

medicaid
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**SCHIP Enrollment in June 2007:
An Update on Current Enrollment and
SCHIP Policy Directions**

Prepared by
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Health Management Associates

and

David Rousseau
Caryn Marks
Robin Rudowitz
Kaiser Commission on Medicaid and the Uninsured

January 2008

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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Executive Summary

The State Children's Health Insurance Program (SCHIP) has enjoyed broad support among state and federal policymakers since its enactment in 1997. States, which administer the program, have been active partners in building upon Medicaid's foundation to promote health insurance coverage for low-income, uninsured children through SCHIP. Following legislative enactment, enrollment in SCHIP increased rapidly; however, this growth was tempered during a period of tight state budget constraints from 2003 to 2006 as states scaled back outreach efforts to find and enroll eligible children. For the past two years, SCHIP enrollment has once again increased, although at a slower pace as states have pushed up against limits in available federal funding.

SCHIP was enacted in 1997 with federal authorization for ten years, through September 30, 2007, with a capped amount of federal funding nationally that is allocated each year by state. SCHIP reauthorization was the subject of considerable attention in Washington over the past year, with the President vetoing two Congressionally-adopted, bipartisan bills that would have significantly expanded the program and provided additional coverage of uninsured children and funding for the next five years. While this debate was ongoing, the Centers for Medicaid and Medicare Services (CMS) issued a new directive in August 2007 significantly restricting states' ability to expand SCHIP coverage to children in families with incomes above 250 percent of the federal poverty level. As the year drew to a close, the Congress and the President agreed in December 2007 to an extension of the program through March 2009 that provides only enough funding to maintain existing enrollment levels.

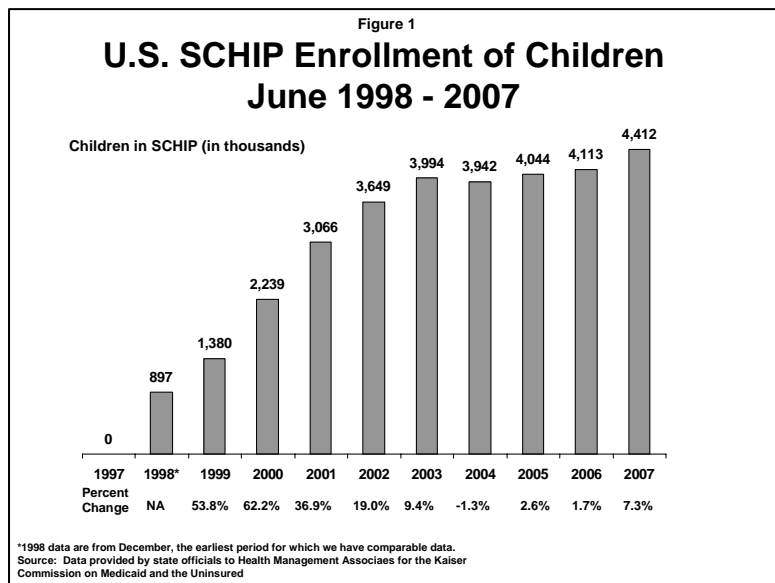
This report provides the latest data on SCHIP enrollment and policy trends nationally and across the states through June 2007, based on survey responses and data provided by SCHIP directors in all 50 states and the District of Columbia.

Enrollment and Policy Trends

SCHIP enrollment reached a monthly high of 4.4 million in June 2007 (Figure 1).

Enrollment increased rapidly during SCHIP's first five years as states established their programs in 1998. Due to the economic downturn and program cutbacks due to state budget constraints, growth slowed and enrollment decreased in 2004. As state fiscal conditions improved, states restored prior cuts and have shown modest annual growth in enrollment in SCHIP.

During the past year, the total number of children enrolled in SCHIP increased by 7.3%, the largest percentage increase since 2003. This growth was attributed



to stronger state revenue pictures and renewed state efforts to find and enroll eligible children. States also anticipated that SCHIP reauthorization would include significant additional program funding, thereby allowing states to continue on a path to streamline enrollment processes, adopt eligibility expansions and cover additional children.

From June 2006 to June 2007, the number of children enrolled in SCHIP increased in 34 states and the District of Columbia. Several large states accounted for most of the net annual enrollment increase of 299,045. Nearly 42 percent of the national enrollment growth occurred in California, where enrollment rose by 125,423 children. Other states with enrollment gains of at least 10,000 children included: Florida, Georgia, Illinois, Massachusetts, Oregon, Pennsylvania and Texas. The increases in Florida and Texas were particularly notable, reversing a recent downward trend in enrollment in these two states. Enrollment increases were attributed to positive policy changes in many states that expanded or improved access to SCHIP programs as well as the continued erosion of employer sponsored health insurance.

The increases in 34 states and DC were partially offset by modest decreases in the number of children enrolled in SCHIP in 16 states. The largest drop in enrollment, a 30 percent decline, occurred in Utah where new enrollment was closed in September 2006 due to state funding restrictions. Other states experiencing significant enrollment declines in 2007 included Alaska, New Mexico, and South Carolina. Decreases in enrollment were related to state policies that increased premium amounts, instituted longer waiting periods before becoming insured, implemented caps on enrollment, or required additional citizenship and identity documentation.

The Deficit Reduction Act of 2005 (DRA) has negatively affected enrollment in SCHIP Medicaid expansion programs. States that have implemented SCHIP through an expansion of their Medicaid programs are subject to the citizenship and identity documentation requirements in the DRA legislation. The provision that requires Medicaid applicants and beneficiaries to provide proof of citizenship and identity to obtain or retain coverage has added an additional burden onto beneficiaries and increased processing times for applicants. With the exception of Utah, which closed enrollment due to a lack of state funding, the three states with significant declines in enrollment from June 2006 to June 2007 (Alaska, New Mexico, and South Carolina) were all Medicaid expansion programs. SCHIP directors report that these more stringent requirements have contributed to decreases or tempered growth in SCHIP enrollment more broadly. The Government Accountability Office (GAO) has reported that these declines are thought to have occurred primarily among eligible citizen children.

Limited federal funding and federal policy changes have made coverage expansions through SCHIP more difficult. Over the last decade SCHIP and Medicaid have contributed to a nearly one-third decline in the number of uninsured children. SCHIP has played a role in moderating the growth in the number of uninsured children by providing access to affordable coverage to low-income children. However, SCHIP directors indicate that state efforts to continue moving forward on expanding children's coverage have been hindered by the DRA's citizenship and documentation requirements, uncertainty about the availability and scope of future federal funding for the program, the limited SCHIP reauthorization resulting in maintenance-level funding, and the August 2007 administrative guidance issued by CMS. Directors responding to our survey offered no measure of support for this new guidance, commenting that the "policy is unnecessary and damaging to a very successful program."

Introduction

The State Children's Health Insurance Program (SCHIP) was established a decade ago to provide health insurance coverage for uninsured, low-income children in families with incomes above Medicaid eligibility levels. Congress established SCHIP through the Balanced Budget Act of 1997, which created Title XXI of the Social Security Act. Like Medicaid, SCHIP is administered by states within broad federal guidelines, and state expenditures for SCHIP qualify for federal matching funds. The federal matching rate for SCHIP varies by state from 65 percent to 83 percent, with higher rates for states with lower average personal incomes. Within federal guidelines, states have the latitude to set income eligibility criteria, define covered benefits and set payment rates. States have the option to establish their program as a Medicaid expansion, as a separate, stand-alone program, or both.

SCHIP is distinct from Medicaid in several important respects. Most significantly, the SCHIP program was authorized and funded initially for a ten year period, with capped funding from which each state receives an annual allotment. Over the past year, as the program faced expiration on September 30, 2007, national health policy discussions were dominated by issues relating to the reauthorization of the program. The debates ranged from the amount of funding to the formula for allotment of funding, to the role of the program in covering parents and adults as well as children in families with incomes above 250 percent of the federal poverty level. With bipartisan support, Congress adopted H.R. 976, a bill that reauthorized SCHIP for five years and provided additional funding and coverage for uninsured low-income children. The President vetoed both this bill as well as a revised version (H.R. 3963) in December 2007.

From October through December 2007, the program operated under a temporary continuing resolution.¹ According to the Congressional Research Service, a total of 21 states faced exhaustion of all federal funds for SCHIP beginning in March 2008.² The uncertainty of federal funding forced policy makers in many states to develop contingency plans, including some that would result in the possible disenrollment of a substantial numbers of children. Unable to pass comprehensive reauthorization, the Congress and the President reached an agreement in late December 2007 on a temporary authorization. This agreement fell short of the broader goals of reauthorization to expand funding and coverage, but provides sufficient funding for all currently-enrolled children for the eighteen months through March 2009. The President signed the temporary authorization on December 29, 2007.³

While the reauthorization debate was taking place in Washington, two other new federal policies were already beginning to have an impact on SCHIP programs throughout the states. First, the Deficit Reduction Act of 2005 (DRA) added new requirements to Medicaid eligibility determinations beginning in July 2006 that forced states to obtain documentation to prove citizenship and identity for all individuals applying for or renewing Medicaid coverage.⁴ While

¹ H.J.Res. 52, P.L. 110-92.

² Congressional Research Service Report for Congress: *FY 2008 SCHIP Allotments*, Updated October 25, 2007. Order code: RS22739.

³ S.2499, P.L. 110-173.

⁴ Section 6036 of The Deficit Reduction Act of 2005 (P.L. 109-171). See "New Requirements for Citizenship Documentation in Medicaid," Kaiser Commission on Medicaid and the Uninsured, December 2007, <http://www.kff.org/medicaid/7533.cfm>.

these provisions did not directly apply to separate SCHIP programs or to Title XXI-funded coverage, states have reported that these new rules have resulted in significant delays in processing applications and renewals for eligible citizens in Medicaid expansion SCHIP programs. Secondly, new administrative guidance issued by CMS on August 17, 2007 has added stringent new requirements that a state must meet before SCHIP eligibility can be expanded above 250% of the federal policy level. These federal policy changes have made it more difficult for states seeking to move forward on expanding coverage for children to do so.

Despite the contentious debate among federal policy makers and the failure to reauthorize SCHIP before its expiration on September 30, 2007, broad support for the program exists across the states. Policy makers have embraced SCHIP as an important part of their strategies to reduce the number of uninsured children in their state by actively finding and enrolling eligible children and simplifying enrollment processes. As one significant measure of its success, over the past decade, SCHIP and Medicaid together directly contributed to a one-third reduction in the uninsured rate among low-income children.⁵ Based on experiences in their own states, SCHIP directors indicate that the program has not only decreased the uninsurance rate for children, but it has also improved access and the quality of needed care. Research has documented that SCHIP has succeeded in improving health status, school performance, immunizations, lead screening and consumer satisfaction among its enrollees.⁶ However, despite remarkable success in assuring health coverage through SCHIP and Medicaid, 9 million American children remain uninsured.⁷

This report describes the latest SCHIP enrollment trends and policy directions across the states for state fiscal year (SFY) 2007.⁸ The report is based on data and survey responses provided by SCHIP directors and their staff in all 50 states and DC.

SCHIP Enrollment and Policy Trends

Overview of Growth in Enrollment in the First Decade of SCHIP

Over the past decade, the number of children enrolled in SCHIP grew to 4.4 million in the month of June 2007. After Congress adopted SCHIP in August of 1997, states moved quickly to fund and implement the program. The initial growth was rapid, as policy makers in virtually every state implemented SCHIP with an enthusiasm rarely seen in public programs. States quickly enacted outreach programs that were an integral part of the federal legislation, resulting in a concerted effort nationwide to find and enroll eligible, low-income uninsured children.

⁵ Leighton Ku, Mark Lin, and Matthew Broaddus, "Improving Children's Health – A Chartbook about the Roles of Medicaid and SCHIP, 2007 Edition," Center on Budget and Policy Priorities, January 2007, p. 7, <http://www.cbpp.org/schip-chartbook.htm>.

⁶ Vernon Smith, Jason Cooke, David Rousseau, Robin Rudowitz and Caryn Marks, *SCHIP Turns 10: An Update on Enrollment and the Outlook on Rerauthorization from the Program's Directors*, Kaiser Commission on Medicaid and the Uninsured, May 2007. Report 7642.

⁷ KCMU Analysis of U.S. Census, August 28, 2007.

⁸ "State fiscal year" in this report refers to the annual period from June to June. All but four states and DC have fiscal years that end on June 30. The New York fiscal year ends March 30; Texas, August 31; Alabama, Michigan and DC, September 30.

The number of children enrolled in June of each year increased by about 900,000 between 1998 and 2001. By June of 2003, SCHIP enrollment had reached almost four million. Growth then slowed as a result of a sluggish economy, decreasing state revenues and across-the-board state budget cuts that ended efforts to find and enroll eligible children in most states. After the economic downturn ended, states were able to use their increased revenues to increase eligibility and find and enroll more children. This led to a slow increase in the enrollment, resulting in an annual growth of nearly 300,000 children (7.3 percent) in fiscal year 2007 and total monthly SCHIP enrollment of 4.4 million children in June 2007. This growth was attributed to improved fiscal situations, the continued erosion of employer sponsored health insurance that resulted in additional uninsured children who were eligible for SCHIP, renewed outreach initiatives, and modest increases in income eligibility.

SCHIP Enrollment Growth in State Fiscal Year 2007

In the fiscal year 2007, the total number of children with SCHIP coverage increased by 299,045 (7.3 percent), resulting in total SCHIP enrollment of 4,412,000 in June 2007 (Figure 1). This growth represents the highest annual rate of growth of children covered by SCHIP since the number enrolled grew by 9.4 percent from June 2002 to June 2003 (Table 1).

As states continued to recover from the effects of the economic downturn and experienced strong revenue growth, more states implemented positive policy changes that increased outreach and enrollment efforts, simplified enrollment procedures, and expanded eligibility and benefits.

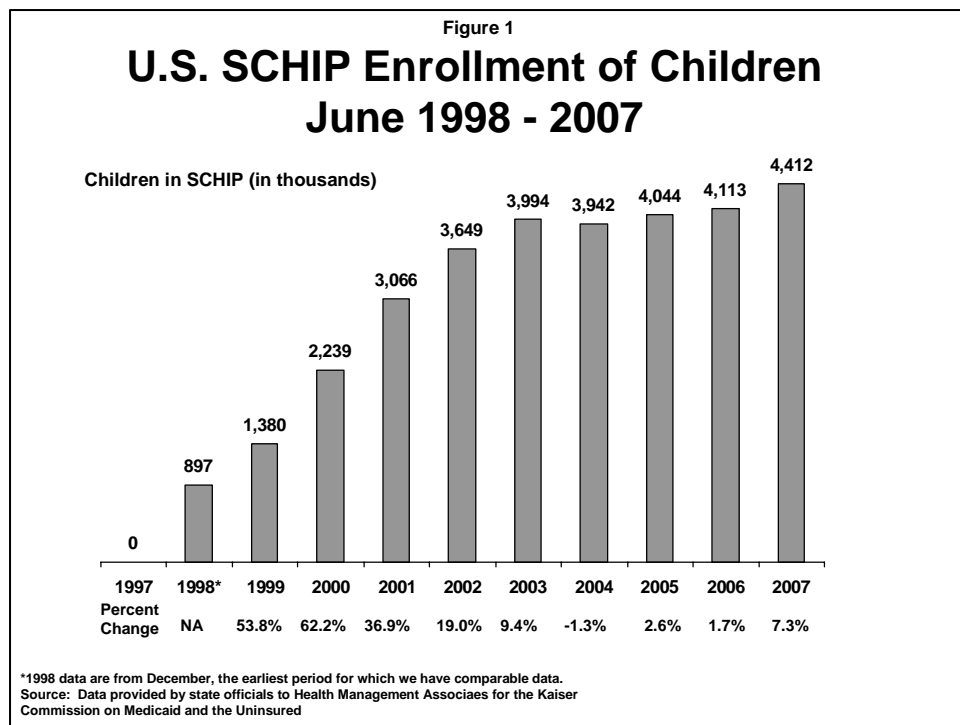


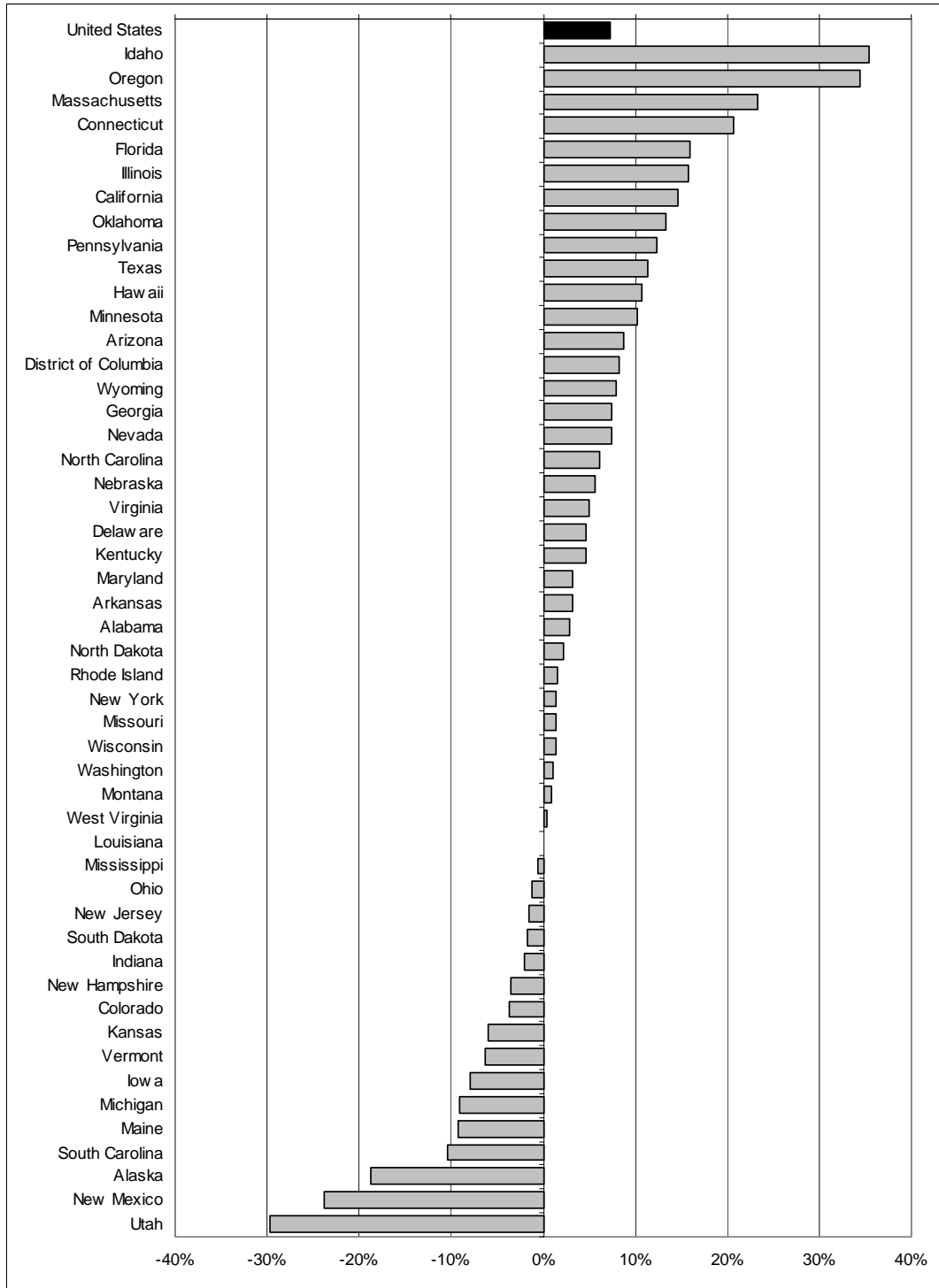
Table 1: Total SCHIP Enrollment of Children, by State, June 2002 – June 2007

	Program Type *							Percent Change				
		Jun-02	Jun-03	Jun-04	Jun-05	Jun-06	Jun-07	Jun 02 to Jun 03	Jun 03 to Jun 04	Jun 04 to Jun 05	Jun 05 to Jun 06	Jun 06 to Jun 07
United States		3,649,131	3,993,508	3,941,608	4,043,863	4,112,845	4,411,890	9.4%	-1.3%	2.6%	1.7%	7.3%
Alabama	S	53,135	60,383	59,019	64,342	65,875	67,715	13.6%	-2.3%	9.0%	2.4%	2.8%
Alaska	M	12,780	12,290	14,243	11,366	9,582	7,793	-3.8%	15.9%	-20.2%	-15.7%	-18.7%
Arizona	S	48,599	50,019	50,373	50,638	59,250	64,453	2.9%	0.7%	0.5%	17.0%	8.8%
Arkansas	M	-	45,982	54,273	62,141	67,170	69,349	NA	18.0%	14.5%	8.1%	3.2%
California	C	608,903	716,550	722,089	819,032	860,888	986,311	17.7%	0.8%	13.4%	5.1%	14.6%
Colorado	S	43,679	53,118	37,069	40,696	53,894	51,939	21.6%	-30.2%	9.8%	32.4%	-3.6%
Connecticut	S	13,816	14,092	15,639	15,696	14,251	17,200	2.0%	11.0%	0.4%	-9.2%	20.7%
Delaware	C	4,082	4,524	3,461	4,360	4,844	5,069	10.8%	-23.5%	26.0%	11.1%	4.6%
District of Columbia	M	3,284	3,854	4,391	4,573	4,750	5,146	17.4%	13.9%	4.1%	3.9%	8.3%
Florida	C	246,432	317,683	331,716	203,983	193,639	224,575	28.9%	4.4%	-38.5%	-5.1%	16.0%
Georgia	S	164,896	183,565	196,934	228,801	257,212	276,551	11.3%	7.3%	16.2%	12.4%	7.5%
Hawaii	C	8,146	10,071	12,261	14,108	15,569	17,226	23.6%	21.7%	15.1%	10.4%	10.6%
Idaho	C	12,113	10,706	11,780	13,787	14,287	19,352	-11.6%	10.0%	17.0%	3.6%	35.5%
Illinois	C	71,407	80,563	119,857	135,984	151,253	175,145	12.8%	48.8%	13.5%	11.2%	15.8%
Indiana	C	48,342	56,880	64,403	68,939	69,787	68,394	17.7%	13.2%	7.0%	1.2%	-2.0%
Iowa	C	26,010	29,057	32,157	34,913	36,286	33,412	11.7%	10.7%	8.6%	3.9%	-7.9%
Kansas	S	26,525	30,023	33,024	34,611	37,631	35,374	13.2%	10.0%	4.8%	8.7%	-6.0%
Kentucky	C	52,492	50,719	48,102	49,377	50,225	52,536	-3.4%	-5.2%	2.7%	1.7%	4.6%
Louisiana	M	74,407	88,129	100,925	107,914	107,777	107,828	18.4%	14.5%	6.9%	-0.1%	0.0%
Maine	C	13,010	12,663	13,967	13,989	14,705	13,346	-2.7%	10.3%	0.2%	5.1%	-9.2%
Maryland	M	102,408	112,758	87,258	95,018	101,552	104,870	10.1%	-22.6%	8.9%	6.9%	3.3%
Massachusetts	C	50,094	56,261	56,208	70,198	75,019	92,506	12.3%	-0.1%	24.9%	6.9%	23.3%
Michigan	C	44,477	51,424	50,876	56,195	47,710	43,375	15.6%	-1.1%	10.5%	-15.1%	-9.1%
Minnesota	M	23	19	1,982	2,122	2,229	2,458	NA	NA	7.1%	5.0%	10.3%
Mississippi	S	52,456	56,690	64,516	68,068	60,457	60,122	8.1%	13.8%	5.5%	-11.2%	-0.6%
Missouri	M	75,078	84,824	88,893	93,730	61,097	61,936	13.0%	4.8%	5.4%	-34.8%	1.4%
Montana	S	9,350	9,550	10,914	10,908	13,165	13,289	2.1%	14.3%	-0.1%	20.7%	0.9%
Nebraska	M	10,712	22,611	22,188	23,132	23,194	24,491	111.1%	-1.9%	4.3%	0.3%	5.6%
Nevada	S	24,138	23,323	26,100	28,836	27,848	29,899	-3.4%	11.9%	10.5%	-3.4%	7.4%
New Hampshire	C	4,966	5,971	6,532	7,022	7,688	7,415	20.2%	9.4%	7.5%	9.5%	-3.6%
New Jersey	C	95,468	92,170	104,165	115,222	127,525	125,494	-3.5%	13.0%	10.6%	10.7%	-1.6%
New Mexico	M	9,838	10,675	10,706	10,647	10,598	8,072	8.5%	0.3%	-0.6%	-0.5%	-23.8%
New York	S	550,402	480,606	438,892	426,529	388,689	394,164	-12.7%	-8.7%	-2.8%	-8.9%	1.4%
North Carolina	C	84,286	100,436	115,571	130,467	144,148	152,954	19.2%	15.1%	12.9%	10.5%	6.1%
North Dakota	C	2,920	3,186	3,586	4,136	4,454	4,553	9.1%	12.6%	15.3%	7.7%	2.2%
Ohio	M	86,106	125,026	128,877	122,796	142,374	140,547	45.2%	3.1%	-4.7%	15.9%	-1.3%
Oklahoma	M	43,423	47,295	46,576	54,427	58,731	66,570	8.9%	-1.5%	16.9%	7.9%	13.3%
Oregon	S	18,133	18,741	20,443	25,014	29,430	39,586	3.4%	9.1%	22.4%	17.7%	34.5%
Pennsylvania	S	120,408	131,695	134,426	136,511	143,501	161,166	9.4%	2.1%	1.6%	5.1%	12.3%
Rhode Island	M	10,890	9,865	11,459	11,756	12,412	12,612	-9.4%	16.2%	2.6%	5.6%	1.6%
South Carolina	M	52,112	49,994	51,479	52,561	40,161	36,001	-4.1%	3.0%	2.1%	-23.6%	-10.4%
South Dakota	C	8,307	9,324	9,805	10,610	11,323	11,136	12.2%	5.2%	8.2%	6.7%	-1.7%
Tennessee	S	2,074	-	-	-	-	1,713	NA	NA	NA	NA	NA
Texas	S	529,980	512,986	359,967	326,473	293,342	326,635	-3.2%	-29.8%	-9.3%	-10.1%	11.3%
Utah	S	21,931	23,777	30,192	28,268	35,724	25,095	8.4%	27.0%	-6.4%	26.4%	-29.8%
Vermont	S	2,982	3,029	2,897	2,992	3,012	2,820	1.6%	-4.4%	3.3%	0.7%	-6.4%
Virginia	C	42,293	52,327	58,676	73,187	78,745	82,731	23.7%	12.1%	24.7%	7.6%	5.1%
Washington	S	6,869	7,305	10,862	21,146	18,790	18,975	6.3%	48.7%	94.7%	-11.1%	1.0%
West Virginia	S	20,043	21,828	23,594	24,515	24,835	24,939	8.9%	8.1%	3.9%	1.3%	0.4%
Wisconsin	M	31,861	35,785	34,957	28,006	30,954	31,368	12.3%	-2.3%	-19.9%	10.5%	1.3%
Wyoming	S	3,045	3,156	3,328	4,121	5,263	5,684	3.6%	5.4%	23.8%	27.7%	8.0%

* Program Type is as of June 2007.

Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2007.

**Figure 2: Percent Change in SCHIP Enrollment of Children, by State
June 2006 –2007**



Note: Tennessee is not included because the TN SCHIP program began in 2007.

Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2007.

Fiscal Year 2007 SCHIP Enrollment and Policy Trends by State

During fiscal year 2007, SCHIP enrollment increased in 34 states and the District of Columbia. A total of 13 states experienced growth in SCHIP child enrollment from June 2006 to June 2007 that exceeded either 10,000 children or 10 percent (Table 2).

- *California* led national enrollment growth, accounting for 42 percent of the total increase in children enrolled in SCHIP. Their growth of over 125,000 children in fiscal year 2007 was boosted by large increases in their separate SCHIP program, Healthy Families, and their new coverage option for unborn children which was implemented in early 2006.⁹
- *Idaho* and *Oregon* reported high percentages of annual growth during fiscal year 2007. Idaho attributed this growth to an expansion of their eligibility when they lowered the lower bound of their income limit for their separate program from 150 percent to 133 percent of the FPL, together with the removal of the resource limit on their program. Oregon commented that the large percentage growth was due to the continued erosion of employer sponsored insurance and a reliance on SCHIP to cover these otherwise uninsured children.
- *Texas* increased enrollment by 33,293 during fiscal year 2007. This growth reversed a prior trend of decreasing enrollment that had been in place since June 2002. Texas SCHIP officials attributed the increase to revisions in their enrollment policies.
- *Florida* enrollment increased by 30,293, reversing a two year trend of enrollment declines. Florida officials attributed the increase to community-based outreach and marketing projects made possible by a \$1 million legislative appropriation of state funds, as well as a new on-line application that made it easier for families to apply for Florida KidCare.
- *Illinois* continued a four-year trend of substantial enrollment growth and increased their enrollment by 23,892 from June 2006 to June 2007. Growth in SCHIP enrollment is attributed to the ongoing implementation of “All Kids” which is part of an initiative that extends health coverage to all children in the state.
- *Georgia* enrollment in “PeachCare for Kids” increased by 19,339 during fiscal year 2007. This growth was tempered by closed enrollment in March 2007 due to concerns about exhausting their allotment of federal SCHIP matching funds.
- *Pennsylvania* increased enrollment by 17,665 children by conducting a marketing and outreach campaign targeted to reaching all children in Pennsylvania, implementing a common application for Medicaid and SCHIP, and expanding SCHIP eligibility to 300 percent FPL in March 2007.

⁹ For this report, enrollment of a pregnant woman in the “Unborn Children” category is counted as enrollment of a child, to be consistent with the definition used by the federal government for its reports.

- *Massachusetts* enrollment continued to increase, rising by 17,387 during fiscal year 2007. Enrollment growth in SCHIP was attributed to outreach efforts, electronic access points for beneficiaries via a “virtual gateway” and the emphasis on broader state health reforms which now require adults to obtain health insurance coverage.

In terms of annual percentage growth for the year from June 2006 to June 2007, almost half of the states (20) reported enrollment growth of five percent or more. The largest percentage increases were in Idaho and Oregon with growth of 36 percent and 35 percent respectively. Other states with significant annual percentage growth included Massachusetts, Connecticut, California, Florida, Illinois, Oklahoma and Pennsylvania.

Table 2: Thirteen States with SCHIP Enrollment Growth above 10 Percent or 10,000 Children, June 2006 to June 2007

State	Monthly Enrollment		Enrollment Growth	Percent Change
	Jun-06	Jun-07	Jun-06 to Jun-07	Jun-06 to Jun-07
United States	4,112,845	4,411,890	299,045	7.3%
California	860,888	986,311	125,423	14.6%
Texas	293,342	326,635	33,293	11.3%
Florida	193,639	224,575	30,936	16.0%
Illinois	151,253	175,145	23,892	15.8%
Georgia	257,212	276,551	19,339	7.5%
Pennsylvania	143,501	161,166	17,665	12.3%
Massachusetts	75,019	92,506	17,487	23.3%
Oregon	29,430	39,586	10,156	34.5%
Oklahoma	58,731	66,570	7,839	13.3%
Idaho	14,287	19,352	5,065	35.5%
Connecticut	14,251	17,200	2,949	20.7%
Hawaii	15,569	17,226	1,657	10.6%
Minnesota	2,229	2,458	229	10.3%

Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2007.

States with growth in their SCHIP enrollment attributed the increase in coverage to outreach initiatives, efforts to streamline the eligibility process and continued erosion in employer sponsored insurance. When asked to identify the most important factors contributing to additional children being covered by SCHIP, states with enrollment gains were most likely to cite specific initiatives aimed at finding and enrolling eligible children. Across the 20 states with annual increases in enrollment of five percent or more, half cited outreach and school-related campaigns as the primary factor in covering more children. Among these states, the second most prevalent factor was the continued simplification of the eligibility process, including the application forms. Also mentioned was the effect of eroding employer sponsored health insurance due to its higher cost, and in two states, the impact of increases in eligibility levels.

Comments from SCHIP directors on the primary factors contributing to enrollment increases in their state:

“We made a concerted outreach and marketing effort to get the word out about the [SCHIP] expansion.”

“...a ‘Back-to-School’ project in which application packets were distributed at the school level to every K-12 public schools student.”

“Extensive marketing and outreach continued in SFY 2007. The marketing and outreach strategy included advertising, media relations and outreach. Television, radio and print advertisements ran during the year.”

“We believe the increase is due to our simplification process and passive renewal.”

“The online application makes it easier for families to apply.”

“As the cost of health insurance continues to rise many individuals are shut out of the employer sponsored insurance market and turn to SCHIP to insure their children.”

In state fiscal year 2007, SCHIP enrollment decreased in sixteen states. Four states experienced declines of either 10 percent or 10,000 children (Table 3).

- *Utah* reported the largest decline in enrollment of 10,629 children or 29.8 percent of their total SCHIP population. The decrease in enrollment occurred due to limited state funding which closed enrollment in September 2006 for the remainder of fiscal year 2007.
- *New Mexico* enrollment decreased by 2,526 children or 23.8 percent. The enrollment declines were attributed to the DRA citizenship and identity documentation requirements.
- *Alaska* enrollment continued a three year downward trend of enrollment declines reporting a loss of 1,789 children (18.7 percent) during fiscal year 2007. Enrollment declines were attributed both to the DRA documentation requirements and frozen eligibility standards that did not increase until July 2007 (after the report time period).
- *South Carolina* reported a decrease of 4,160 children (10.4 percent) attributed to increased monitoring and timeliness of reviews by eligibility staff in their state.

States with decreased enrollment attributed the declines to the Deficit Reduction Act (DRA) citizenship and identity documentation requirement. Three of the four states that experienced significant declines in SCHIP enrollment all operate Medicaid expansion programs and reported that enrollment declines resulted from the mandatory implementation of the DRA citizenship and identity documentation requirements.¹⁰ The Government Accountability Office

¹⁰ Section 6036 of The Deficit Reduction Act of 2005 (P.L. 109-171) required that as of July 1, 2006, all United States citizens applying for or renewing Medicaid (though not separate SCHIP) coverage present “satisfactory

(GAO) has reported that these declines are thought to have occurred primarily among eligible citizen children.¹¹ Other reasons cited by the states for decreased enrollment during fiscal year 2007 included the increasing cost of premiums, the end of outreach campaigns and the closing of enrollment due to limits on state or federal funding.

Table 3: Four States with SCHIP Enrollment Drops of at least 10 Percent or 10,000 Children, June 2006 to June 2007

State	Monthly Enrollment		Enrollment Growth	Percent Change
	Jun-06	Jun-07	Jun-06 to Jun-07	Jun-06 to Jun-07
United States	4,112,845	4,411,890	299,045	7.3%
Utah	35,724	25,095	(10,629)	-29.8%
New Mexico	10,598	8,072	(2,526)	-23.8%
Alaska	9,582	7,793	(1,789)	-18.7%
South Carolina	40,161	36,001	(4,160)	-10.4%

Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2007.

Prenatal and Adult Coverage under SCHIP

SCHIP coverage of Unborn Children

Pursuant to CMS policy, since 2002, states have had the option to use SCHIP funds to provide prenatal care and other medical services to pregnant women. States are able to implement this coverage through a state plan amendment to provide “Unborn Child” coverage under SCHIP without the need for a program waiver.¹² Official CMS policy includes these individuals in the count of children enrolled in SCHIP. This report (and all prior reports in the series) uses the CMS direction and includes these individuals in the total count of enrolled children. In June 2007, twelve states used the Unborn Child option to provide coverage for 142,919 individuals, an increase of 96,501 people over the past year.

Adults Covered by SCHIP Funds

Some states also cover adults with SCHIP funds under waiver authority. The law that established SCHIP in 1997 specifically authorized SCHIP waivers and past federal policy has encouraged states to obtain waivers to cover adults, including pregnant women, parents, and childless adults, using SCHIP funds. These waivers require states to prioritize children’s coverage and do not allow states to close enrollment or decrease eligibility for children while the

documentary evidence” of their citizenship. See “New Requirements for Citizenship Documentation in Medicaid,” Kaiser Commission on Medicaid and the Uninsured, December 2007, <http://www.kff.org/medicaid/7533.cfm>.

¹¹ GAO-07-889 *Medicaid Citizenship Documentation Requirement*, June 2007.

¹² This option allows states to extend program eligibility to the unborn fetus.

waiver for adult coverage is in effect. Congress prohibited further SCHIP waivers for childless adults as part of the Deficit Reduction Act of 2005.

State coverage for adults under SCHIP waivers differs in size and scope, reflecting specific state objectives for using an SCHIP waiver to cover adults. For example, some states had limited ability to use SCHIP funds for children because they had already expanded children's coverage through Medicaid, some pursued their waivers with a goal of increasing coverage and improving care for children by covering families, and others focused on reducing adult uninsured rates.¹³ As of June 2007, a total of 14 states used a SCHIP waiver to cover 395,887 pregnant women, parents, and childless adults (Table 4). Two states, *Arkansas* and *Nevada*, added this coverage in 2007.

Table 4: Parents, Pregnant Women and Childless Adults with Health Coverage Financed through Title XXI SCHIP Funds, June 2007

	<i>Pregnant Women</i>	<i>Parents</i>	<i>Childless Adults</i>	<i>Total</i>
<i>United States</i>	2,320	322,849	70,718	395,887
Arizona	-	14,045	-	14,045
Arkansas	-	217	-	217
Colorado	1,207	-	-	1,207
Idaho	-	212	79	291
Illinois	-	148,327	1,428	149,755
Michigan	-	-	59,000	59,000
Minnesota	-	17,195	-	17,195
Nevada	105	2	-	107
New Jersey	141	86,584	-	86,725
New Mexico	-	2,415	5,029	7,444
Oregon	-	5,787	5,182	10,969
Rhode Island	110	11,706	-	11,816
Virginia	757	-	-	757
Wisconsin	-	36,359	-	36,359

Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2007.

SCHIP Policy Changes in State Fiscal Year 2007

Fourteen states authorized SCHIP eligibility level increases. The *District of Columbia* and *Pennsylvania* implemented eligibility increases for children up to 300 percent FPL, while *Tennessee* established a separate SCHIP program with income eligibility set at 250 percent FPL and *Montana* increased the eligibility level to 175 percent FPL. During FY 2007, nine other states authorized eligibility increases to 300 percent FPL and one state, *South Carolina* to 200 percent FPL. However, due in large part to new federal restrictions imposed by CMS in their August 17, 2007 directive, many of these expansions have yet to be implemented.

¹³ Samantha Artiga and Cindy Mann, "Family Coverage Under SCHIP Waivers," Kaiser Commission on Medicaid and the Uninsured, May 2007, <http://www.kff.org/medicaid/7644.cfm>.

Enrollment caps were imposed in three states in year 2007. Federal law permits states to limit enrollment in SCHIP and over the past decade, states have periodically imposed enrollment caps that have limited the number of children enrolled in SCHIP.

- *Utah* limited enrollment based on funding provided by the state legislature which resulted in an enrollment cap that closed new enrollments as of September 2006. This cap resulted in the largest drop in enrollment across all states during fiscal year 2007.
- *Georgia* froze new enrollments in March 2007 as a result of insufficient federal funding and concerns over the level of future federal funding as the SCHIP reauthorization debate continued. During the first nine months of fiscal year 2007, enrollment in Georgia's SCHIP program increased by 27,629 children or 10.7 percent, reaching almost 285,000. This trend immediately reversed upon enactment of the enrollment freeze in March, resulting in a decrease of 8,290 covered children in the final months of fiscal year 2007 and an overall moderated growth rate of only 7.5 percent. The enrollment freeze was lifted in July 2007 and a new enrollment cap was set at 295,000.
- *Florida* sets a target enrollment for each year that can be sustained based on funding appropriated by the legislature. Enrollment caps in 2005 and 2006 led to declines in enrollment in those years. For fiscal year 2007, the legislature authorized additional state funding, resulting in a 16 percent increase in enrollment.

Other policies that limited enrollment were reported in *North Carolina*, which limited growth in enrollment to three percent per six month period, and *Arkansas*, which capped enrollment for their new SCHIP/HIFA waiver, but did not reach the cap during fiscal year 2007.

Five states enhanced SCHIP benefit packages. *Alabama* changed substance abuse benefit limits, *Delaware* added a dental benefit, *Idaho* changed its separate SCHIP program to a Medicaid expansion program resulting in additional benefits, *North Dakota* added coverage for morbid obesity surgery, and *Wyoming* amended their vision coverage and added preventive dental services outside of their \$1,000 cap on dental coverage.

Premiums and Enrollment Fees were added in three states. A total of 35 states assess premiums or enrollment fees for children and adults in SCHIP. The three new states that implemented premiums include: *Arkansas*, which added premiums that apply only to adults under a HIFA waiver, *Pennsylvania*, that is charging a premium based on the percentage of the actual cost of coverage for children from 200-300 percent FPL and a full premium for those above 300 percent FPL, and *West Virginia* which implemented a premium for children between 200-300 percent FPL. Eight other states made minor changes in their enrollment fees or premiums. A full listing of premiums and enrollment fees by state is available in Appendix B.

Other Policy Changes in FY 2007:

DRA citizenship and identity documentation requirements were implemented in states with Medicaid expansion programs. In addition to the states with Medicaid expansion programs that were required to implement the DRA requirements, some states (including *Iowa* and *New Hampshire*) with combination or separate SCHIP programs also instituted this requirement.

Other state program policy changes in fiscal year 2007:

- **Arkansas** implemented adult coverage called ARHealthNet through a HIFA waiver.
- **Idaho** added a “Preventive Health Assistance” benefit, under which a parent can earn an offset to premiums of \$30 per quarter per child by keeping current the child’s immunizations and well-child checkups.
- **Kansas** changed dental coverage from a capitated model to fee-for-service.
- **Maryland** used a state plan amendment to transfer their separate SCHIP program into a Medicaid expansion program.
- **Massachusetts** implemented a six-month waiting period for their expansion group between 200-300 percent of the FPL.
- **Nevada** added a HIFA waiver for pregnant women between 133 and 185 percent of the FPL, and added a premium assistance program for parents with incomes below 200 percent of the FPL.
- **Virginia** exempted pregnant women from their four-month waiting period.
- **West Virginia** exempted some copayments for those who choose a medical home, and increased the required period of uninsurance from six months to twelve months for children in families above 200 percent of the FPL.

Issues for Reauthorization

At the time the survey was being completed by SCHIP directors in the fall of 2007, reauthorization of SCHIP was still being debated in Washington. With the outcome of SCHIP reauthorization in doubt, the survey included a question on whether the funding uncertainty was having an impact at the state level, and how the state might respond depending on which decisions might be made by Congress and the President on future funding for the program.

State decision making was somewhat affected by the uncertainty of SCHIP reauthorization.

While some states reported no significant impact on state decision making due to SCHIP reauthorization, other states were affected by the uncertainty surrounding future federal funding and reauthorization. One state expressed a common view that the uncertainty “...makes it impossible to plan for future state budgets or address possibilities for program expansion.” Some states scaled back their program or chose not to implement expansions. *Louisiana* had passed legislation to expand coverage to 300% of poverty, but pared back their program expansion in light of the uncertainty of future federal funding. *Colorado* held off on moving the premium assistance program from a pilot status to a fully implemented program. The *Virginia* legislature chose to defer any discussion of a Buy-in program in 2007 until funding levels are determined

through reauthorization. *North Dakota* indicated that the 2007 legislature approved an increase in the FPL but it was not implemented “due to uncertainty of funding.” In light of a projected shortfall in federal funding, *Georgia* researched options to either transfer children from SCHIP to Medicaid by adjusting eligibility thresholds, but opted to avoid a shortfall by capping program enrollment. *California* responded to the uncertainty by preparing and obtaining approval for a contingency plan for disenrolling children from the current program, if funds were not authorized.

Additional federal funding would result in new outreach campaigns, expanded eligibility and other program enhancements. State officials were also asked to suggest how state policy makers might respond if additional federal funding were made available through SCHIP reauthorization. Half of the states responded to this question and overwhelmingly indicated that their state would expand coverage to serve additional children. The most frequently mentioned action was to conduct outreach campaigns to find eligible, but un-enrolled children. A dozen states mentioned the possibility of expanding eligibility levels. One state indicated that additional funding would likely help them avoid a cap on enrollment while another reported that removing the uncertainty of adequate federal funding would correct a historically low SCHIP allotment for the state and reduce the need to rely on redistributed funds from other states each year.

The August 17, 2007 letter impacted state policymakers decisions to expand programs. States were given the opportunity in the survey to comment on the impact of a CMS letter issued on August 17, 2007 that defined new requirements for states contemplating SCHIP expansions to cover children in families above 250 percent of FPL. The August 17 letter indicated that the new standards were intended “to limit substitution of SCHIP coverage for coverage under group health plans.”

The new requirements included:

- “Assurance that the State has enrolled at least 95 percent of children in the State below 200 percent of the FPL who are eligible for either SCHIP or Medicaid” and
- “Assurance that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five year period.”

A number of states indicated that the new requirements would impact their programs, particularly if they already were approved for coverage above 250 percent of the poverty level, or if they were contemplating such coverage. These states were concerned that policy makers might have to revise plans to cover additional children and the national trend of increasing uninsurance among children would continue to grow.

The letter also indicated new requirements for crowd-out strategies that include comparable cost sharing and a minimum one-year period of uninsurance prior to receiving SCHIP coverage. Responding states indicated that this would be a significant change that would have a material impact on enrollment in SCHIP. Many states have either a six-month or two month waiting period. One stated affected by the change indicated that: “...this is a significant change that will

impact the family's ability to enroll their children." Other states indicated that their SCHIP policy is in state statute and would require a legislative change. Another state wrote that "waiting periods are very detrimental to enrollment and limit our ability to maximize employer contributions."

Documenting these trends in the employer-sponsored insurance market was also regarded as problematic. Not only is timely and accurate state-level data not always available, but some states expressed concern that this new requirement would hold states accountable for events over which they had no control. One state responded that:

"States have no control over the trends in the private health insurance market. Many of the drivers of the decline in employer sponsored insurance are due to factors such as high underlying health care costs, high rates of emergency department utilization (regardless of the type of insurance) and regional variability of health care costs."

Among responding states, there was no measure of support for the new requirements, but there was hope that the issue might be addressed and mitigated during reauthorization. One state summarized state views on this policy as follows:

"The policy is unnecessary and damaging to a very successful program...CMS has set standards without any guidance on how to measure them. It is hard to see the standards as more than administrative barriers for states and applicants."

Conclusion

The key issue on the minds of state SCHIP officials in 2007 was the future of the SCHIP program. The uncertainty created by extended contentious and ideological debates, Continuing Resolutions and Presidential vetoes served to dampen state efforts to expand coverage for low-income, uninsured children. Two years of increasing numbers of uninsured children, something that previously had not happened since the enactment of SCHIP more than a decade ago, makes future state and federal actions regarding SCHIP all the more significant.

Nevertheless, the number of children enrolled in SCHIP across the states grew from June 2006 to June 2007. Enrollment increased to 4.4 million children and at an annual rate of 7.3 percent across all states. Growth in the number of children enrolled in SCHIP for state fiscal year 2007 was driven by increases across a number of large states, but was moderated by decreases in others. Overall growth in the program was attributed to concerted outreach efforts to find and enroll eligible children, streamlined administrative processes, and the continued erosion of employer sponsored health insurance. With the President, House, and Senate all proposing additional new funding for a reauthorized SCHIP program during the first half of 2007, many states were focused on using state funds available from the relatively strong revenues collected in 2005 and 2006 to expand coverage for children.

This recent trend in enrollment growth may not continue through state fiscal year 2008, however. Following the President's veto of two bi-partisan expansions of SCHIP, Congress and the

President were only able to reach agreement on enough federal funds to maintain existing enrollment levels through March 2009. With the national economy slowing and possibly heading toward recession, fiscal realities may make it difficult for most states to do anything other than maintain existing enrollment. Indeed, several states indicated that state and federal fiscal limits and the new CMS requirements for expansions outlined in the August 17, 2007 letter might cause them to scale back their existing programs or planned expansions. Consideration of these actions is occurring at the same time that the downturn in the economy and the continued erosion of employer-sponsored insurance can be expected to cause additional children to become uninsured and eligible for the program. The outlook is that states will face difficult challenges as they try to provide coverage for low-income uninsured children over the next year.

Appendix A: Data Definitions and Methodology

The data in this report reflect the number of children and adults enrolled in SCHIP programs in each state in the indicated month. For this report, state SCHIP officials provided data specifically for the months of September and December 2006 and for March and June 2007. States were encouraged to review data included in previous reports in this series and to update data as might be appropriate. Each report including this one reflects updated data provided by states for previous periods. The data for this report were requested in August 2007 and responses were returned through November 2007.

The data in this report are “point-in-time,” which means the number of individuals enrolled in a state program in a specific month, such as June 2007 for this report. A “point-in-time” count of enrollees is distinct from the “ever-enrolled” count, which is provided in reports issued by the federal Centers for Medicare and Medicaid Services (CMS). The most recent annual report from CMS was for federal fiscal year 2006, the year ending in September 2006 (issued on March 1, 2007). CMS reported a total of 6,624,152 children enrolled at any point in time and for any length of time during that year. In contrast, the number of children enrolled in the month of September 2006 per data provided by state officials for these reports was 4,153,598. A comparison of these two sets of data indicates that of the unduplicated count of 6,624,152 children enrolled at any point in time and for any length of time over the twelve months from October 2005 through September 2006, a total of 4,153,598 or 62.7 percent remained enrolled in September 2006, and 2,470,554 or 37.3 percent were no longer enrolled.

The annual count of children ever-enrolled will always exceed the number enrolled at any point in time, as long as new enrollments and disenrollments occur during the year. The greater the new enrollment and disenrollment, the greater will be the difference between these two counts. Recent experience is that just over one-third of SCHIP enrollees ever enrolled at any time and for any length of time during the year were not enrolled at the end of the year. The percentages calculated in the manner indicated above for recent fiscal years are: 37.3 percent in FFY 2006; 34.1 percent in FFY 2005; 35.1 percent in FFY 2004; 33.3 percent in FFY 2003; 31.5 percent in FFY 2002; and 29.9 percent in FFY 2001.

Differences may occur between the federal reports issued by CMS and data in this report. These differences occur when states provide an enrollment count for this report for a day other than the final day of the quarter, or when states provide an updated enrollment count, such as may occur with retroactive eligibility for a Medicaid expansion SCHIP program, or when a state does not provide a final count to CMS within deadlines for a response. Both point-in-time and ever-enrolled enrollment counts are useful measures that together provide insight into issues of coverage, departure rates, retention and turnover among SCHIP enrollees over time.

Appendix B: SCHIP Premiums and Enrollment Fees as of June 2007

State	Requires Premiums or Enrollment Fees		Premium Amounts
	Yes	No	
U.S. Total	32	19	
Alabama	✓		\$50 per child for families from 100-150% FPL \$100 per child for families 151-200% FPL Maximum of 3 children per family pay premiums. No premiums for Native Americans.
Alaska		✓	
Arizona	✓		100 -150% FPL: \$10 for one child; \$15 two or more children; Parents: 3% of monthly family income. 151-175% FPL: \$20 for one child; \$30 two or more children. Parents: 4% of monthly family income. 175-200% FPL: \$25 one child, \$35 two or more children; Parents: 5% of monthly family income.
Arkansas	✓		Premiums for adults only, based on age and sex. Approximately \$30 per month on average
California	✓		Based upon income. Premiums range from \$4-\$15 per month per child with a family maximum of \$45 per month. 25% discount for those using Electronic funds transfer.
Colorado	✓		151-200% FPL: \$25 per year for one child, \$35 per year for two or more children.
Connecticut	✓		Band 1 = 185-235% FPL: No premium Band 2 = 235-300% FPL: \$30 per child per month, \$50 per month two or more children. Band 3 = 300%+ FPL: based on group rate between \$158-\$230 per child per month.
Delaware	✓		\$10, \$15, \$25 per family per month based upon income.
District of Columbia		✓	
Florida	✓		<150% FPL: \$15 per month per family >150% FPL: \$20 per month per family
Georgia	✓		FPL: One Child Family Cap 100-150%: \$10.00 \$15.00 151-160%: \$20.00 \$40.00 161-170%: \$22.00 \$44.00 171-180%: \$24.00 \$48.00 181-190%: \$26.00 \$52.00 191-200%: \$28.00 \$56.00 201-210%: \$29.00 \$58.00 211-220%: \$31.00 \$62.00 221-230%: \$33.00 \$66.00 231-235%: \$35.00 \$70.00
Hawaii	✓		No premiums up to 250% FPL; Sliding scale of up to \$60 per child per month for families 250-300% FPL
Idaho	✓		133 – 150% FPL: \$10 per child per month 150% of FPL and above: \$15 per month per child in Separate program
Illinois	✓		150% of FPL and above: \$15 for one child, \$25 for two, \$30 for three; \$35 for four; \$40 for five or more

State	Requires Premiums or Enrollment Fees		Premium Amounts
	Yes	No	
			children, per family per month.
Indiana	✓		150-175% FPL: \$22 for one child, \$33 two or more, per month, 175-200% FPL: \$33 for one child, \$50 two or more, per month.
Iowa	✓		> 150% FPL: \$10 per child per month; \$20 per family (more than one child) per month.
Kansas	✓		151-175% of FPL: \$20 per month per 176-200% FPL \$30 per month per family
Kentucky	✓		\$20 per month per family with incomes > 150% FPL
Louisiana		✓	
Maine	✓		\$8-\$64 per month depending upon family size and income.
Maryland	✓		185-200% FPL: \$0 PFPM 200-250% FPL: \$45 PFPM 250-300% FPL: \$57 PFPM
Massachusetts	✓		To 150% FPL: \$12 per child per month with family maximum of \$15 per month. 150 - 200% FPL: \$12 per child per month to family maximum of \$36 201 – 250% FPL: \$20 per child per month, to family maximum of \$60 251 – 300% FPL: \$28 per child per month, to family maximum of \$84
Michigan	✓		\$10 per family per month.
Minnesota	✓		Premiums are determined on a sliding scale based upon income and family size, and apply only to MinnesotaCare parents and caretakers covered under the Section 1115 waiver.
Mississippi		✓	
Missouri	✓		150-300% FPL: \$12-\$282 per month, based on income and family size.
Montana		✓	
Nebraska		✓	
Nevada	✓		Based upon family size and income: 0-35% FPL: \$0 36 - 150% FPL: \$15 151-175% FPL: \$35 176-200% FPL: \$70 Native Americans are exempt from all premiums.
New Hampshire	✓		185-250% FPL: \$25 per child per month with \$100 max per month 250-300% FPL: \$45 per child per month with \$135 max per month.
New Jersey	✓		For children: 150 - 200% FPL: \$18 per month per family 201 - 250% FPL: \$36 per month per family 251 - 300% FPL: \$72 per month per family 301 - 350% FPL: \$120 per month per family For parents:

State	Requires Premiums or Enrollment Fees		Premium Amounts
	Yes	No	
			150 – 200% FPL: \$30.50 for first parent, plus \$12.50 for second parent
New Mexico		✓	
New York	✓		\$9 to \$15 per child, up to maximum \$27 / \$45 per family, based on income
North Carolina	✓		Enrollment fee of \$50 per child, or maximum of \$100 per family for families between 150-200%FPL, no enrollment fee for families below 150% FPL.
North Dakota		✓	
Ohio		✓	
Oklahoma		✓	
Oregon		✓	
Pennsylvania	✓		>200% - 250% FPL: 25% of cost to state, approximately \$38 per child per month >250% - 275% FPL: 35% of cost to state, approximately \$53 per child per month >275% - 300% FPL: 40% of cost to state, approximately \$60 per child per month >300% FPL: Families can buy CHIP benefit at the cost to the state, approximately \$150 per child per month
Rhode Island	✓		150-185% FPL: \$61 per family per month 185-200% FPL: \$77 per family per month 200-250% FPL: \$92 per family per month
South Carolina		✓	
South Dakota		✓	
Tennessee		✓	
Texas	✓		Enrollment fee for each six months. 133 – 150% FPL: \$0 per family 151 – 185% FPL: \$35 per family 186 – 200% FPL: \$50 per family
Utah	✓		101-150% FPL: \$13 per quarter per family 151-200% FPL: \$25 per quarter per family
Vermont	✓		\$80 per month per family
Virginia		✓	
Washington	✓		\$15 per child per month to maximum of \$45 per month per household.
West Virginia	✓		200% FPL and above: \$35 per month for one child; \$71 per month for two or more children
Wisconsin	✓		5% of net income for those at or above 150% of FPL.
Wyoming		✓	

Note: Information in this table was provided by state SCHIP officials in August 2007 through November 2007 in response to the survey question: “As of June 2007, were there premiums or enrollment fees?”

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