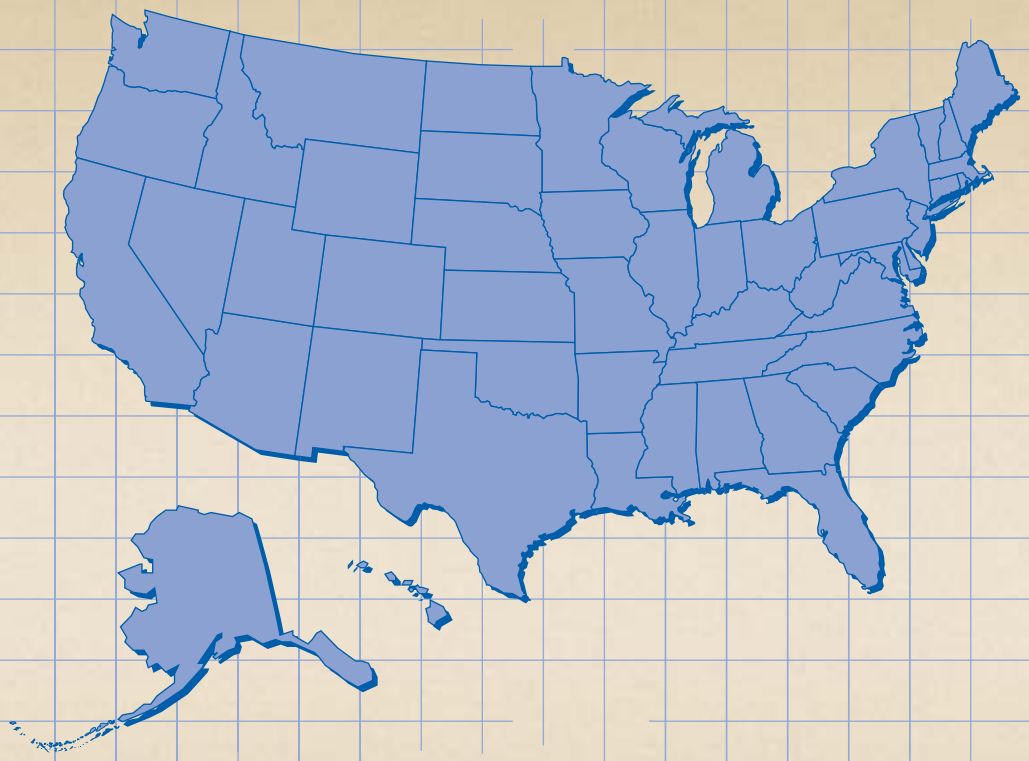
SCHIP ENROLLMENT IN 50 STATES

December 2004 Data Update



SEPTEMBER 2005

THE HENRY J. KAISER FAMILY FOUNDATION

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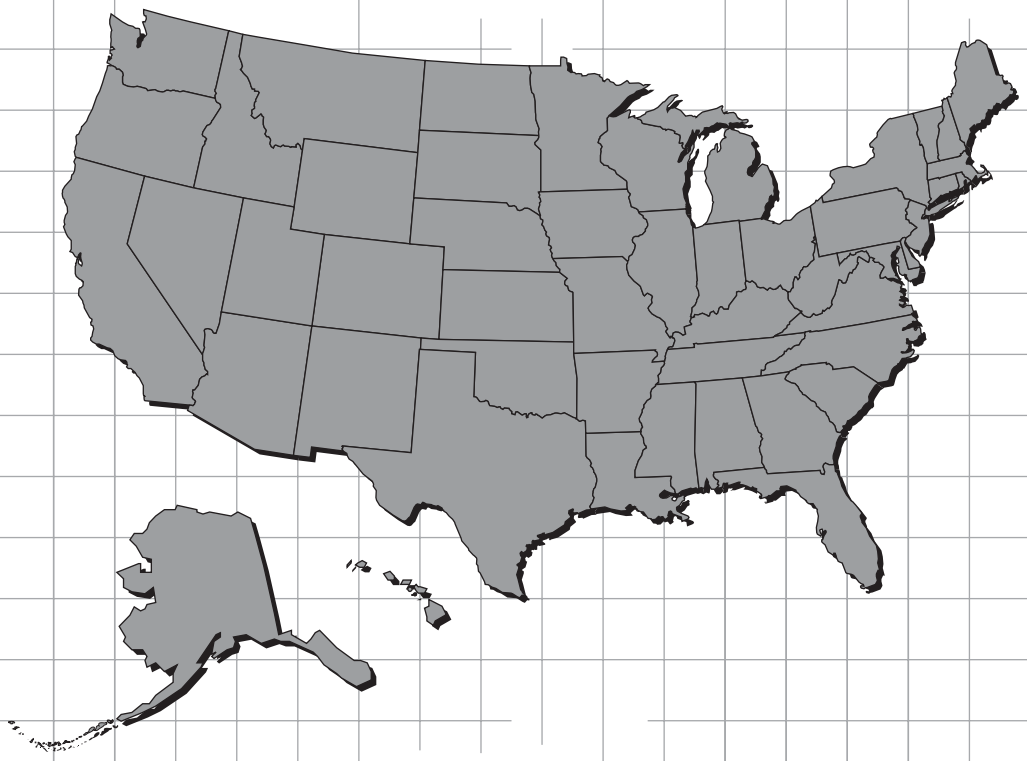

SEPTEMBER 2005

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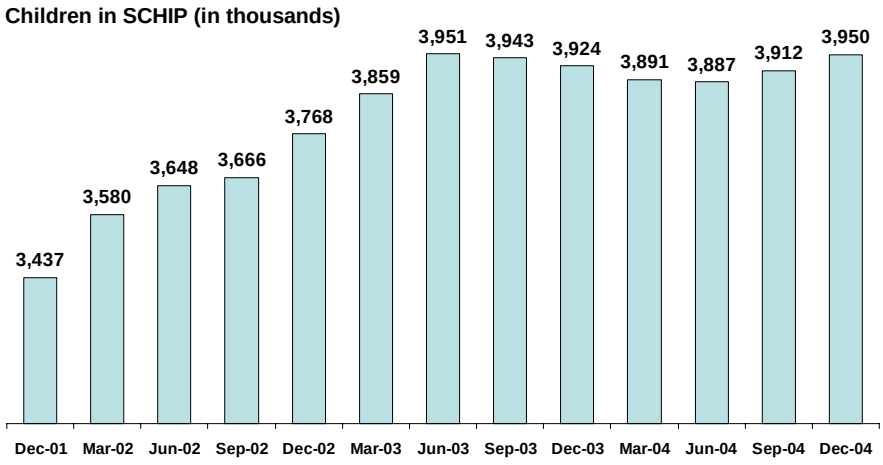
SCHIP Enrollment in December 2004

Key Findings

State Children's Health Insurance Programs (SCHIP) provided health insurance coverage to 3.9 million low-income children in December 2004 (Figure 1). Enrollment grew slightly (1.6%) during the last two quarters of calendar year 2004, reversing a trend of modest national enrollment declines over the previous four quarters, beginning in the June to September 2003 period.[1]

Figure 1

U.S. SCHIP Monthly Enrollment
Dec 2001 – Dec 2004



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

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Between December 2003 and December 2004, national SCHIP enrollment grew by roughly 25,000 or 0.6%. While enrollment increased in 35 states and in the District of Columbia, 13 states experienced SCHIP enrollment declines during this period. California, which operates the nation's largest SCHIP program, had the largest enrollment growth of 48,000 or 6.7%. Washington state experienced the largest percentage growth, 48%, though this resulted from enrollment growth of only 4,000 in a relatively small program. Illinois had both double-digit percentage growth of 33% and significant enrollment growth of 31,000, ranking it second in the nation in both measures of growth. The states with the largest declines were Texas (-102,000 or -23%), Florida (-48,000 or -15%), and Colorado (-12,000 or -24%). Overall, national SCHIP enrollment has still not fully rebounded from its peak of 3,951,000[2] in June 2003.

In response to ongoing state budget difficulties, four states (FL, ID, MT, and UT) continued to place caps on enrollment in their SCHIP programs as of December

2004, and 8 of the 30 states that charge premiums or enrollment fees increased the amounts charged during 2004. While four states (FL, GA, NV, TX) adopted more restrictive eligibility criteria, three states expanded eligibility (ID, IL, and MD) and five states (FL, MO, NY, OR, and PA) implemented changes in eligibility rules or procedures designed to facilitate enrollment, re-enrollment, or retention of SCHIP coverage. Eight states (AZ, AR, IL, MI, MN, NJ, RI, and WI) and DC used available SCHIP funding to cover a total of 335,000 adults nationally in December 2004. Despite modest improvement in many states' revenue collections, SCHIP directors expressed ongoing concern about the availability of sufficient federal and state funding to meet expected enrollment demand among children. Assuming availability of funding, SCHIP directors in 35 states provided estimates indicating that future SCHIP enrollment growth would rebound to annual national rates of growth of 3.5%, 5.4% and 5.0% in 2005, 2006, and 2007, respectively.

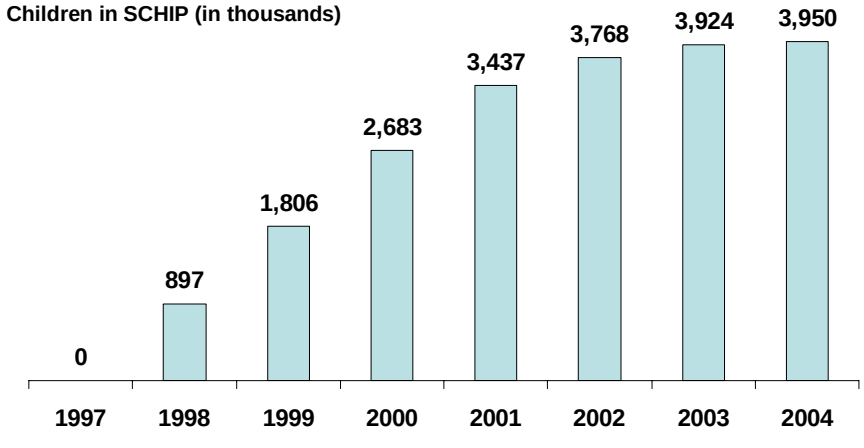
Background and Overview of National SCHIP Enrollment

The State Children's Health Insurance Program (SCHIP) was established by Congress through the Balanced Budget Act of 1997 (P.L. 105-33) as a federal-state partnership to extend health coverage to uninsured children in low-income families. Each state establishes its own eligibility criteria, income limits and covered benefits within broad federal guidelines. By federal law, a child who is eligible for Medicaid or who has any employer-sponsored health insurance coverage is not eligible to enroll in SCHIP. States acted quickly to implement their programs, with children in some states first gaining SCHIP coverage as early as January 1998.

SCHIP enrollment grew steadily from 1998 through 2000, increasing by approximately 900,000 each of these first three years, and by over 750,000 in 2001. By December 2001, enrollment had reached over 3.4 million children in only four years (Figure 2).

Figure 2

U.S. SCHIP Enrollment of Children
December of Each Year,1997 to 2004



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

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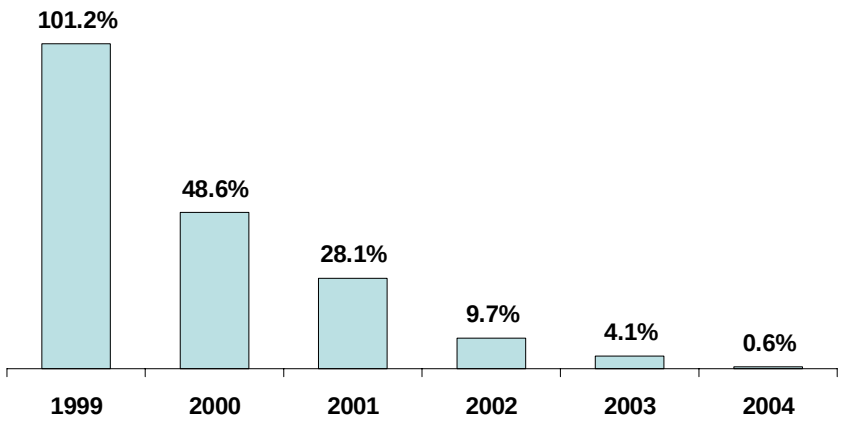
However, state fiscal difficulties related to declining tax revenues during the economic downturn led many states to curtail the outreach and program simplification efforts they had successfully used to find and enroll low-income uninsured children. Some states also increased premiums or took steps to restrict eligibility or benefits. As a result, the rate of SCHIP enrollment growth slowed dramatically. Program enrollment had increased by 49% in 2000 and by 28% in 2001, but it slowed to 9.7% in 2002 and to 4.1% for 2003 (Figure 3). Although a portion of this slowdown may be attributed to the end of the rapid growth expected to accompany the early years of program implementation, budgetary pressures played a significant role in slowing growth in a program that still had not reached an estimated 2.8 million eligible uninsured children who remained unenrolled in 2002.[3]

Figure 3

Annual Percentage Changes in U.S. SCHIP Enrollment, Dec 1999 - Dec 2004



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

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National SCHIP enrollment peaked in June 2003 when it reached 3,951,000. Then, over the next six months the number of children enrolled in SCHIP nationally declined for the first time in the history of the program to 3,924,000 in December 2003, and dropped further over the next six months to 3,887,000 in June 2004, for a total decline of nearly 64,000 between June 2003 and June 2004.

In the last half of calendar 2004, national SCHIP enrollment began to rise once again, although at a slow pace. From June 2004 to December 2004, enrollment increased from 3,887,000 to 3,950,000 (Table 1), producing a six-month gain in national enrollment of over 62,000 or 1.6%. This growth was enough to offset the drop of about 37,000 that occurred in the previous six-month period

Table 1

Total SCHIP Enrollment, June 2003 to December 2004

	Program Type *	Monthly Enrollment						Percent Change			
		Jun-03	*Dec-03*	*Mar-04*	*Jun-04*	*Sep-04*	*Dec-04*	*Jun 03 to Dec 03*	*Dec 03 to Jun 04*	*Jun 04 to Dec 04*	*Dec 03 to Dec 04*
United States		**3,951,141**	**3,924,243**	**3,891,664**	**3,887,335**	**3,911,685**	**3,949,578**	**-0.7%**	**-0.9%**	**1.6%**	**0.6%**
Alabama	S	60,383	58,696	54,932	59,019	60,655	62,817	-2.8%	0.6%	6.4%	7.0%
Alaska	M	12,290	11,666	12,299	14,243	11,674	11,078	-5.1%	22.1%	-22.2%	-5.0%
Arizona	S	50,019	50,721	51,270	50,373	49,148	48,061	1.4%	-0.7%	-4.6%	-5.2%
Arkansas	C	-	-	-	-	-	-				
California	C	720,044	722,901	740,288	722,089	746,807	771,283	0.4%	-0.1%	6.8%	6.7%
Colorado	S	53,118	49,978	42,979	37,069	38,189	38,189	-5.9%	-25.8%	3.0%	-23.6%
Connecticut	S	14,092	13,906	15,285	15,639	14,082	14,685	-1.3%	12.5%	-6.1%	5.6%
Delaware	S	4,524	4,751	4,931	3,461	4,093	4,413	5.0%	-27.2%	27.5%	-7.1%
District of Columbia	M	3,854	3,720	4,273	4,391	4,421	4,379	-3.5%	18.0%	-0.3%	17.7%
Florida	C	317,683	319,477	306,996	331,716	324,786	271,946	0.6%	3.8%	-18.0%	-14.9%
Georgia	S	183,565	196,615	195,723	196,934	191,299	211,857	7.1%	0.2%	7.6%	7.8%
Hawaii	M	10,071	10,907	11,707	12,261	13,126	13,719	8.3%	12.4%	11.9%	25.8%
Idaho	C	10,706	11,237	11,467	11,780	12,953	12,884	5.0%	4.8%	9.4%	14.7%
Illinois	C	80,563	92,144	108,308	119,857	122,194	122,711	14.4%	30.1%	2.4%	33.2%
Indiana	C	56,880	61,577	61,749	64,403	74,900	71,401	8.3%	4.6%	10.9%	16.0%
Iowa	C	29,057	30,701	31,603	32,157	32,250	33,553	5.7%	4.7%	4.3%	9.3%
Kansas	S	30,023	31,012	31,773	33,024	33,578	34,169	3.3%	6.5%	3.5%	10.2%
Kentucky	C	50,719	51,381	48,776	48,102	48,474	49,638	1.3%	-6.4%	3.2%	-3.4%
Louisiana	M	88,129	94,799	98,315	100,925	130,621	106,091	7.6%	6.5%	5.1%	11.9%
Maine	C	12,663	13,085	13,493	13,967	14,213	14,436	3.3%	6.7%	3.4%	10.3%
Maryland	C	112,758	89,574	88,506	87,258	89,064	90,852	-20.6%	-2.6%	4.1%	1.4%
Massachusetts	C	56,261	61,968	58,133	56,208	60,342	57,450	10.1%	-9.3%	2.2%	-7.3%
Michigan	C	51,424	53,767	51,209	50,876	50,622	50,789	4.6%	-5.4%	-0.2%	-5.5%
Minnesota	C	19	2,039	2,094	1,982	2,484	2,206	NA	-2.8%	11.3%	8.2%
Mississippi	S	56,690	61,159	63,211	64,516	65,668	67,015	7.9%	5.5%	3.9%	9.6%
Missouri	M	84,824	89,811	87,879	88,893	91,911	94,457	5.9%	-1.0%	6.3%	5.2%
Montana	S	9,550	10,626	10,732	10,914	10,885	10,929	11.3%	2.7%	0.1%	2.9%
Nebraska	M	22,611	22,659	22,670	22,188	22,090	23,697	0.2%	-2.1%	6.8%	4.6%
Nevada	S	23,323	24,914	26,174	26,100	25,512	26,375	6.8%	4.8%	1.1%	5.9%
New Hampshire	C	5,971	6,431	6,490	6,532	6,551	6,752	7.7%	1.6%	3.4%	5.0%
New Jersey	C	92,170	97,940	101,301	104,165	101,899	102,765	6.3%	6.4%	-1.3%	4.9%
New Mexico	M	10,675	11,393	11,720	10,706	11,899	12,076	6.7%	-6.0%	12.8%	6.0%
New York	C	480,606	457,317	448,407	438,892	438,151	452,938	-4.8%	-4.0%	3.2%	-1.0%
North Carolina	S	100,436	104,923	111,235	115,571	117,279	122,613	4.5%	10.1%	6.1%	16.9%
North Dakota	C	3,307	3,495	3,497	3,586	3,448	3,671	5.7%	2.6%	2.4%	5.0%
Ohio	M	125,026	128,602	129,543	128,877	135,373	136,849	2.9%	0.2%	6.2%	6.4%
Oklahoma	M	47,295	46,110	47,083	46,576	-	54,905	-2.5%	1.0%	17.9%	19.1%
Oregon	S	18,741	20,473	21,132	20,443	21,585	24,254	9.2%	-0.1%	18.6%	18.5%
Pennsylvania	S	131,695	137,429	136,353	134,426	133,550	134,160	4.4%	-2.2%	-0.2%	-2.4%
Rhode Island	C	9,865	10,955	11,255	11,459	11,406	11,842	11.0%	4.6%	3.3%	8.1%
South Carolina	M	49,994	45,534	50,024	51,479	52,727	51,469	-8.9%	13.1%	0.0%	13.0%
South Dakota	C	9,324	9,595	9,638	9,805	10,185	10,466	2.9%	2.2%	6.7%	9.1%
Tennessee	M	-	-	-	-	-	-				
Texas	S	512,986	438,164	388,281	359,967	355,528	335,751	-14.6%	-17.8%	-6.7%	-23.4%
Utah	S	23,777	27,943	25,197	30,192	27,395	24,021	17.5%	8.0%	-20.4%	-14.0%
Vermont	S	3,029	2,911	2,703	2,897	3,145	3,418	-3.9%	-0.5%	18.0%	17.4%
Virginia	C	52,327	56,258	56,679	58,676	63,714	68,524	7.5%	4.3%	16.8%	21.8%
Washington	S	7,305	9,206	10,644	10,862	12,831	13,585	26.0%	18.0%	25.1%	47.6%
West Virginia	S	21,828	22,790	23,146	23,594	23,594	24,283	4.4%	3.5%	2.9%	6.6%
Wisconsin	M	35,785	37,839	37,356	34,957	31,588	30,302	5.7%	-7.6%	-13.3%	-19.9%
Wyoming	S	3,156	3,144	3,205	3,328	3,796	3,854	-0.4%	5.9%	15.8%	22.6%

** M = Medicaid Expansion Program (12) / S = Separate Program (19) / C = Combined Program (20) SCHIP program classification is as of December 2004.*

Note: Increases in excess of 1,000% reported as NA.

Source: Compiled by Health Management Associates from state enrollment reports. Prepared for the Kaiser Commission on Medicaid and the Uninsured.

from December 2003 to June 2004, producing a net gain for calendar year 2004 of about 25,000, or 0.6%. National enrollment in December 2004 was back within 1,600 of the peak enrollment of 3,951,000 attained 18 months earlier in June 2003.

Enrollment by Program Type

Federal law allows a state to implement its SCHIP program as a separate program or as a Medicaid expansion program, or to operate both separate and Medicaid expansion programs in combination. In December 2004, a total of 39 states operated separate programs and 33 states operated Medicaid expansion programs. These totals include 18 states with separate programs only, 11 states and the District of Columbia with only Medicaid expansion programs, and 20 states with a combination of separate and Medicaid expansion programs.[4] The only changes during 2004 that occurred in this distribution of state programs occurred when two Medicaid expansion states (Arkansas and Idaho) added separate programs in July 2004 to become classified as combination states.[5]

The growth in national SCHIP enrollment that occurred in 2004 reflected net gains across Medicaid expansion SCHIP programs, offset by net declines across separate SCHIP programs. In December 2004, Medicaid expansion programs (including those in combination states) accounted for 29% of all children enrolled in SCHIP. Among these programs in calendar year 2004, Medicaid expansion enrollment increased by 110,000 children or 11%. On the other hand, across all separate programs (which accounted for 71% of all enrollees in December 2004), enrollment dropped by 87,000 or about 3%.

Enrollment Increases and Decreases by State

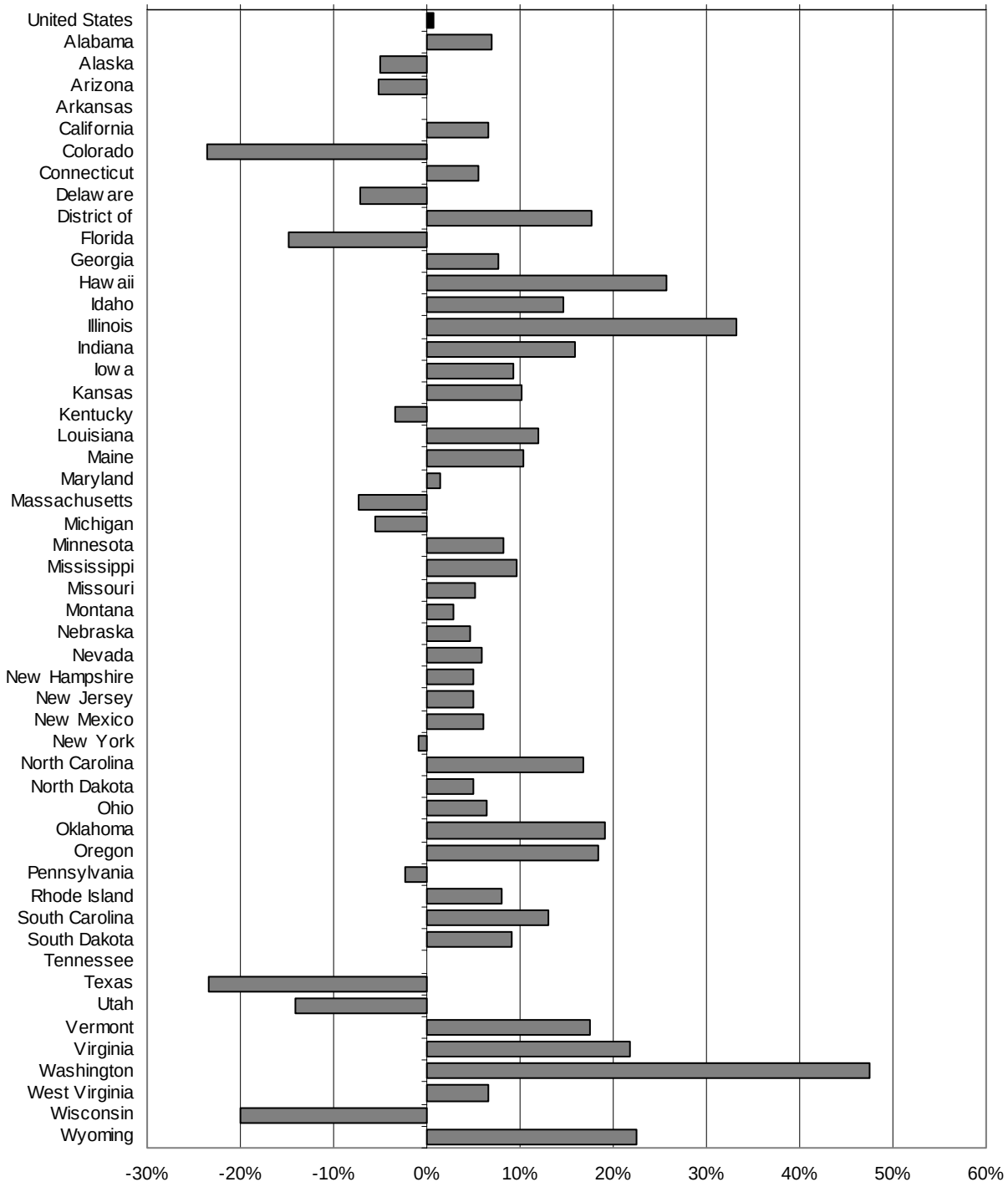
Across all states and the District of Columbia, the national enrollment growth from December 2003 to December 2004 was 0.6%, the smallest calendar year enrollment change in the seven year history of the program. However, enrollment increased in most states, with declines reported in just 13 states. Enrollment growth exceeded 5% in 32 states, including 16 states where enrollment growth exceeded 10% and five states where growth exceeded 20% (Figure 4).

The five states with annual growth in 2004 exceeding 20% included Hawaii, Illinois, Virginia, Washington and Wyoming. Sixteen states (including the District of Columbia) experienced enrollment growth in excess of 10% (Table 2).

California has the nation's largest SCHIP program, which it refers to as "Healthy Families." California's Healthy Families enrollment reached 771,000 children in

Figure 4

Percentage Change in SCHIP Enrollment December 2003 to December 2004



Source: Compiled by Health Management Associates from state enrollment reports. Prepared for the Kaiser Commission on Medicaid and the Uninsured.

Table 2

16 States with SCHIP Enrollment Growth Above 10% or 10,000

December 2003 to December 2004

State *(ordered by percent change)*	Monthly Enrollment Dec-03	Monthly Enrollment Dec-04	Enrollment Growth 12/03-12/04	Percent Change 12/03-12/04
Washington	9,206	13,585	4,379	48%
Illinois	92,144	122,711	30,567	33%
Hawaii	10,907	13,719	2,812	26%
Wyoming	3,144	3,854	710	23%
Virginia	56,258	68,524	12,266	22%
Oklahoma	46,110	54,905	8,795	19%
Oregon	20,473	24,254	3,781	18%
District of Columbia	3,720	4,379	659	18%
Vermont	2,911	3,418	507	17%
North Carolina	104,923	122,613	17,690	17%
Indiana	61,577	71,401	9,824	16%
Idaho	11,237	12,884	1,647	15%
South Carolina	45,534	51,469	5,935	13%
Louisiana	94,799	106,091	11,292	12%
Maine	13,085	14,436	1,351	10%
Kansas	31,012	34,169	3,157	10%
Georgia	196,615	211,857	15,242	8%
California	722,901	771,283	48,382	7%

Source: Compiled by Health Management Associates from state enrollment reports. Prepared for the Kaiser Commission on Medicaid and the Uninsured.

December 2004, reflecting an annual increase of over 48,000 children or almost 7%. Other than California, the largest increase in SCHIP enrollment occurred in Illinois. The state experienced annual growth of nearly 31,000 children in KidCare, which increased from 92,000 to roughly 123,000 children. In Illinois, the growth in the number of children with KidCare health coverage resulted from a concerted state effort to enroll low-income, uninsured children and families. Illinois implemented strategies in the spring of 2004 to simplify income verification and allow for presumptive eligibility. Illinois' efforts resulted in its being one of only four states in the country with an increase in SCHIP coverage of children between the Decembers of 2003 and 2004 in excess of both 10,000 and 10%.

The three other states with annual increases in SCHIP enrollment exceeding both 10,000 and 10% in 2004 were North Carolina (+18,000 and 17%), Virginia (+12,000 and 22%), and Louisiana (+11,000 and 12%).

The most significant drops in enrollment in 2004 occurred in two key states: Texas and Florida. Texas SCHIP enrollment continued to decrease in 2004, dropping from 438,000 in December 2003 to 360,000 in June 2004. The enrollment continued to drop to 336,000 in December 2004, yielding an annual decrease of 102,000 children or 23% in 2004. This extended a downward trend that began in 2002 when the state took steps to make eligibility rules more

restrictive. Texas SCHIP enrollment had grown dramatically from roughly 40,000 in June 2000 to almost 530,000 children in June 2002, but reversed course and dropped by more than 194,000 or 37% over the next 30 months through December 2004.

Florida SCHIP enrollment dropped from 319,000 in December 2003 to less than 272,000 in December 2004, a decrease of 48,000 or 15%. The drop in enrollment in Florida was primarily due to a legislative restriction on funding that limited new enrollment during the fall of 2004, after enrollment had increased to 332,000 in June 2004.

Together, the enrollment decreases in Texas and Florida totaled nearly 150,000 children during 2004.

Notable decreases also occurred in Colorado, New York and Wisconsin. Colorado SCHIP enrollment was frozen due to a funding limit imposed by the legislature, which resulted in drop of 12,000 children enrolled during 2004, a decrease of 24%. However, the restrictions were lifted in the second half of 2004, allowing enrollment to increase slightly (3.0%). In New York, SCHIP enrollment dropped over the first nine months of the year, and then increased by over 14,000 in the final quarter of calendar 2004. From December 2003 to December 2004, overall New York enrollment dropped by 4,379 or 1.0%. In Wisconsin, enrollment dropped by 7,054 or 20%.

Adults with Health Coverage through SCHIP

Several states have redirected unspent federal Title XXI SCHIP funding to finance health coverage for adults through the use of Section 1115 waivers, or in certain situations, through state plan amendments. In December 2004 a total of nine states used this authority to provide health care for 335,000 adults (Table 3).

Table 3

SCHIP Enrollment of Adults by State

December 2003 to December 2004

	Monthly Enrollment				% Change		
	Dec-03	*Jun-04*	*Sep-04*	*Dec-04*	Dec 03 to June 04	June 04 to Dec 04	Dec 03 to Dec 04
United States	**268,246**	**353,815**	**352,429**	**335,458**	**31.9%**	**-5.2%**	**25.1%**
Arizona	45,298	44,344	46,475	45,942	-2.1%	3.6%	1.4%
Arkansas	-	-	297	630	NA	NA	NA
District of Columbia	-	9,336	9,268	9,352	NA	0.2%	NA
Illinois	41,594	51,458	79,537	84,862	23.7%	64.9%	104.0%
Michigan	-	89,753	78,697	62,715	NA	-30.1%	NA
Minnesota	25,011	24,667	24,323	23,203	-1.4%	-5.9%	-7.2%
New Hampshire	6,431	-	-	-	-100.0%	NA	-100.0%
New Jersey	91,448	78,588	61,729	57,035	-14.1%	-27.4%	-37.6%
Rhode Island	13,508	14,036	14,022	14,328	3.9%	2.1%	6.1%
Wisconsin	44,956	41,633	38,081	37,391	-7.4%	-10.2%	-16.8%

Source: Compiled by Health Management Associates from state enrollment reports. Prepared for the Kaiser Commission on Medicaid and the Uninsured.

This represented an annual enrollment increase of 67,000 or 25% above the 268,000 adults enrolled in December 2003.

The enrollment gain nationally was primarily driven by Illinois, which more than doubled enrollment in its program during 2004, covering nearly 85,000 adults by year's end. Michigan initiated its waiver program during 2004 and used SCHIP funding to finance coverage for 63,000 adults in December 2004. Similarly, the District of Columbia began its program during 2004, covering 9,352 enrollees by December 2004. Arkansas began its separate program in July 2004 with coverage limited to pregnant women not eligible for Medicaid under the state plan option for unborn children. Enrollment in Arkansas reached 630 in December 2004. Annual increases in enrollment also occurred in Arizona and Rhode Island. Despite these overall gains, decreases in Title XXI-covered adults occurred in Minnesota, New Jersey and Wisconsin between the Decembers of 2003 and 2004, and New Hampshire dropped its program for adults altogether in early 2004.

State Policy Changes in 2004

Several states made policy changes in their SCHIP programs during 2004. The survey asked SCHIP officials to indicate changes that occurred in enrollment caps, premiums, eligibility standards, covered benefits, copayments or other policy changes. SCHIP directors were also asked about their view on the outlook for SCHIP funding and future enrollment trends in their programs.

Enrollment Caps

SCHIP enrollment caps were in place in December 2004 in four states: Florida, Idaho, Montana and Utah. In Florida, new enrollment was limited beginning in July 2004 based on funding provided by the legislature for FY 2005. Idaho operated both a Medicaid expansion and a separate program that was newly implemented in July 2004. This new separate program caps enrollment at 5,600, though as of December 2004, enrollment stood at 1,723 and had not yet reached the cap. In Montana, the cap was set at 10,900. Enrollment was near the cap throughout calendar year 2004, with new enrollments coming from a waiting list. Utah enrollment had a cap based on the funding level allocated by the legislature; enrollment up to the cap of 28,000 in December 2004 could occur during specified open enrollment periods.

In Maryland, the freeze on enrollments of new applicants in families with incomes above 200% of the FPL ended on July 1, 2004.

Premiums

Among the 38 separate programs operating in December 2004, a total of 30 reported that they required premiums for enrollment. In general, premiums were payable monthly, although two states collected premiums annually, and one collected premiums quarterly. Premiums ranged in amount from $5 per month per family to over $100 per month per family, depending on family income and the number of children. Most states have a sliding scale and a family maximum for premiums.

In eight states, premiums in effect in December 2004 were higher than those in effect one year earlier. Premiums in effect in December 2004 are listed by state in Appendix A.

Eligibility Changes in FY 2005

Three states reported changes in eligibility levels that were effective from July 2004 through December 2004. Each of these changes expanded eligibility. Idaho expanded coverage from 150% to 185% of the Federal Poverty Level (FPL) with the implementation of its separate SCHIP program on July 1, 2004, though as noted above, enrollment is limited to 5,600 individuals. Maryland raised the qualifying level for the Medicaid expansion program (for which there is no premium) from 185% to 200% of the FPL, also effective July 1, 2004. Illinois raised the qualifying income level for parents under the Title XXI - funded "FamilyCare" program from 90% to 133% of the FPL effective September 1, 2004 as part of an ongoing strategy to expand health coverage to low-income and uninsured families.

Five states reported changes in eligibility rules or procedures designed to facilitate enrollment, re-enrollment or retention of SCHIP coverage. In Florida, the penalty for non-payment of premium changed in September 2004 from six months cancellation of coverage to 60 days, returning to the policy that was in effect prior to December 2003. In Missouri, beginning in July 2004, a child with special health needs without access to affordable employer-subsidized health insurance was exempt from the requirement to be without insurance for six months before enrollment in SCHIP, and was not subject to the 30 day waiting period. In New York, health plans were required to provide enrollees a prospective one month grace period for the payment of a required monthly family contribution (only required of those families above 160% of FPL). In Oregon, effective October 2004, the allowed liquid asset limit was increased from $5,000 to $10,000. In Pennsylvania, income verification requirements were simplified to allow documentation "reasonably representative of the applicant's circumstances" (such as a single pay stub for a person who routinely receives the same wages each pay period) for both new applications and renewals.

On the other hand, four states reported changes resulting in more restrictive eligibility criteria. In Florida, applicants were required to provide additional documentation. Beginning in July 2004 a family's statement of income was not sufficient. Families were required to provide the previous year's income tax return and W-2 statements plus pay stubs from the previous month. This requirement was modified in December 2004 to require only the previous year's income tax return, or other proof of income if the tax return was unavailable. The renewal procedure also was changed for fiscal year 2005. Previously, a passive process was used, where each family received a pre-populated form and only needed to return it if there were any changes. As of July 2004, families received a partially pre-populated form to complete, sign and return with the same documentation required with initial applications.

In Georgia, children whose coverage was cancelled due to non-payment of premium are now ineligible to re-enroll in PeachCare for three months. Nevada eliminated provisional enrollment of children who appeared to be eligible for Medicaid. Under the new policy such children are denied SCHIP coverage and referred directly to the Medicaid eligibility division. In Texas, an asset test for families above 150% of the FPL was implemented in August 2004.[6]

Benefits, Copays and Other Changes in FY 2005

No states reported changes in covered benefits for FY 2005, although in a few states, changes in program structure might affect benefits in certain situations. For example, in Maryland, some children eligible for the separate SCHIP program had been enrolled in employer-sponsored insurance plans with copayments, which were limited to 5% of annual income. Effective July 2004 these children were transferred to HealthChoice, the Maryland managed care program, which does not require copayments.

West Virginia SCHIP began purchasing vaccines for children enrolled in its program through the state immunization program in order to receive the federal contract rate available through the Vaccines for Children Program.

Idaho implemented a premium assistance program under Section 1115 / HIFA authority as an alternative to receiving a direct benefit under either CHIP-A or B programs.

Impact of Federal Discussions of Re-Authorization of SCHIP Funding

Like Medicaid, SCHIP is jointly financed by state funds and federal matching funds. Unlike Medicaid, however, federal matching funds for SCHIP are capped annually, both nationwide and state-by-state. These annual federal allotments were originally set in 1997, and the amount of available federal funds does not

always match actual SCHIP spending levels in many states. Within specified rules, states with unexpended funds are able to carry them forward, or obtain a federal waiver to use them to cover parents or uninsured adults. States with a need for SCHIP funding that exceeds their allotment must either limit their program or depend on a federal reallocation of funds that were not expended in other states.[7]

At the time of the survey in the spring of 2005, discussion was occurring in Congress about the reauthorization of SCHIP funding. For the first time in the program's history, Congress did not reallocate $1.06 billion in unspent allotments to states with funding shortfalls at the end of FY 2004, and instead allowed these funds to expire and revert to the federal treasury. At the time, six states were facing projected federal funding shortfalls in 2005, 11 states in 2006, and 18 in 2007.[8] A number of states indicated that this situation and discussions surrounding the reauthorization of SCHIP, which expires after 10 years at the end of FY 2007, has been having an impact on decision-making in their state as they made plans for the future.

SCHIP director responses to survey questions on how federal funding caps and redistribution of Title XXI funds affect state decisions:

"There is some concern that if we obtain additional non-federal funds and expand our enrollment, there may not be sufficient federal funds for matching these funds and sustaining enrollment in the future."

"Budgeting for the SCHIP program in [our state] is always done against federal availabilities. It is a balance between funding and children. Because we are at maximum capacity we have been unable to address parents, uninsured adults, etc."

"The Legislature is aware of the federal funding available to the program and bases its decisions on expanding the program on availability of these funds."

"We are totally reliant on redistribution funds to cover the costs associated with our Title XXI expansion. Our total program costs run about four times more than the allotment dollars that are allocated to us."

Outlook for the Future: SCHIP Enrollment Projections for 2005, 2006 and 2007

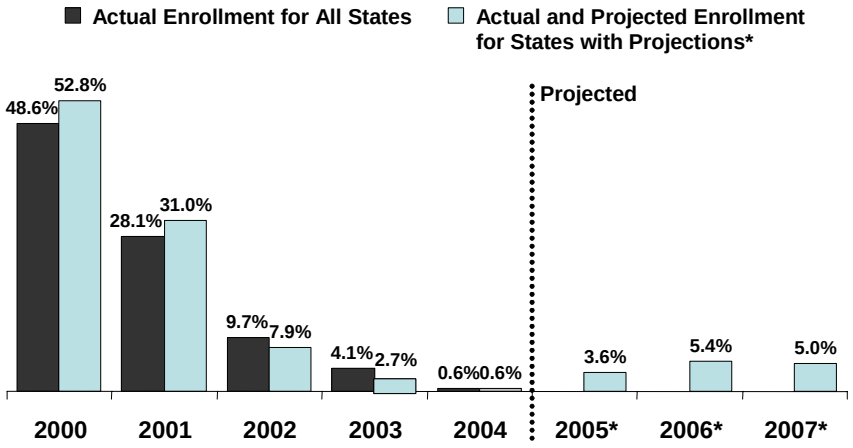
At the time that states provided actual SCHIP enrollment data for December 2004, states were also asked to provide state projections for enrollment of children in their SCHIP programs for the months of December 2005, December 2006 and December 2007. A total of 38 states were able to provide one-year projections to December 2005.[9] These 38 states accounted for 81% of U.S. SCHIP enrollment in December 2004. 35 states were able to provide three-year projections through December 2007.[10] These 35 states accounted for 78% of U.S. SCHIP enrollment in December 2004. States not reporting projections indicated that possible changes under consideration in their legislatures made projections difficult or impossible, or that they had not made such projections.

Because data were not available for all states, the projections summarized here cannot be regarded as national projections for future SCHIP enrollment. Nevertheless, the collective projections for more than two-thirds of the states represent an important indicator of the expectations of state officials for enrollment in their programs over the next three years.

For calendar 2005, across the 38 states (including the District of Columbia) for which projections were available, SCHIP officials foresaw total SCHIP enrollment increasing by 3.6% for the year ending in December 2005 (Figure 5). Among these 38 states, SCHIP officials in 10 states projected declines in enrollment over this period, and officials in 28 states and the District of Columbia expected positive enrollment growth during calendar year 2005.

Figure 5

Annual Percent Growth in SCHIP Enrollment of Children, December of Each Year



* Projected annual enrollment growth (38 states for '05 and 35 for '06 and '07). Actual enrollment for states with projections based on 35 states with projections through '07.

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

KAISER COMMISSION ON Medicaid and the Uninsured

Looking ahead two and three years, 35 states projected slightly higher average rates of enrollment growth. The projection was for an average rate of growth of 5.4% for the year ending in December 2006, and an average annual rate of growth of 5.0% for the year ending in December 2007 (Figure 5). Only one of the reporting states indicated a projected drop in enrollment in 2006. In 2007, just one state again (a different state than in 2006) projected an annual drop in enrollment.

If these projections were to materialize nationally, monthly U.S. SCHIP enrollment of children would reach 4.1 million in December 2005, would exceed 4.3 million in December 2006 and would be over 4.5 million by December 2007.

In describing their projections, several SCHIP officials commented on the impact of the economy on their program. In particular, some commented that the economic downturn made more children eligible for Medicaid, or that they were seeing a shift in enrollment from their stand-alone SCHIP program to their Medicaid expansion program as family economic circumstances changed. Other states commented on the erosion of employer-sponsored health insurance; as the cost of health insurance has increased and become less affordable, more families turn to SCHIP for health coverage for their children.

Comments of SCHIP directors on changes in the economy and the availability of employer-sponsored health insurance affect SCHIP:

"Erosion of employer-sponsored coverage continues to apply significant pressure to public coverage."

"SCHIP children are growing faster than anticipated. We suspect that this is due to the affordability of health insurance."

"Our enrollment hasn't been as high as expected because we are denying a lot of children and sending them back to Medicaid because they are under income."

Summary and Conclusion: SCHIP Enrollment in 2004

National SCHIP enrollment remained at approximately 3.9 million children throughout calendar 2004. Enrollment dropped in the first half of the year from 3,924,000 in December 2003 to 3,887,000 children in June 2004. This was the second six months of continuous decline in the monthly number of children covered. The twelve-month enrollment decline that began in June 2003 was the first drop in enrollment in the program's history. In the last half of calendar 2004, enrollment rebounded to reach 3,950,000 in December. National enrollment previously had peaked in June 2003 at 3,951,000.

Throughout 2004 the effects of the economic downturn were still being felt by SCHIP programs across the U.S. The dramatic decrease in revenues experienced by most states made it difficult for states to allocate scarce state dollars to fund the program, and contributed to the end of many outreach and enrollment simplification initiatives that had helped them find and enroll large numbers of low-income, uninsured children. At the same time, continued erosion of employer-sponsored health insurance, especially among employers offering low wage jobs, made SCHIP an important source of health coverage for many families in this population.

When asked about the future, SCHIP officials indicated they expected their programs would provide health coverage for more children on average for each of the next three years, although the growth rate would be modest. Based on state projections for enrollment growth for 2005, 2006 and 2007 provided by 35 states, annual rates of growth would average about 4% in 2005 and about 5% in 2006 and 2007. However, state officials also indicated that federal decisions on the reauthorization of SCHIP funding, and the reallocation of funding to states that exceed their allotment, would be critical to future state decisions regarding SCHIP coverage.

Data Definitions and Methodology

The data provided by state officials for this report are "point-in-time" counts of enrollment, reflecting the number of children and adults enrolled in SCHIP programs in each state in the indicated month. For this report, state SCHIP officials provided data specifically for the months of September and December 2004. Other data cited in this report were provided in earlier surveys, which have been conducted every six months since 1999. States are encouraged to review data included in previous reports in this series and to update data whenever appropriate. Each report including this one reflects updated data provided by states for previous periods. The data for this report were requested in February 2005 and provided in March and April 2005.

"Point-in-time" data in this report differ from an "ever-enrolled, for any length of time" count of enrollees, such as in reports issued by the federal Centers for Medicare and Medicaid Services (CMS). The most recent report from CMS (issued May 23, 2005), for federal fiscal year 2004, reported a total of 6,153,033 children enrolled at any point in time and for any length of time during the twelve months ending with September 2004.[11] In contrast, the number of children enrolled in the month of September 2004 per data provided for this report was 3,904,562. For federal fiscal year 2003, CMS reported a total of 5,984,772 children enrolled in the twelve months that ended with September 2003. Based on data provided for this report, the number enrolled in the month of September 2003 was 3,943,087. The annual count of children ever-enrolled will always exceed the number enrolled at any point in time, as long as there are enrollees who leave the program during the year and do not re-enroll. The greater the rate of disenrollment during a year, the greater will be the difference between these two measures of program enrollment. Recent experience is that approximately one-third of SCHIP enrollees during a year are not enrolled at the end of the year. Both point-in-time and ever-enrolled enrollment counts are useful measures that provide insight into dynamics of coverage, retention and turnover among SCHIP enrollees over time.

Appendix A: SCHIP Premiums and Enrollment Fees as of December 2004

State	Requires Premiums or Enrollment Fees		Notes
	Yes	*No*	
Alabama	✓		100-150% FPL: $50 per year per child, $150 maximum premiums per family; 151-200% FPL $100 per child per year, $300 maximum family premiums.
Alaska		✓	
Arizona	✓		100-150% of FPL: $15 for parents. $10 for one child, $15 for two or more children. 150-175%: $20 for parents, $20 for one child, $30 for two or more children. 175-200%: $25 per parent, $25 one child, $35 two or more children.
Arkansas		✓	
California	✓		Based upon income. Premiums range from $4-$9 per month per child with a family maximum of $27 per month. 25% discount for those using Electronic funds transfer.
Colorado	✓		Up to 150%, no enrollment fee. 151-185% FPL $25 single child, $35 for two or more children. Fee waived for families with eligible pregnant women
Connecticut	✓		Band 1 $30 per child, $50 two ore more children. Band 2 $50 per child, $75 two or more children. Band 3 based upon group rate between $158-$230 per child per month.
Delaware	✓		101 -133% FPL: $10 per family per month , 134 -166%: $15 PFPM 167 -200%: $25 PFPM
District of Columbia		✓	
Florida	✓		$15 per family per month below 150% FPL $20 per family per month above 150% FPL
Georgia	✓		Monthly household premiums are based on FPL, for one child and a family cap: 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		✓	

State	Requires Premiums or Enrollment Fees		Notes
	Yes	*No*	
Idaho	✓		$15 per month
Illinois	✓		150% FPL: $15 one child, $25 for two, $30 three or more
Indiana	✓		150-175% FPL: $11-$16.50 per month, 175-200% FPL: $16.50-$24.75 per month
Iowa	✓		$10 per child per month up to $20 per family (more than one child) per month.
Kansas	✓		151-175% FPL: $15 per month per family, 176-200% FPL: $30 per month per family
Kentucky	✓		$20 Per Family Per Month
Louisiana		✓	
Maine	✓		$8-$64 per month depending upon family size and income.
Maryland	✓		200-250% FPL: $41 PFPM 250-300% FPL: $52 PFPM
Massachusetts	✓		Below 150% FPL $12 per child, per month with a maximum of $15 PFPM. Above 150% FPL $12 per month per child with a maximum of $36 PFPM
Michigan	✓		$5 per family per month.
Minnesota	✓		For the parents and relative caretakers under the Section 1115 waiver, premiums are determined on a sliding scale based upon income.
Mississippi		✓	
Missouri	✓		226-300% FPL, $62-$252 monthly premium, depending upon income and family size.
Montana		✓	
Nebraska		✓	
Nevada	✓		100-150% FPL: $15 151-175% FPL: $35 176-200% FPL: $70
New Hampshire	✓		185-250% FPL: $25 per child per month with a $100 max per month 250-300% FPL: $45 per child per month with a $135 max per month.
New Jersey	✓		below 250%: Family monthly premium is $17; 250-299%: $34 300-349%; $68 above 350%: $113.50
New Mexico		✓	
New York		✓	Note: Although not reported on the survey, families above 160% FPL are required to pay a monthly premium of $9 or $15 per child (up to 3 children) depending on income and family size. Above 250%, the family must pay the full premium charged by the health plan.
North Carolina	✓		Annual enrollment fee for above 150% FPL: $50 per child with max of $100 per family
North Dakota		✓	

State	Requires Premiums or Enrollment Fees		Notes
	Yes	*No*	
Ohio		✓	
Oklahoma		✓	
Oregon		✓	
Pennsylvania		✓	
Rhode Island	✓		150-185% FPL: $61 PFPM; 185-200% FPL: $77 PFPM 200-250% FPL: $92 PFPM
South Carolina		✓	
South Dakota		✓	
Tennessee		✓	
Texas	✓		Sliding scale based upon income.
Utah	✓		Below 100% FPL: none. 101-150% FPL $13 per family per quarter 151-200% FPL $25 per family per quarter
Vermont	✓		$70 per month per family
Virginia		✓	
Washington	✓		$15 per month per child; max of $45 per family
West Virginia		✓	
Wisconsin	✓		150% of FPL or above: 5% of income
Wyoming		✓	

Note: Information in this table was provided by state SCHIP officials in March 2005 in response to the survey question: “As of December 2004, were there premiums or enrollment fees?”

Endnotes

[1] This report is the latest in an ongoing series of reports on SCHIP enrollment trends. This report focuses on December-to-December changes. Enrollment counts in this report update those in historical periods as shown in earlier reports.

[2] Enrollment data for counts above 10,000 are rounded to the nearest thousand in the text of this report. Exact counts are available in the accompanying tables.

[3] See Selden, T et al., "Tracking Changes In Eligibility And Coverage Among Children, 1996–2002," *Health Affairs*, 23(5), September/October 2004, pp. 39-50.

[4] In December 2004, two states (Arkansas and Tennessee) did not operate specific programs for children under SCHIP. Tennessee covers children under TennCare, its Section 1115 waiver program. Arkansas is classified as a "Combination" SCHIP program. Arkansas covers children under its ARKids First Program, which predates SCHIP, which is classified as a Medicaid expansion program. Title XXI funds are claimed two-years retroactively for a portion of the ARKids program and therefore it is not possible to identify enrollment counts for children for current periods. In July 2004 Arkansas began a separate SCHIP program as a state plan option to cover unborn children. Enrollment for the Arkansas separate SCHIP program is shown under adult coverage for this report reflecting the number of adult pregnant women enrolled.

[5] Arkansas added a separate program under a state plan option for unborn children. Enrollment for this report is reflected as pregnant women under adult coverage financed with Title XXI. Idaho added a separate program that expanded coverage for children from 150% up to 185% of the federal poverty level.

[6] See Dunkelberg and O'Malley, "Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts," *The Kaiser Commission on Medicaid and the Uninsured*, July 2004, available at http://www.kff.org/medicaid/7132.cfm.

[7] For a more detailed discussion of SCHIP financing issues, see Mann and Rudowitz, "Financing Health Coverage: The State Children's Health Insurance Program Experience," *The Kaiser Commission on Medicaid and the Uninsured*, February 2005, available at http://www.kff.org/medicaid/7252.cfm and the Congressional Research Service, "SCHIP Financing: Funding Projections and State Redistribution Issues," July 6, 2005. CRS Report for Congress, Order Code RL32807.

[8] See Park and Broaddus, "Assessing the Administration's Claims that Extending $1.1 Billion in Expiring SCHIP Funds Is Not Necessary to Sustain Existing Children's Enrollment," *Center on Budget and Policy Priorities*, September 2004, available at http://www.cbpp.org/9-30-04health.pdf.

[9] One-year projections for December 2005 were provided by all except the following 13 states: AR, CO, CT, FL, HI, ID, IL, ME, OH, OK, RI, SC, and TN

[10] In addition to the 13 states that did not provide one year projections, three-year projections were not available for NV, NJ and VT.

[11] Report accessed at: www.cms.hhs.gov/schip/enrollment/schip04rev.pdf

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