and adults through the prevention of the spread of pathogens.<sup>xl</sup>

School-age children with health insurance and their parents would benefit from the coverage of other eligible but uninsured children through decreased exposure to untreated, preventable communicable diseases.

State-specific studies have investigated various public health benefits associated with enrollment in SCHIP programs. A study based on Colorado's Child Health Plan Plus (CHP+) found that the percentage of families who reported in a survey that it was “very easy” or “easy” to obtain necessary health care for their children increased from 53.9 percent to 73.1 percent after enrollment in the program.<sup>xli</sup> Furthermore, the percentage of families who reported that their children saw health care providers as soon as wanted when they were sick or injured increased from 77.5 percent to 90.9 percent. Necessary specialists' visits also increased from 34.0 percent to 56.6 percent.<sup>xlii</sup> Enrollment in New York's SCHIP program increased primary care visits by forty-two percent and lowered hospitalizations by thirty-six percent.<sup>xliii</sup> Increased utilization of primary care and reduction of hospitalizations indicates better health outcomes overall since preventive primary care is more effective at maintaining health than reliance on hospitalizations for emergency situations. These examples indicate that increasing enrollment in PCK is a vital step toward improving access of care and health outcomes for Georgia's children.

### **Wisconsin, Medicaid, and BadgerCare: A Case Study**

Wisconsin's Medicaid program provides an example of the effects of documentation requirements on enrollment. Between July 31, 2006 and March 1, 2007, 19,413 Medicaid-eligible individuals had their Medicaid coverage denied or terminated as a result of citizenship documentation requirements.<sup>xliv</sup> Although Wisconsin attempted to reduce the impact of the DRA requirement by obtaining birth records electronically from its Vital Records agency, enrollment still decreased. Obtaining original documentation, especially if administrators required

applicants to provide proof of identity with additional proof of citizenship, was a major factor contributing to the drop in enrollment. Of the applicants denied Medicaid, 66.5 percent lacked an identity document, whereas 19.9 percent of applicants lacked required citizenship documents. Only 12.3 percent lacked both citizenship and identity documents, where citizenship documents included certificates of citizenship and naturalization and identity documents included government-issued identity cards.<sup>xlv</sup> These percentages indicate that applicants denied Medicaid coverage were U.S. citizens rather than non-citizens attempting to obtain public benefits; if applicants are able to provide citizenship documentation, the likelihood is high that they are eligible citizens. Increased documentation requirements likely created additional hassles that amplified the time and effort required to apply for health care benefits. Wisconsin's SCHIP program, BadgerCare, also experienced declines in enrollment. Between August 1, 2006 and January 1, 2008, Wisconsin reported that 32,907 children were blocked from receiving Medical Assistance or BadgerCare because of documentation requirements. In 62 percent of these cases, termination or denial was due only to lack of identification rather than lack of documentation confirming citizenship.<sup>xlvi</sup>

James D. Jones, the director of the Bureau of Eligibility Management of the Wisconsin Department of Health and Family Services, stated that "Congress wanted to crack down on illegal immigrants who got Medicaid benefits by pretending to be U.S. citizens . . . but the [DRA] is hurting U.S. citizens, throwing up roadblocks to people who need care."<sup>xlvii</sup> After determining that the majority of applicants being denied coverage through Medicaid or SCHIP were actually eligible for benefits, Wisconsin reported that the difficulty of obtaining out-of-state records, increased hassle and time required for enrollment, and complications caused by documentation requirements played a major role in these denials. Wisconsin responded to

declining SCHIP enrollment by removing the requirement for documentation of income and implementing administrative verification instead. The state did not remove citizenship and identity documentation requirements. However, increased enrollment after the elimination of the income documentation requirement indicates that enrollment would further increase with reductions in other types of required documentation for eligibility determination. Wisconsin's experiences with fluctuating enrollment of eligible children in response to changing documentation requirements suggest that increased documentation requirements played a major role in the recent decline in enrollment in PCK. Simplification of these requirements would result in increased enrollment of eligible but uninsured children.

#### **Challenges Involved with Increasing PCK Enrollment:**

In light of long-term SCHIP funding challenges, PCK funding shortfalls, and recent national and statewide economic struggles, the main challenges facing increased enrollment in PCK are financial. Policymakers in the Georgia DCH may be concerned about the responses of the Georgia Legislature, governor, and citizens if they change eligibility requirements to decrease documentation required for enrollment. The cost of increasing insurance coverage for children may seem unaffordable, but health insurance for children is relatively inexpensive. The cost of uncompensated care and other forms of healthcare provided for treatment rather than prevention is higher than the cost of providing insurance coverage. Health insurance will result in the utilization of primary care and can prevent many serious and expensive health problems.<sup>xlviii</sup> Citizens of Georgia may have to pay increased taxes during the period in which large numbers of eligible but uninsured children are enrolled in PCK. However, the taxpayer burden will likely decrease over time as administrative costs to enroll children in PCK and

uncompensated care and emergency hospitalization costs for preventable health problems decline.

Higher enrollment in health insurance tends to result in increased use of preventive care and decreased use of uncompensated care. In 2004 the U.S. spent \$40.7 billion dollars on healthcare for people lacking health insurance; \$5.4 billion of this spending was for uninsured children.<sup>xlix</sup> All U.S. citizens must pay increased taxes and insurance costs due to uncompensated care for the uninsured. In 2005 private employer health insurance was \$922 higher on average per family due to the costs of the uninsured.<sup>l</sup> The Kaiser Family Foundation estimated that federal and state enrollment costs of insuring eligible but uninsured children would amount to about \$8.8 billion dollars a year after increasing efficiencies in eligibility.<sup>li</sup> A \$3.4 billion dollar increase (\$5.4 billion subtracted from \$8.8 billion) in federal and state spending due to children's health care is relatively small, especially when compared to current federal and state spending on Medicaid (\$316 billion).<sup>lii</sup> A \$3.4 billion dollar increase also does not include reductions in spending on uncompensated care or resulting decreases in insurance premiums. Spending on uncompensated hospital care would be reduced because insured children require fewer emergency room visits, and these visits will no longer result in uncompensated care costs.<sup>liii</sup> Funds spent on children's health insurance that will prevent health problems are more effective than dollars spent on uncompensated care to treat issues that arise due to lack of preventive care.

Another challenge to relaxing documentation requirements for PCK eligibility may be Georgia citizens' and state officials' concerns that non-citizens will benefit from this public insurance program without paying taxes to support it. Whether or not non-citizen children should receive public health insurance benefits is not an issue this policy addresses, but the steps involved in implementing this policy strive to uphold the integrity of PCK enrollment. Self-

attestation and administrative verification of income, presumptive eligibility, and use of social security numbers to determine citizenship or immigration status all incorporate checks conducted by PCK administrators to verify information that applicants provide. A small number of ineligible children might receive health care coverage, but the benefits provided by covering the estimated 100,000 eligible but uninsured children in Georgia (a thirty-one percent increase in total PCK enrollment) outweigh the negative repercussions of a handful of ineligible children receiving care.<sup>liv</sup>

Stringent procedures involving documentation decrease enrollment and cause eligible U.S. citizens to lose coverage. Hurdles to eligibility also increase the time required to process all of the necessary forms, further raising administrative costs. The various challenges associated with documentation to prove income, citizenship, and identity result in poorer health outcomes due to decreased health insurance coverage of children. However, ninety percent of Americans support adequate health care coverage for low-income children.<sup>lv</sup> Health care for children clearly has the support of most Americans. Children represent investments in the nation's future, and healthy children will grow up to become healthy, productive adults. Challenges associated with insuring eligible but uninsured children exist, but the benefits of insuring these children give reason to consider these challenges carefully and to search for possible solutions.

**Conclusion:**

Health care for children represents a commitment to the health outcomes and wellbeing of Georgia's children. Simplification of PCK documentation requirements for eligibility will result in increased enrollment. By utilizing practices such as a single application for PCK and Medicaid, self-attestation and administrative verification of income, presumptive eligibility, and use of social security numbers to determine citizenship and identity, the Georgia DCH will

streamline the processes through which children can receive benefits from PCK while maintaining standards that will prevent ineligible applicants from receiving coverage. The short-term costs of increased enrollment in PCK may cause some citizens and legislators to oppose this policy; however, long-term benefits include fewer taxes paid by Georgia citizens to cover uncompensated care and preventable emergency hospitalizations, better health of society as a whole, and increased coverage for children who are already eligible for PCK benefits. In light of the recent passage of H.R. 2 (now P.L. 111-3), the DCH should institute the measures recommended in this policy and utilize newly available federal funding to offset short-term costs.<sup>lvi</sup> Coverage for children is a stated goal of both federal and state legislation regarding SCHIP and PCK. The steps outlined in this policy proposal apply directly to PCK but also provide examples of policy measures that can be implemented in other states to increase enrollment of eligible children in SCHIP programs.



<sup>i</sup> Ross, Donna Cohen, Aleya Horn, and Caryn Marks. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles." Kaiser Commission on Medicaid and the Uninsured. [www.kff.org/medicaid/7740.cfm](http://www.kff.org/medicaid/7740.cfm) (accessed Sep. 15, 2008).

<sup>ii</sup> Summers, Carie. "Amended FY 2009 and FY 2010 Program Budgets." Georgia Department of Community Health.

[http://dch.georgia.gov/vgn/images/portal/cit\\_1210/20/14/120952990Augustpercent2028,percent202008percent20Budgetpercent20Proposalspercent20forpercent20DCHpercent20Boardpercent20Considerationpercent20-percent20FINAL.pdf](http://dch.georgia.gov/vgn/images/portal/cit_1210/20/14/120952990Augustpercent2028,percent202008percent20Budgetpercent20Proposalspercent20forpercent20DCHpercent20Boardpercent20Considerationpercent20-percent20FINAL.pdf) (accessed September 16, 2008).

<sup>iii</sup> Ross, "Health Coverage."

<sup>iv</sup> Szilagyi, Peter G., Jack Zwanziger, Lance E. Rodewald, Jane L. Holl, Dana B. Mukamel, Sarah Trafton, Laura Pollard Shone, Andrew W. Dick, Lynne Jarrell, and Richard F. Raubertas. "Evaluation of a State Health Insurance Program for Low-Income Children: Implications for State Child Health Insurance Programs." *Pediatrics* 105 (2000): 363-370.

<sup>v</sup> Selden, Thomas, and Julie Hudson. "Access to Care and Utilization Among Children: Estimating the Effects of Public and Private Coverage." *Medical Care* 44 (2006): 19-26.

<sup>vi</sup> "Balanced Budget Act of 1997." (P.L. 105-33), *United States Statutes at Large*.

<sup>vii</sup> Section 49-5-273. *The Official Code of Georgia*.

<sup>viii</sup> "A Snapshot of the Georgia Department of Community Health." The Georgia Department of Community Health.

[dch.georgia.gov/vgn/images/portal/cit\\_1210/58/31/70648888DCH.12.2007.FINAL.pdf](http://dch.georgia.gov/vgn/images/portal/cit_1210/58/31/70648888DCH.12.2007.FINAL.pdf) (accessed Oct. 14, 2008).

<sup>ix</sup> "Issue Brief: PeachCare for Kids Funding." Emory University.

[http://www.sph.emory.edu/WHP/documents/2007percent20Session/PeachCare\\_Issue.pdf](http://www.sph.emory.edu/WHP/documents/2007percent20Session/PeachCare_Issue.pdf) (accessed Sep. 20, 2008).

<sup>x</sup> "Enrollment Freeze for PeachCare for Kids Lifted." Georgia Department of Community Health.

[http://dch.georgia.gov/vgn/images/portal/cit\\_1210/37/11/86098649PR-PeachCare\\_Enrollment\\_Freeze\\_Lift.pdf](http://dch.georgia.gov/vgn/images/portal/cit_1210/37/11/86098649PR-PeachCare_Enrollment_Freeze_Lift.pdf) (accessed September 18, 2008).

<sup>xi</sup> Ibid.

<sup>xii</sup> "Issue Brief," Emory University.

<sup>xiii</sup> Summers, "Amended FY 2009 and FY 2010."

<sup>xiv</sup> Ibid.

<sup>xv</sup> Grady, April. "Medicaid Citizenship Documentation." Congressional Research Service Report for Congress. <http://aging.senate.gov/crs/medicaid14.pdf> (accessed Oct. 3, 2008).

<sup>xvi</sup> "Citizenship and Identity Requirements." PeachCare for Kids. [www.peachcare.org/FAQView.aspx?displayFaqId=9](http://www.peachcare.org/FAQView.aspx?displayFaqId=9) (accessed September 28, 2008).

<sup>xvii</sup> Summers, "Amended FY 2009 and FY 2010."

<sup>xviii</sup> Ross, "Health Coverage."

<sup>xix</sup> "HHS Issues Citizenship Guidelines for Medicaid Eligibility." Centers for Medicare and Medicaid Services. <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1878> (accessed Oct. 18, 2008).

<sup>xx</sup> Ross, Donna Cohen. "New Medicaid Citizenship Documentation Requirement is Taking a Toll: States Report Enrollment is Down and Administrative Costs are Up." Center on Budget and Policy Priorities. <http://www.cbpp.org/2-2-07health.htm> (accessed Oct. 5, 2008).

<sup>xxi</sup> "HHS Issues Citizenship Guidelines."

<sup>xxii</sup> Grady, "Medicaid Citizenship Documentation."

<sup>xxiii</sup> Ibid.

<sup>xxiv</sup> Ross, "Health Coverage."

<sup>xxv</sup> Summers, "Amended FY 2009 and FY 2010."

<sup>xxvi</sup> "More Americans, Including More Children, Now Lack Health Insurance." Center on Budget and Policy Priorities. <http://www.cbpp.org/8-28-07health.htm> (accessed Nov. 1, 2008).

<sup>xxvii</sup> Horner, Dawn, and Beth Morrow. "Opening Doorways to Health Care for Children: 10 Steps to Ensure Eligible but Uninsured Children Get Health Insurance." Kaiser Commission on Medicaid and

the Uninsured. <http://www.kff.org/medicaid/7506.cfm> (accessed Oct. 1, 2008).

<sup>xxviii</sup> “HB 340-PeachCare Reductions.” Georgia Budget and Policy Institute.

<http://www.gbpi.org/pubs/healthcare/20070320.pdf> (accessed Nov. 1, 2008).

<sup>xxix</sup> “Georgia Considers How to Adapt to SCHIP Funding Shortfall.” National Conference of State Legislatures. <http://www.ncsl.org/programs/health/shn/2007/sn486a.htm> (accessed Nov. 1., 2008).

<sup>xxx</sup> Ross, Diana Cohen, and Ian T. Hill. "Enrolling Eligible Children and Keeping Them Enrolled." *The Future of Children* 13 (2003): 81-97.

<sup>xxxi</sup> Ibid.

<sup>xxxii</sup> Horner and Morrow, “Opening Doorways.”

<sup>xxxiii</sup> Kronebusch, Karl, and Brian Elbel. "Simplifying Children's Medicaid and SCHIP." *Health Affairs* 23 (2004): 233-246.

<sup>xxxiv</sup> Ross, “Enrolling Eligible Children.”

<sup>xxxv</sup> Kronebusch and Elbel, “Simplifying Children’s Medicaid.”

<sup>xxxvi</sup> Ross, “Enrolling Eligible Children.”

<sup>xxxvii</sup> Baron, Juliane, Jessica H. Kleinmann, and Kathleen Sylvester. "Health Insurance for Children: Issues and Ideas." *The Future of Children*. [http://www.futureofchildren.org/usr\\_doc/tfoc13-1\\_iig.pdf](http://www.futureofchildren.org/usr_doc/tfoc13-1_iig.pdf) (accessed Nov. 1, 2008).

<sup>xxxviii</sup> Szilagyi, “Evaluation of a State Health Insurance Program.”

<sup>xxxix</sup> Fairbrother, Gerry, Melinda Dutton, Deborah Bachrach, Kerry-Ann Newell, Patricia Beozang, and Rachel Cooper. "Costs of Enrolling Children in Medicaid and SCHIP ." *Health Affairs* 23 (2004): 237-243.

<sup>xl</sup> Horner and Morrow, “Opening Doorways.”

<sup>xli</sup> Kempe, Allison, Brenda L. Beaty, Lori A. Crane, Johan Stokstad, Jennifer Barrow, Shira Belman, and John F. Steiner. "Changes in Access, Utilization, and Quality of Care After Enrollment Into a State Child Health Insurance Plan." *Pediatrics* 115 (2005): 364-371.

<sup>xliii</sup> Ibid.

<sup>xliiii</sup> Szilagyi, "Evaluation of a State Health Insurance Program."

<sup>xliiv</sup> Ross, "New Medicaid Citizenship Documentation Requirement."

<sup>xliiv</sup> Ibid.

<sup>xlivi</sup> Horner and Morrow, "Opening Doorways."

<sup>xliiii</sup> Ross, "New Medicaid Citizenship Documentation Requirement."

<sup>xliiii</sup> Szilagyi, "Evaluation of a State Health Insurance Program."

<sup>xlix</sup> Horner and Morrow, "Opening Doorways."

<sup>i</sup> Ibid.

<sup>ii</sup> Ibid.

<sup>iii</sup> Ibid.

<sup>iii</sup> Szilagyi, "Evaluation of a State Health Insurance Program."

<sup>liv</sup> "Georgia Considers," National Conference of State Legislatures.

<sup>lv</sup> Horner and Morrow, "Opening Doorways."

<sup>lvi</sup> "To Amend Title XXI of the Social Security Act to Extend and Improve the Children's Health Insurance Program, and for Other Purposes." (P.L. 111-3), *United States Statutes at Large*.