THE KAISER COMMISSION ON
Medicaid and the Uninsured

SCHIP PROGRAM ENROLLMENT:
December 2003 UPDATE

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July 2004

The Kaiser Commission on Medicaid and the Uninsured is the Henry J. Kaiser Family Foundation's largest operating program and serves as the organizing vehicle for the Foundation's work on health care for low-income people. The Commission functions as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is based at the Foundation's Washington, DC office. The Foundation is an independent national health care philanthropy headquartered in Menlo Park, California, and is not associated with Kaiser Permanente or Kaiser Industries.

Acknowledgements

This report is based on data provided by the SCHIP directors, Medicaid directors and other state officials responsible for data and statistical reporting. We acknowledge and thank these public servants for their timely responses to our requests and for confirming the accuracy of the data. Their contributions were invaluable.

David Fosdick of Health Management Associates assisted with the compilation and organization of the data. His work was very much appreciated.

The Henry J. Kaiser Family Foundation and the Kaiser Commission on Medicaid and the Uninsured provided support for this project. We extend special thanks to Barbara Lyons, Deputy Director of the Kaiser Commission on Medicaid on the Uninsured for her ongoing support of this project.

SCHIP Enrollment in December 2003 –

Key Findings

For the past six years, the State Children's Health Insurance Program (SCHIP) has provided states with an effective vehicle to expand health insurance coverage for low-income children.[1] SCHIP, together with the larger Medicaid program, has made substantial gains in reducing the nation's number of uninsured children. However, 2003 marked a turning point for enrollment in SCHIP. Despite the program's striking success in covering low-income children, ongoing fiscal difficulties led some states to make program changes that led to reductions in SCHIP enrollment.

As of December 2003, SCHIP provided coverage to 3,927,000 children, a decline of roughly 37,000 from June 2003 when enrollment peaked at 3,964,000. This decline marks the first time in the program's history that enrollment has fallen. Despite this overall decline, 37 states continued to experience modest increases in enrollment during the last six months of 2003. However, these increases were offset by declines of nearly 145,000 in 11 states and DC, with Texas accounting for more than half (52%) of the total decrease over this six month period. Texas implemented numerous program changes to SCHIP to address the state's budget deficit.

The relatively modest SCHIP growth in 2003, as well as the enrollment decline that occurred in the second half of the year, can be attributed in part to state policy changes. In most states, outreach funds were cut in 2002 and not restored in 2003. In addition, four states cut eligibility levels, one imposed an enrollment cap, several increased premiums and nine states cut or restricted benefits. However, reflecting broad political support for SCHIP even in difficult fiscal times, one state eliminated an enrollment cap, six states expanded eligibility and four states added or restored benefits.

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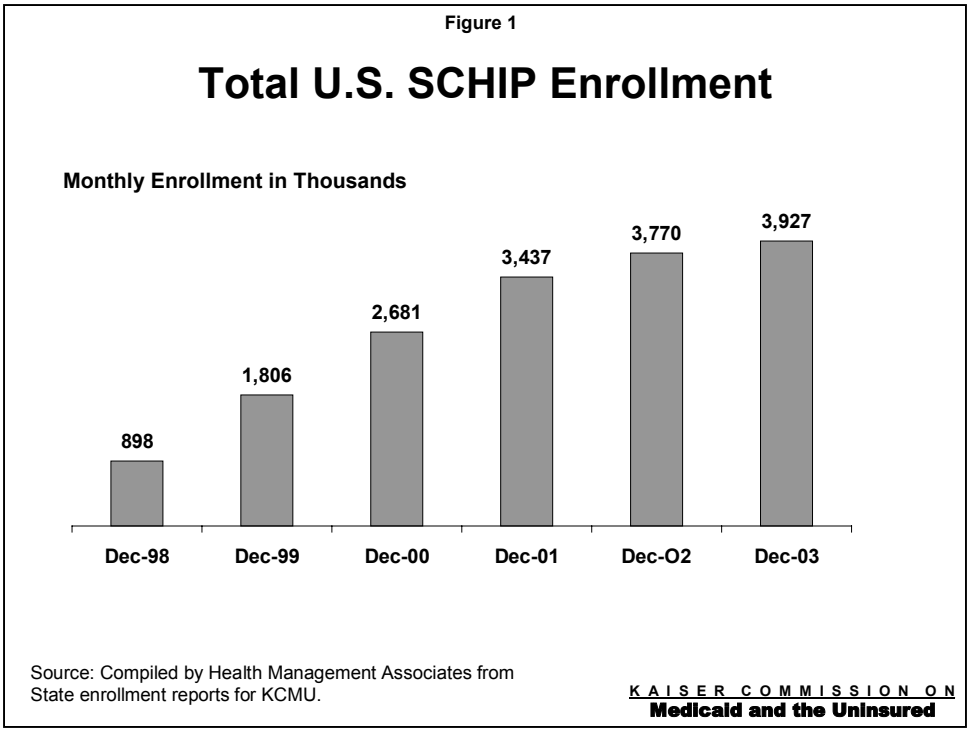
[1] This is the latest in a series of reports on SCHIP enrollment trends. For the previous report see: Vernon K. Smith and David M. Rousseau, *SCHIP Program Enrollment: June 2003 Update,* Kaiser Commission on Medicaid and the Uninsured, December 2003. Publication #4148. Available at: http://www.kff.org/medicaid/4148.cfm

Overview

Enacted through the Balanced Budget Act of 1997 (P.L. 105-33), the SCHIP program builds on the Medicaid program to provide health coverage for low-income children. Together, these programs have made significant strides in covering low-income children as a result of expanded eligibility levels, streamlined enrollment processes, and increased outreach efforts. During the past six years, the percentage of poor children who were uninsured declined from 22.4% in 1997 to 15.4% in 2003.[2] Uninsurance rates have declined even more dramatically among the group of slightly higher income children who were the main target of SCHIP - among children in families with incomes between 100-200% of the federal poverty level (FPL), uninsurance rates have fallen from 22.8% in 1997 to 14.7% in 2003, a decline of more than one-third (36%).[3]

Most states moved quickly to implement their SCHIP programs, spurred on by the program's enhanced federal financial contribution and a desire to lower the rates of uninsurance among low-income children. Enrollment began in January 1998 and increased rapidly over the first four years, reflecting a concerted effort across states to find and enroll eligible children. By December of 2001, the number of children with SCHIP coverage had reached 3.4 million, and by December 2003, enrollment had risen to more than 3.9 million children (Figure 1 and Table 1).

Figure 1



[2] Robin Cohen and Zakia Coriaty Nelson, *Health Insurance Coverage: Estimates from the National Health Interview Survey, 2003*, The National Center for Health Statistics, June 2004.
[3] Ibid.

Table 1

Total SCHIP Enrollment, December 1998 to December 2003

	Program Type*	Monthly Enrollment						Percent Change from Previous December				
		Dec-98	Dec-99	Dec-00	Dec-01	Dec-02	Dec-03	Dec-99	Dec-00	Dec-01	Dec-02	Dec-03
United States		**897,630**	**1,805,949**	**2,681,378**	**3,436,696**	**3,769,619**	**3,927,411**	**101%**	**48%**	**28%**	**10%**	**4%**
Alabama	S	22,102	33,638	32,915	46,971	55,423	58,696	52%	-2%	43%	18%	6%
Alaska	M	0	7,346	9,882	12,152	14,158	14,165	NA	35%	23%	17%	0%
Arizona	S	3,710	27,765	41,501	54,917	49,985	50,721	648%	49%	32%	-9%	1%
Arkansas[1]	M	341	1,021	1,498	1,686	0	0	199%	47%	13%	-100%	NA
California	C	66,482	230,820	388,790	542,283	637,666	722,901	247%	68%	39%	18%	13%
Colorado	S	11,704	23,013	28,120	38,228	48,500	49,978	97%	22%	36%	27%	3%
Connecticut	S	5,524	9,088	10,572	12,458	13,436	13,906	65%	16%	18%	8%	3%
Delaware	S	0	2,510	3,823	3,502	4,515	4,751	NA	52%	-8%	29%	5%
District of Columbia	M	569	2,187	3,178	2,554	3,786	3,720	284%	45%	-20%	48%	-2%
Florida	C	56,265	124,763	188,364	221,388	283,079	319,477	122%	51%	18%	28%	13%
Georgia	S	213	56,116	106,574	150,330	171,702	196,615	NA	90%	41%	14%	15%
Hawaii	M	0	0	3,854	7,190	8,886	10,907	NA	NA	87%	24%	23%
Idaho	M	2,937	4,728	9,150	11,940	11,197	11,237	61%	94%	30%	-6%	0%
Illinois	C	24,897	47,020	61,123	70,953	76,928	92,144	89%	30%	16%	8%	20%
Indiana	C	24,982	34,656	45,572	48,814	55,800	61,577	39%	31%	7%	14%	10%
Iowa	C	7,004	12,677	18,013	24,488	26,487	30,701	81%	42%	36%	8%	16%
Kansas	S	0	15,206	19,148	24,138	29,918	31,012	NA	26%	26%	24%	4%
Kentucky	C	5,188	28,068	52,653	50,486	50,340	51,381	441%	88%	-4%	0%	2%
Louisiana	M	3,741	26,649	40,551	69,906	81,077	94,799	612%	52%	72%	16%	17%
Maine	C	4,490	8,147	9,519	11,595	12,864	13,085	81%	17%	22%	11%	2%
Maryland	C	35,757	62,893	82,065	96,581	109,827	89,574	76%	30%	18%	14%	-18%
Massachusetts	C	28,146	52,508	60,854	53,130	56,429	61,968	87%	16%	-13%	6%	10%
Michigan	C	16,044	32,464	42,293	52,736	47,224	53,767	102%	30%	25%	-10%	14%
Minnesota	C	8	4	16	12	8	2,731	NA	NA	NA	NA	NA
Mississippi	S	8,276	11,191	30,827	49,608	53,937	61,159	35%	175%	61%	9%	13%
Missouri	M	23,998	54,306	70,888	77,811	81,707	89,811	126%	31%	10%	5%	10%
Montana	S	0	2,458	9,700	9,500	9,540	10,626	NA	295%	-2%	0%	11%
Nebraska	M	3,525	6,204	6,921	9,602	18,918	22,659	76%	12%	39%	97%	20%
Nevada	S	2,782	7,573	14,241	22,240	25,361	24,914	172%	88%	56%	14%	-2%
New Hampshire	C	11	2,169	3,468	4,340	5,928	6,431	NA	60%	25%	37%	8%
New Jersey	C	22,733	55,430	76,749	87,839	93,477	97,940	144%	38%	14%	6%	5%
New Mexico	M	0	2,395	6,174	9,085	11,170	11,393	NA	158%	47%	23%	2%
New York	C	270,683	425,025	529,149	538,108	513,764	457,317	57%	24%	2%	-5%	-11%
North Carolina	S	17,887	55,723	72,024	64,815	89,446	104,923	212%	29%	-10%	38%	17%
North Dakota	C	79	1,026	2,225	2,659	3,104	3,495	NA	117%	20%	17%	13%
Ohio	M	35,300	45,103	66,649	83,741	121,058	128,602	28%	48%	26%	45%	6%
Oklahoma	M	15,523	32,503	37,000	40,707	43,217	46,110	109%	14%	10%	6%	7%
Oregon	S	10,336	14,118	16,617	18,436	19,748	20,473	37%	18%	11%	7%	4%
Pennsylvania	S	68,376	87,592	104,326	118,047	125,424	137,429	28%	19%	13%	6%	10%
Rhode Island	C	2,981	6,978	10,619	12,179	9,847	10,955	134%	52%	15%	-19%	11%
South Carolina	M	38,006	43,773	44,392	47,680	42,395	45,534	15%	1%	7%	-11%	7%
South Dakota	C	1,405	2,789	5,545	7,689	9,020	9,595	99%	99%	39%	17%	6%
Tennessee[1]	M	13,603	16,805	12,873	6,320	0	0	24%	-23%	-51%	-100%	NA
Texas	S	35,477	28,513	200,290	492,803	500,567	438,164	-20%	602%	146%	2%	-12%
Utah	S	4,390	13,745	20,389	26,427	26,318	27,943	213%	48%	30%	0%	6%
Vermont	S	406	1,632	2,485	3,058	3,278	2,911	302%	52%	23%	7%	-11%
Virginia	C	1,420	19,569	29,967	36,091	46,611	56,258	NA	53%	20%	29%	21%
Washington	S	0	0	3,522	6,169	7,569	9,206	NA	NA	75%	23%	22%
West Virginia	S	329	8,935	15,653	20,593	21,348	22,790	NA	75%	32%	4%	7%
Wisconsin	M	0	17,107	26,178	29,661	34,445	37,839	NA	53%	13%	16%	10%
Wyoming	S	0	0	2,479	3,050	3,187	3,121	NA	NA	23%	4%	-2%

** M = Medicaid Expansion Program (14) / S = Separate Program (19) / C = Combined Program (18) SCHIP program classification is as of December 2003.*

[1] Arkansas and Tennessee phased out their Medicaid expansion programs in September 2002 and are included as a Medicaid expansion category, although no enrollment was reported for June 2003.

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.

As the program matured, the rate of enrollment growth moderated, falling off from the 101% and 48% growth rates between the Decembers of 1998 and 1999 and Decembers of 1999 and 2000, respectively, to the more modest 28% and 10% growth seen over the next two December periods. Beginning in State Fiscal Year (SFY) 2002, most states began to experience large budget shortfalls caused by significant reductions in the growth of tax revenues during the economic downturn. For the next two consecutive fiscal years, states faced budget deficits that reached nearly $80 billion in SFY 2003 alone.[4] At first, states were able to deal with these deficits by using one-time fixes such as special "rainy day" and tobacco settlement funds or general reserves. Once these mechanisms were exhausted, however, many states began to institute policies in 2002 and 2003 specifically designed to slow growth in health program spending, including SCHIP.

In most states, SCHIP remains an extremely popular program with a strong constituency among consumers, politicians and providers. The program, with its enhanced matching rate, relatively low cost per enrollee, and its success in lowering the number of uninsured children, was largely spared during early budget cuts. But starting in state fiscal year 2003, many states reduced spending on outreach, some instituted enrollment caps, increased premiums and cost sharing, reduced eligibility, intensified eligibility verification and changed enrollment procedures in ways that would limit program growth.[5] National enrollment in the State Children's Health Insurance Program (SCHIP) declined slightly during the second half of 2003, marking the first time in the program's six-year history that the number of children covered by SCHIP has decreased.

As of December 2003, SCHIP provided coverage to 3,927,000 children – a decrease of roughly 37,000 from June 2003 when enrollment in the program reached 3,964,000. Despite this nearly 1% decline in national enrollment, the majority of states (37) continued to experience enrollment increases during this period. However, these increases were offset by declines of nearly 145,000 spread across 11 states and DC, with Texas accounting for more than half (52%) of the total decrease over this six month period. Indeed, nearly 75,000 Texas children lost SCHIP coverage in the aftermath of significant changes to program eligibility, benefits, enrollment procedures, premiums, and cost sharing.[6] These changes were made largely in response to ongoing fiscal difficulties in the state.

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[4] National Conference of State Legislatures, State Budget Update, November 2003.
[5] See Ian Hill, Holly Stockdale, and Brigette Courtot, *Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis*, The Urban Institute, June 2004. Available at http://www.urban.org/url.cfm?ID=311015
[6] Anne Dunkelberg and Molly O'Malley, "Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts," Kaiser Commission on Medicaid and the Uninsured. July 2004.

December 2002 to December 2003: Enrollment Growth Slows

In December 2003, the total number of children enrolled in the State Children's Health Insurance Program (SCHIP) was 3,927,000. One year earlier, in December 2002, the total enrollment count was 3,770,000. Enrollment increased from December 2002 to December 2003 by 158,000 or 4.2 percent. This annual rate of growth in calendar year 2003 was less than half the 9.7 percent rate of growth in calendar year 2002, and less than one-sixth the 28 percent growth in 2001.

Across the U.S., more than 4 out of every 5 states (82%) experienced enrollment increases in 2003. Indeed, double-digit growth between the Decembers of 2002 and 2003 occurred in more than one-third of all states (35%).

Listed in Table 2 below are the states that reported enrollment increases from December 2002 to December 2003 in excess of 10,000 children, or with percentage increases in enrollment exceeding 15 percent.

Table 2

12 States with SCHIP Enrollment Increases in Excess of 10,000 or 15%
December 2002 to December 2003

State	Enrollment Increase	Percentage Increase
California	85,235	13.4%
Florida	36,398	12.9%
Georgia	24,913	14.5%
Hawaii	2,021	22.7%
Illinois	15,216	19.8%
Iowa	4,214	15.9%
Louisiana	13,722	16.9%
Nebraska	3,741	19.8%
North Carolina	15,477	17.3%
Pennsylvania	12,005	9.6%
Virginia	9,647	20.7%
Washington	1,637	21.6%

Noteworthy increases occurred in several states. Illinois placed a priority on expanding coverage for children and parents through SCHIP. In July 2003 the eligibility level for children expanded from 185 to 200 percent of the federal poverty level, and for parents from 49 percent to 90 percent. In addition, eligibility processes were streamlined. Louisiana made a special priority on enrollment and retention of children enrolled in SCHIP. The increase in Florida occurred during the first half of 2003; in July 2003 the SCHIP program was frozen and enrollment declined.

From December 2002 to December 2003, a total of six states and the District of Columbia experienced decreases in the number of children enrolled. Across these six states and DC, enrollment declined by 140,049 children. Enrollment

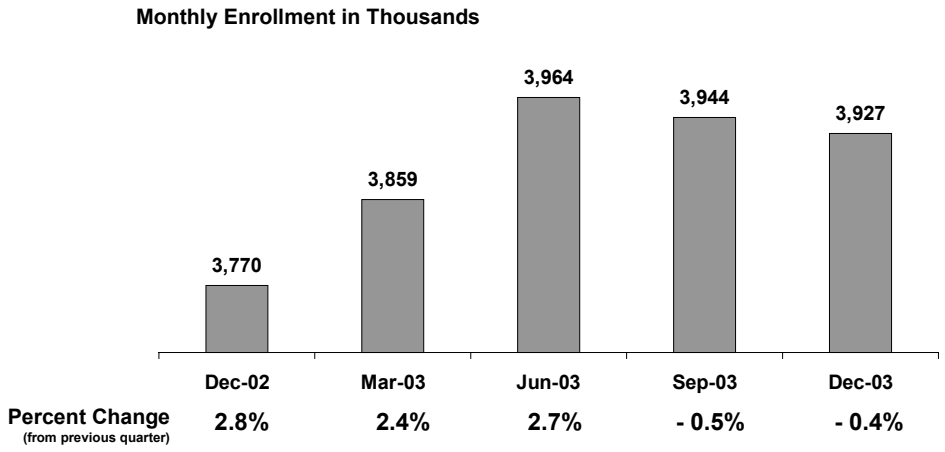
decreases in three states (Nevada, Vermont and Wyoming) and the District of Columbia were minimal. Among all states and DC with decreases in enrollment, three states (Maryland, New York and Texas) accounted for 99.3 percent of the total decrease.

June 2003 to December 2003: Enrollment Declines

The program reached a significant turning point in mid-2003. During the last half of 2003, total U.S. enrollment in SCHIP fell for the first time in the six-year history of the program. National SCHIP enrollment peaked in June 2003 at 3,964,000, declining over the next six months by 37,000 or 0.9 percent to 3,927,000 in December 2003 (Figure 2 and Table 3).

Figure 2

Quarterly Change in Total U.S. SCHIP Enrollment, December 2002 to December 2003



Source: Compiled by Health Management Associates from State enrollment reports for KCMU.

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Between June and December 2003, significant declines in enrollment occurred in three states – Maryland, New York and Texas – which resulted in a net decrease in national SCHIP enrollment over this six-month period. From June 2003 to December 2003, SCHIP enrollment across these three states dropped by 121,000.

Texas reported the largest decrease in enrollment over this period with roughly 75,000 fewer children enrolled. New York and Maryland also reported significant decreases in enrollment, each with drops of roughly 23,000 for this six-month period. Noteworthy drops also occurred in Florida, Colorado and South Carolina.

The enrollment decreases in these states more than offset the increases that continued to occur in 37 other states over the last six months of 2003 (Figure 3).

Table 3

Total SCHIP Enrollment, December 2002 to December 2003

	Program Type*	Monthly Enrollment					Percent Change from Previous Quarter				Percent Change Jun-03 to Dec-03
		Dec-02	Mar-03	Jun-03	Sep-03	Dec-03	Mar-03	Jun-03	Sep-03	Dec-03	
United States		**3,769,619**	**3,858,789**	**3,964,224**	**3,944,109**	**3,927,411**	**2%**	**3%**	**-1%**	**0%**	**-1%**
Alabama	S	55,423	58,908	60,383	62,449	58,696	6%	3%	3%	-6%	-3%
Alaska	M	14,158	12,164	12,290	12,353	14,165	-14%	1%	1%	15%	15%
Arizona	S	49,985	50,520	50,019	50,825	50,721	1%	-1%	2%	0%	1%
Arkansas[1]	M	0	0	0	0	0	NA	NA	NA	NA	NA
California	C	637,666	693,909	720,044	711,405	722,901	9%	4%	-1%	2%	0%
Colorado	S	48,500	51,192	53,118	51,479	49,978	6%	4%	-3%	-3%	-6%
Connecticut	S	13,436	13,788	14,092	14,513	13,906	3%	2%	3%	-4%	-1%
Delaware	S	4,515	4,024	4,524	4,744	4,751	-11%	12%	5%	0%	5%
District of Columbia	M	3,786	3,742	3,854	3,767	3,720	-1%	3%	-2%	-1%	-3%
Florida	C	283,079	300,483	330,866	322,209	319,477	6%	10%	-3%	-1%	-3%
Georgia	S	171,702	179,227	183,565	189,966	196,615	4%	2%	3%	4%	7%
Hawaii	M	8,886	9,640	10,071	10,699	10,907	8%	4%	6%	2%	8%
Idaho	M	11,197	10,917	10,706	10,954	11,237	-3%	-2%	2%	3%	5%
Illinois	C	76,928	76,453	80,563	73,993	92,144	-1%	5%	-8%	25%	14%
Indiana	C	55,800	56,518	56,880	62,640	61,577	1%	1%	10%	-2%	8%
Iowa	C	26,487	28,447	29,057	30,151	30,701	7%	2%	4%	2%	6%
Kansas	S	29,918	29,035	30,023	30,130	31,012	-3%	3%	0%	3%	3%
Kentucky	C	50,340	50,536	50,719	51,226	51,381	0%	0%	1%	0%	1%
Louisiana	M	81,077	84,717	88,129	90,817	94,799	4%	4%	3%	4%	8%
Maine	C	12,864	13,188	12,663	12,864	13,085	3%	-4%	2%	2%	3%
Maryland	C	109,827	109,455	112,758	89,011	89,574	0%	3%	-21%	1%	-21%
Massachusetts	C	56,429	56,412	56,261	60,041	61,968	0%	0%	7%	3%	10%
Michigan	C	47,224	48,590	51,424	53,541	53,767	3%	6%	4%	0%	5%
Minnesota	C	8	13	19	2,762	2,731	63%	46%	NA	-1%	NA
Mississippi	S	53,937	55,002	56,690	58,601	61,159	2%	3%	3%	4%	8%
Missouri	M	81,707	83,157	84,824	87,859	89,811	2%	2%	4%	2%	6%
Montana	S	9,540	9,550	9,550	9,550	10,626	0%	0%	0%	11%	11%
Nebraska	M	18,918	24,181	22,611	22,913	22,659	28%	-6%	1%	-1%	0%
Nevada	S	25,361	25,848	23,323	24,125	24,914	2%	-10%	3%	3%	7%
New Hampshire	C	5,928	5,786	5,871	6,124	6,431	-2%	1%	4%	5%	10%
New Jersey	C	93,477	89,851	92,170	96,038	97,940	-4%	3%	4%	2%	6%
New Mexico	M	11,170	11,451	10,675	10,913	11,393	3%	-7%	2%	4%	7%
New York	C	513,764	486,098	480,606	463,024	457,317	-5%	-1%	-4%	-1%	-5%
North Carolina	S	89,446	93,743	100,436	99,993	104,923	5%	7%	0%	5%	4%
North Dakota	C	3,104	3,186	3,307	3,481	3,495	3%	4%	5%	0%	6%
Ohio	M	121,058	122,721	125,026	126,239	128,602	1%	2%	1%	2%	3%
Oklahoma	M	43,217	45,000	47,295	43,881	46,110	4%	5%	-7%	5%	-3%
Oregon	S	19,748	17,644	18,741	18,610	20,473	-11%	6%	-1%	10%	9%
Pennsylvania	S	125,424	127,519	131,695	133,462	137,429	2%	3%	1%	3%	4%
Rhode Island	C	9,847	10,454	9,865	10,615	10,955	6%	-6%	8%	3%	11%
South Carolina	M	42,395	47,469	49,994	53,560	45,534	12%	5%	7%	-15%	-9%
South Dakota	C	9,020	9,210	9,324	9,380	9,595	2%	1%	1%	2%	3%
Tennessee[1]	M	0	0	0	0	0	NA	NA	NA	NA	NA
Texas	S	500,567	503,344	512,986	507,259	438,164	1%	2%	-1%	-14%	-15%
Utah	S	26,318	25,953	23,777	29,924	27,943	-1%	-8%	26%	-7%	18%
Vermont	S	3,278	3,081	3,029	3,164	2,911	-6%	-2%	4%	-8%	-4%
Virginia	C	46,611	50,383	52,327	52,788	56,258	8%	4%	1%	7%	8%
Washington	S	7,569	7,577	7,305	8,012	9,206	0%	-4%	10%	15%	26%
West Virginia	S	21,348	19,953	21,828	22,410	22,790	-7%	9%	3%	2%	4%
Wisconsin	M	34,445	35,546	35,785	36,658	37,839	3%	1%	2%	3%	6%
Wyoming	S	3,187	3,204	3,156	2,987	3,121	1%	-1%	-5%	4%	-1%

** M = Medicaid Expansion Program (14) / S = Separate Program (19) / C = Combined Program (18) SCHIP program classification is as of December 2003.*

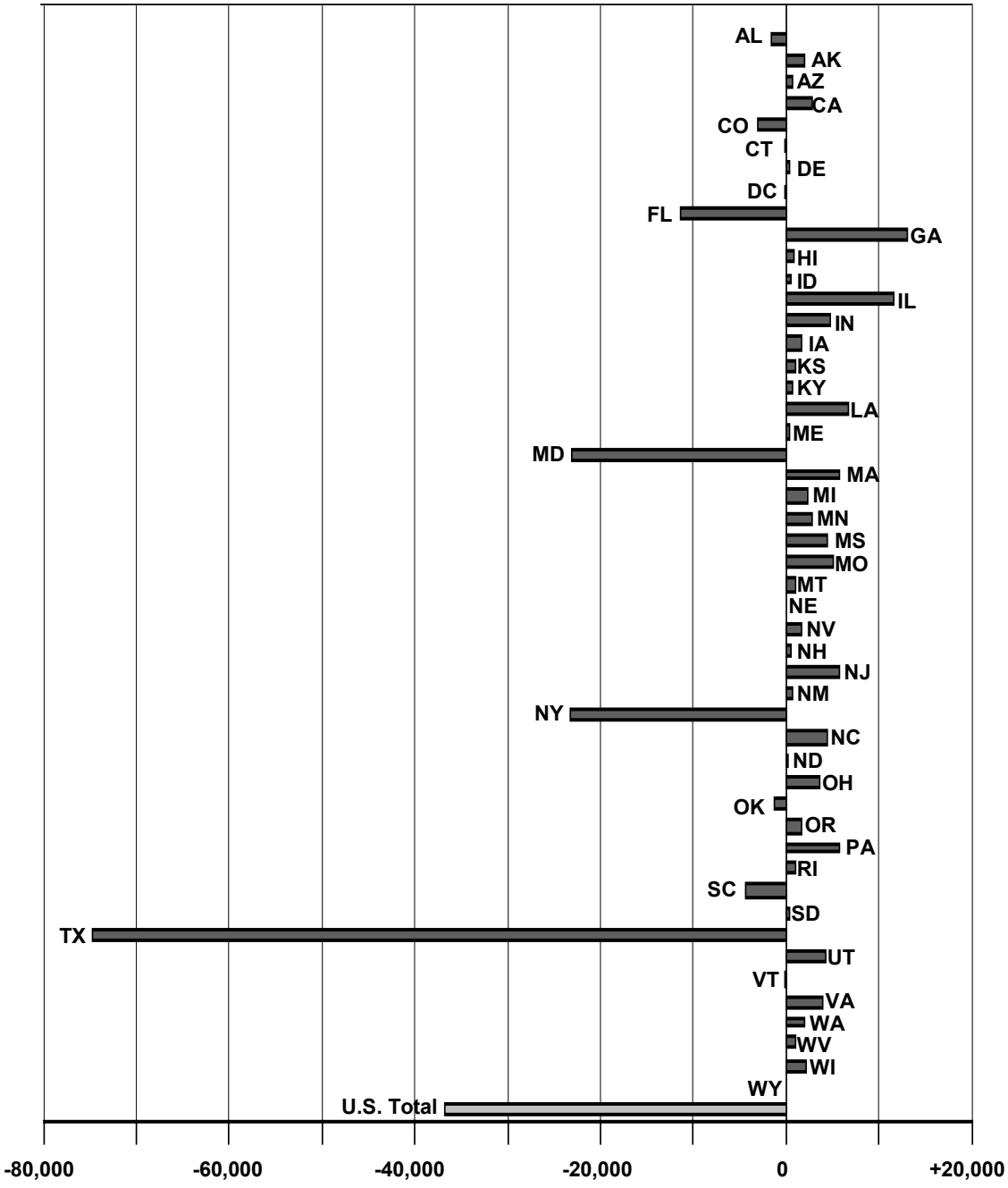
[1] Arkansas and Tennessee phased out their Medicaid expansion programs in September 2002 and are included as a Medicaid expansion category, although no enrollment was reported for June 2003.

Note: Increases in excess of 1,000% reported as NA. California and Nebraska saw less than 1 percent increases in enrollment.

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

Figure 3

Change in SCHIP Enrollment
June 2003 to December 2003



Note: AR and TN phased out their Medicaid expansion programs in September 2002
SOURCE: Compiled by Health Management Associates from State Medicaid enrollment reports.

Texas began fiscal year 2004 with a legislative directive to reduce SCHIP enrollment by over 100,000 children primarily through more restrictive eligibility and enrollment procedures. New policies included more restrictive treatment of income by eliminating "disregards" when determining eligibility, adding an asset test, reducing continuous eligibility, a new 90-day waiting period after being determined eligible before coverage could begin, and an increase in premiums and copayments. In New York and Maryland, significant numbers of children lost SCHIP coverage as a result of focused reviews of eligibility, but the majority maintained health coverage through Medicaid. In these states some children left SCHIP when they were found to have employer health insurance. In Maryland a new premium on families with incomes between 185 and 200 percent of the poverty level led to a drop in SCHIP enrollment of 1,600 children. In addition, Maryland stopped enrollment of children in families with incomes between 200 and 300 percent of poverty if they were not enrolled in Medicaid or MCHP in the previous month, contributing to the decline in enrollment since July 2003. Note, however, that the Maryland legislature eliminated the premiums for families with incomes between 185 and 200 percent of poverty and ended the enrollment freeze for children in families between 200 and 300 percent of poverty effective July 1, 2004.[7]

Reflecting both the economic downturn and the significant drop in the growth of state revenues over the past two years, the growth in SCHIP enrollment slowed in 2003. The resulting budget shortfalls meant many states have scaled back their focus on SCHIP outreach and enrollment that had characterized the program from 1998 through 2001. In some cases, SCHIP eligibility requirements were tightened, enrollment barriers increased, premiums and cost sharing requirements increased, and benefits reduced. Many states initiated these actions in 2002, and others in 2003. These actions together resulted in the slowing of enrollment growth, even as the economic downturn was associated with an increase in the number of low-income, uninsured children who would qualify for SCHIP. In many states, the budget-driven program restrictions in SCHIP were minimal compared to cuts that occurred in Medicaid and in other state programs. However, in a few states, budget cuts were applied to SCHIP as well. The most dramatic cuts in eligibility occurred in Texas, where the legislature adopted eligibility and enrollment restrictions designed to reduce enrollment by over one-fourth.

SCHIP Coverage for Adults

In addition to financing health coverage for children, a limited number of states have taken advantage of an option to use SCHIP funds to finance health coverage for adults under the provisions of a waiver granted by the federal CMS. For the month of December 2003 a total of seven states reported SCHIP-financed coverage for 268,000 adults, an annual increase of almost 27,000 or

[7] Presentation by John G. Folkemer, Maryland Department of Mental Health and Hygiene, for the Kaiser Commission on Medicaid and the Uninsured, July 23, 2004.

11.2 percent from the 241,000 adults enrolled in these same seven states in December 2002 (Table 4).

Table 4

SCHIP Enrollment of Adults by State, December 2002 to December 2003

	Monthly Enrollment			Percent Change
	Dec-02	Jun-03	Dec-03	12/02-12/03
United States	**241,327**	**244,636**	**268,246**	**11%**
Arizona	30,917	41,257	45,298	47%
Colorado	188	467	NA	NA
Illinois	12,703	20,690	41,594	227%
Minnesota	25,935	26,067	25,011	-4%
New Hampshire	NA	NA	6,431	NA
New Jersey	118,279	101,180	91,448	-23%
Rhode Island	12,626	12,699	13,508	7%
Wisconsin	40,679	42,276	44,956	11%

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

Policy and Program Changes in SCHIP Programs in State Fiscal Year 2004

States implemented a number of SCHIP policy changes in the first half of their fiscal year 2004. When state SCHIP officials provided their enrollment data for December 2003, they also indicated policy changes that occurred in state fiscal year 2004 (i.e., over the period from July 2003 to December 2003), including changes in SCHIP enrollment caps, premiums or enrollment fees, eligibility levels, covered benefits and other policy changes.

Enrollment caps: North Carolina eliminated its enrollment cap for fiscal year 2004. As of December 2003, five states indicated they had enrollment caps in place: Florida, Louisiana, Montana and Utah continued previous enrollment caps, and Alabama implemented its enrollment cap and waiting list in October 2003.[8] In July 2003, Maryland eliminated enrollment for new applicants whose family income was between 200 percent and 300 percent of the federal poverty level (FPL). This change contributed to the drop in overall enrollment in Maryland.

Premiums or enrollment fees: A total of 29 states indicated that they required payment of premiums or an enrollment fee for SCHIP. Typically, the amount is based on a percentage of the federal poverty level, which is scaled to family size and income. A number of states indicated that premiums were increased at the beginning of the fiscal year in July 2003, but from this survey it was not possible to identify the specific number of states where premiums or enrollment fees had increased for FY 2004.

[8] Louisiana, Montana, and Alabama have recently lifted their caps. Enrollment caps remain in both Florida and Utah.

A table indicating state policies on premiums and enrollment fees can be found in Appendix A.

Eligibility: A total of ten states indicated changes in SCHIP eligibility levels for children. In six states, eligibility was increased. In Illinois, coverage for children was increased in July 2003 from 185 percent to 200 percent of the FPL, and in addition eligibility for parents was raised from 49 percent to 90 percent of the FPL, and income verification requirements were simplified. In November 2003, Minnesota added coverage for prenatal care for women not eligible for Medicaid up to 275 percent of FPL. Also in November 2003, Pennsylvania increased the standard income deduction from $90 to $120 per month. Utah made changes streamlining enrollment relating to the addition of newborn children and treatment of private insurance. Virginia reduced the waiting period since prior insurance from six months to four months, and added 12 months continuous coverage in its separate SCHIP program. In Wyoming, coverage for children was increased in October 2003 from 133 percent to 185 percent of the FPL.

Eligibility cuts were implemented in four states: Alaska in October 2003 cut coverage from 200 percent to 175 percent of FPL. Connecticut discontinued continuous eligibility and guaranteed eligibility. Maryland in July 2003 changed the type of coverage available for children between 185 percent and 200 percent of FPL, by changing the maximum income level for the Medicaid expansion program and the minimum income for the separate "premium" program from 200 percent to 185 percent of FPL. In September 2003, Texas eliminated the use of income disregards in calculating the amount of countable income when determining eligibility, instituted a 90-day waiting period for the effective date of coverage, changed the term of coverage from twelve months to six months and decided to institute an asset test for families above 150 percent of FPL later in 2004.

Covered benefits and copays: Thirteen states indicated that changes had been made in SCHIP covered benefits in fiscal year 2004. Four states added or restored benefits, and nine states restricted or eliminated covered benefits, or increased co-payments.

States adding coverage included: Louisiana added hospice services. North Carolina added preventive dental fluoride wash as a benefit for children ages 0-3. Utah restored dental benefits that had been previously cut. Virginia added community mental health benefits to bring coverage under SCHIP to the same as coverage under Medicaid.

States cutting or restricting benefits or increasing copays included: Alabama increased co-payments. Florida capped dental services at $750 annually for children in the Florida Healthy Kids Program. Georgia eliminated coverage for root canals as a dental benefit. Maine instituted co-payments for selected services. Maryland stopped enrolling children into employer sponsored

insurance, and adjusted cost sharing to five percent of family income. Nebraska restricted coverage of orthodontic services. Texas discontinued coverage of a broad range of services, including: dental, eye exams and eyeglasses, chiropractic, hospice, skilled nursing facility, most mental health services (most eliminated mental health services were later restored in February 2004), substance abuse treatment and tobacco cessation services. Wisconsin increased co-payments for prescription drugs, and increased the maximum monthly limit on co-payments from $5 to $12. Wyoming limited dental services to preventative and specific basic services with an annual limit of $750, and ended coverage for transportation, transplants and hearing aids.

Outlook for SCHIP in Fiscal Year 2005

State officials were asked to comment on the outlook for SCHIP in their state for the next fiscal year. In many states, officials indicated that their legislature was still dealing with the state budget at the time of their response (March 2004), so the outlook was uncertain.

Nevertheless, officials in 20 states responded to this question. Among these states, several were decidedly optimistic. One state wrote: “Everyone remains strong in their support for SCHIP. We haven’t done anything to benefits or eligibility for children. We will increase premiums on July 1, but that is all.” Another state wrote: “We have no indications of any cutbacks in benefits or eligibility.” Other states noted that proposals were being considered for changes such as adding copays, adding eligibility documentation requirements, or adding a case management component for the highest cost children. Several states noted that budget shortfalls continue in their states, so future funding will continue to be a challenge.

Summary and Conclusion

The year 2003 marked a turning point for enrollment in the State Children’s Health Insurance Program, as enrollment of children in SCHIP declined during the last half of calendar year 2003 for the first time since enactment of SCHIP in 1997. Enrollment reached a total of almost 4 million children in June of 2003, but then decreased from this peak, resulting in large part from significant decreases in Texas, New York and Maryland. Large increases in enrollment continued in states such as California, Florida, Georgia, Illinois, Louisiana, North Carolina, Pennsylvania and Virginia, and smaller programs in states such as Hawaii, Iowa, Nebraska and Washington experienced large percentage increases. Although 37 states saw an increase in enrollment from June 2003 to December 2003, the increases were offset by declines in enrollment in 11 states and the District of Columbia.

While states have used SCHIP as an effective way to expand health coverage for low-income children, fiscal pressures over the past two years have meant many

states have scaled back their focus on SCHIP outreach and enrollment. While some SCHIP enrollment declines can be credited to properly transferring children to Medicaid when they are eligible, there were also state actions to cut eligibility, raise copays and premiums, and institute administrative requirements that contributed to enrollment declines. The most significant cuts by far occurred in Texas where over 75,000 children lost coverage in the second half of 2003. In the majority of states, however, the focus remains on assuring, and finding and enrolling low-income, uninsured children.

Data Definitions and Methodology

The data in this report are "point-in-time" data 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 2003. 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 February 2004 and provided in March and April 2004.

The "point-in-time" data in this report differ from the "ever-enrolled" count of enrollees in reports issued by CMS. The most recent annual report from CMS was for federal fiscal year 2003, the year ending in September 2003. CMS reported a total of 5,841,351 children enrolled at any point in time and for any length of time during that year. CMS also reported a total of 5,353,812 children enrolled in the previous year that ended with September 2002. CMS has expanded its data reporting to include enrollment on the last day of each quarter, beginning with federal fiscal year 2003. For the last day of September 2003 the CMS report shows point-in-time enrollment of 3,719,320. (The CMS reports may be found at http://www.cms.hhs.gov/schip/enrollment/.) In contrast, the number of children enrolled in the month of September 2003 per data states provided for this report was 3,944,109. These differences in the point-in-time data in this report compared to those in CMS reports may arise from different days in a month for which data are reported or because in some states data are not yet available to report point-in-time Medicaid expansion SCHIP enrollment for CMS reports. The timeframes for this report allow inclusion of data for all states for all SCHIP components.

Note that the annual count of children ever-enrolled will always exceed the number enrolled at any point in time, as long as there are departures from program enrollment during the year. The greater the departure rate, the greater will be the difference between these two measures of program enrollment. Recent experience is that approximately one-third of SCHIP enrollees leave the program during a year. Both point-in-time and ever-enrolled enrollment counts are useful measures that provide insight into issues of coverage, retention and turnover among SCHIP enrollees over time.

Appendix A: SCHIP Premiums and Enrollment Fees in State Fiscal Year 2004

State	Requires Premiums or Enrollment Fees		Notes
	Yes	*No*	
Alabama	✓		$50 for families from 100-150% FPL, $100 for families 151-200% FPL. Max of 3 per family pay premiums.
Alaska		✓	
Arizona	✓		<150% $0 for children. 150-175% $15 for parents. $10 for one child, $15 for two or more children. 175-200% -- $20 per parent, $20 one child, $25 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	✓		>150% no enrollment fee. 151-185% FPL $25 singled 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	✓		$10, $15, $25 PFPM based upon income.
District of Columbia		✓	
Florida	✓		Monthly household premiums are $15 for families <150% FPL, and $20 for families <150% FPL.
Georgia	✓		Children ages 0-5: free; ages 6+ $10 PMPM. $15 PFPM at or below 150% FPL, $20 PFPM 151-235%FPL for SFY 2004.
Hawaii		✓	
Idaho		✓	
Illinois	✓		Children with income greater than or equal to 150% FPL.
Indiana	✓		$11-$16.50 per month 150-175% FPL, $16.50-$24.75 for 175-200% FPL.
Iowa	✓		$10 per child per month up to $20 per family (more than one child) per month.
Kansas	✓		$20 per month per family for families with income between 151-175% of FPL, $30 per month per family for families 176-200% FPL
Kentucky	✓		$20 Per Family Per Month starting November 1, 2003.
Louisiana		✓	
Maine	✓		The premium for stand-alone enrollees increased 5%, $5-$40 per month depending upon family size and income.
Maryland	✓		$37 PFPM 185-200% FPL; $40 PFPM 200-250% FPL; $50 PFPM 250-300% FPL.

State	Requires Premiums or Enrollment Fees		Notes
	Yes	*No*	
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	✓		For 226-300% FPL, $59-$225 depending upon income and family size.
Montana		✓	
Nebraska		✓	
Nevada	✓		Based upon family size and income: $15 for 100-150% FPL; $35 for 151-175% FPL; $70 for 176-200% FPL.
New Hampshire	✓		$25 per child per month for 185-250% FPL with a $100 max per month and $45 per child per month for 250-300% FPL with a $135 max per month.
New Jersey	✓		Family premium is $16.50 below 250%; $33 for 250-299%; $66 for 300-349%; $110 for above 350%.
New Mexico		✓	
New York		✓	
North Carolina	✓		Changed co-pays on prescription drugs only. Formerly $6 per drug for those over 150% FPL. Added for those below 150% FPL $1 for generic, $1 for brand with no generic alternative and $10 for brand.
North Dakota		✓	
Ohio		✓	
Oklahoma		✓	
Oregon		✓	
Pennsylvania	✓		$0 premium for children in families with incomes less than 200% FPL. Average of $62.38 per child per month for 200-235% FPL.
Rhode Island	✓		$61 PFPM 150-185% FPL; $77 PFPM for 185-200% FPL; $92 PFPM 200-250% FPL
South Carolina		✓	
South Dakota		✓	
Tennessee		✓	
Texas	✓		Sliding scale based upon income.
Utah	✓		>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		✓	

State	Requires Premiums or Enrollment Fees		Notes
	Yes	*No*	
Washington		✓	
West Virginia		✓	
Wisconsin	✓		5% of income for those at or above 150% of FPL.
Wyoming		✓	

Note: Information in this table was provided by state SCHIP officials in March 2004 in response to the survey question: "Do You Require Premiums or Enrollment Fees in FY 2004?"

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