The State Children's Health Insurance Program
Annual Enrollment Report
October 1, 1998 - September 30, 1999

Executive Summary

Assuring health insurance to vulnerable Americans has been a long-standing goal of President Clinton and Congress. The State Children's Health Insurance Program (SCHIP) was created in the bi-partisan Balanced Budget Act of 1997 (the BBA), appropriating $24 billion over five years and $40 billion over ten years to help States expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private health insurance. SCHIP, the single largest expansion of health insurance coverage for children since the enactment of Medicaid, has presented an historic opportunity to reduce the number of uninsured children in the United States. According to Census Bureau data, 11 million American children -- about one in seven -- are uninsured and therefore at significantly increased risk for preventable health problems.

States have enthusiastically responded to SCHIP. Together with the federal government, States are using this opportunity to increase the number of children with health insurance coverage and improve children's access to quality health care services. In addition to expanding the number of children who are eligible for coverage, States are adopting new and creative ways to reach and enroll children who may be eligible for the new expanded coverage, as well as children who are eligible for Medicaid but not enrolled—strategies such as simplifying application procedures, making applications available at a range of community sites, and promoting enrollment through school lunch applications and at back-to-school events. The federal government is encouraging State innovation and outreach, and promoting family-friendly enrollment procedures. In addition, working with the National Governors' Association, the Administration has sponsored a national, toll-free hotline, 1-877-KIDS NOW, to connect parents directly to the appropriate State agency handling SCHIP and Medicaid.

The SCHIP law offers States three options for covering uninsured children. States can use SCHIP funds to provide coverage through separate children's health insurance programs, expand coverage available under Medicaid, or combine both strategies. As of January 1, 2000, each of the States and Territories had an approved SCHIP plan in place, and an additional 37 amendments to those plans have also been approved. According to State-reported data:

- Nearly two million children were enrolled in SCHIP between October 1, 1998 and September 30, 1999 (Federal Fiscal Year 1999).

- Through the 53 programs in operation during this period, over 1.2 million children were served by separate programs, and almost 700,000 children were served by Medicaid expansions.

- Although reporting systems were not fully in place for all States in December 1998, it appears that the number of children served by SCHIP has nearly doubled from the December 1998 estimates.

These findings reflect the early implementation experience of most States. SCHIP enrollment has grown since these data were reported by the States and will continue to grow as States expand their programs, conduct effective outreach, streamline the application process, and improve procedures to assure that children retain coverage for as long as they are eligible.

In addition, one of the intended goals of SCHIP is to identify and enroll children already eligible for Medicaid but not enrolled. Although there are no data on the number of children who have been enrolled in Medicaid as a result of SCHIP-related initiatives, many States report that SCHIP-related outreach and simplified and coordinated eligibility processes have led to enrollment of a significant number of Medicaid-eligible children.

This report reviews SCHIP enrollment data for all States participating in SCHIP during Fiscal Year 1999 (FY 1999), which began on October 1, 1998, and ended September 30, 1999. It is the first in a series of reports by the Department of Health and Human Services (HHS) on SCHIP and Medicaid enrollment, reviewing State and federal progress toward providing health coverage to previously uninsured children. State-by-State enrollment data for this time period is provided in Table 1.

Progress on SCHIP Implementation

State Plan Approvals

On January 30, 1998, the State of Alabama's Medicaid expansion program became the first approved SCHIP plan; the approval of the first separate SCHIP plan, from the State of Colorado, followed on February 18, 1998. Since then, a great deal of progress has been made:

- By September 30, 1999, SCHIP plans had been approved for all 56 States, Territories and the District of Columbia. States have received approval for 15 separate programs, 27 Medicaid expansion programs and 14 combination programs.

- Since September 30, 1999, three more States have received approval for separate program expansions that now make them combination programs. In light of these recent approvals, as of January 1, 2000, there were 15 separate programs, 24 Medicaid expansions, and 17 combination programs.

Implementation

Plan approval allows States to begin to use SCHIP funds to enroll children into coverage. The number of States enrolling children under approved plans has grown over the past year. At the beginning of FY 1999, 39 States and Territories had implemented SCHIP. One year later, 53 programs were implemented. As of October 1, 1999, only Hawaii, Washington and Wyoming had not yet begun enrolling children in SCHIP.

The scope of coverage offered under SCHIP is also evolving. Many States initially adopted modest expansions of coverage under SCHIP and then proposed further expansions of coverage through SCHIP plan amendments. Of the 43 amendments submitted as of September 30, 1999, 23 of these amendments proposed to expand eligibility to children in families with higher income levels.

- In March 1997, before the enactment of SCHIP, four States covered all children with family incomes up to at least 200 percent of the Federal Poverty Level (FPL) in their Medicaid programs.[1]

- As of January 1, 2000, 30 States had approved plans to cover children with incomes up to at least 200 percent of the FPL. Five of these States (Connecticut, Missouri, New Hampshire, Rhode Island and Vermont) have plans approved to cover children in families with incomes up to 300 percent of the FPL and New Jersey is covering children in families with incomes up to 350 percent of the FPL.[2]

It is important to note that the enrollment data in this report reflect enrollment up through September 30, 1999. These data, therefore, do not show the number of children enrolled since October 1, 1999 and the data also do not include States' expansions to higher levels of poverty approved after September 30, 1999. For example, Texas' amendment to expand coverage to children with family incomes up to 200 percent of the FPL was approved in November 1999 but the expansion will not be implemented until later in 2000. Similarly, Indiana, Kentucky, North Dakota and Mississippi have expansions approved that will be implemented later this year.

State Data Reporting Requirements and Evaluation

In designing SCHIP, Congress and the Administration included strong accountability measures for States and the federal government. Title XXI of the Social Security Act, which created SCHIP, requires performance measurement, evaluation, and the collection and analysis of data that are critical to understanding the impact of SCHIP on children's coverage, access to care, and use of health care services.[3]

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[1] The four States are Minnesota, Vermont, Washington and Tennessee. Under its section 1115 Medicaid demonstration, Tennessee has no upper eligibility limit.

[2] SCHIP eligibility is generally limited to "targeted low-income children," defined in section 2110 of title XXI as a child whose family income exceeds the Medicaid applicable income level, but not by more than 50 percent or whose family income is at or below 200 percent of the federal poverty line, whichever is higher. States have broad flexibility under the federal SCHIP law to provide coverage to children at higher income levels through the use of income disregards.

[3] Sections 2107 and 2108 of title XXI of the Social Security Act.

State Reports

In order to assess progress in covering uninsured children, States are required to provide statistical and financial reports. States report on the number of children under 19 years of age who are enrolled in separate SCHIP and Medicaid SCHIP expansion programs, as well as in the regular Medicaid program, by age, family income and service delivery categories.[4] In addition, States annually report an unduplicated count of the number of children served over the course of the year.

While States have noted some challenges in meeting these reporting requirements, particularly in light of the need for Y2K and necessary system changes, most States are now reporting as required. As of December 1999, 35 out of 48 States reported their FY 1999 SCHIP data for all quarters, as required.[5]

States are also required to report their regular Medicaid enrollment for children as part of their SCHIP data reporting requirements; however, fewer States have met this requirement. As of January 1, 2000, 26 out of 48 States reported both their required SCHIP data and their regular Medicaid data for all quarters of FY 1999, as required. Regular Medicaid enrollment data for children based on these reports will be available when more State data are submitted and reviewed.

SCHIP Evaluations and the Report to Congress

Title XXI also requires States to assess the operation of their State plans and to report to the Secretary annually on their progress in reducing the number of uninsured, low-

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[4] States report on family income in relation to the poverty level, using State definitions of family income and family size. Delivery systems include fee-for-service, managed care arrangements, and primary care case management. These data are being reviewed as a part of the national SCHIP evaluation.

[5] Only those States that have implemented their programs are required to submit statistical data. Therefore, Washington, Hawaii, and Wyoming are not yet required to report. Puerto Rico and the Territories have not been included in the count of States that must report or that have reported. In this discussion, "States" includes the District of Columbia but does not include the Territories.

income children. In addition, by March 31, 2000, each State is required to submit an evaluation that includes the following:[6]

- An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage;
- An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable health coverage for children;
- A description and analysis of the characteristics of children and families served by SCHIP, including children's access to other health insurance coverage prior and subsequent to their coverage under the State SCHIP plan;
- A description and analysis of the effectiveness of service areas, time limits for coverage, types of benefits, and quality of health coverage under the State plan;
- A review and assessment of State activities to coordinate SCHIP with other health care and health care financing programs;
- An analysis of trends in the State that affect the access, affordability and quality of health care and health care coverage provided to children;
- A description of any State plans for improving the availability of children's coverage and health care; and
- Recommendations for improving SCHIP.

These evaluations are to be used by the Secretary of the Department of HHS to prepare a Report to Congress by December 31, 2001. That report will provide an overview of State programs, document achievements and ongoing challenges, and identify best practices in areas such as outreach and streamlined enrollment and reenrollment. HCFA has awarded a five-year contract to Mathematica Policy Research to prepare background information for the Report to Congress, including a

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[6] Section 2108(b) of Title XXI of the Social Security Act.

synthesis of State annual reports, State evaluations, and statistical data; a review of external studies of SCHIP; and an assessment of SCHIP in important areas such as outreach and enrollment, as well as access to, and quality of, health coverage.

In addition, the Balanced Budget Refinement Act of 1999 recently directed the Secretary of HHS to conduct a new $10 million federal evaluation of SCHIP using a sample of ten States. The evaluation will include surveys of the target population, an assessment of the effectiveness of different outreach strategies, a review of the coordination between SCHIP and Medicaid programs, an analysis of the effects of cost-sharing requirements and an evaluation of retention issues. This new report is also due to Congress on December 31, 2001.

Interpreting the Enrollment Data

The SCHIP data reported in Table 1 are based on enrollment data under the 53 plans that were implemented on or before the close of FY 1999.[7] These data represent the unduplicated number of children ever enrolled in FY 1999, showing how many children were enrolled at any time during the fiscal year. This is a useful way to identify the number of children helped by SCHIP because it counts all the children that received SCHIP-funded coverage during the year. Each child is counted only once, no matter how many times a child may have been enrolled in FY 1999. Since these data show the total number of children ever enrolled during the year, these enrollment numbers generally will be higher than the number of children enrolled in SCHIP at any given point during the year.

Except as described below, these data were reported by the States to the Health Care Financing Administration (line #6 on HCFA forms 21-E and 64.21E). Most, but not all, States have submitted the full complement of reporting data for SCHIP for this past fiscal year. Therefore, in order to provide enrollment data for all States that implemented SCHIP in FY 1999, this report includes State-estimated enrollment data for ten States (AL, KY, MN, NM, NC, NY, OK, SC, TN, VT). Together, the estimated enrollment for these States accounts for less than 10 percent (193,000) of the nearly two million children enrolled in SCHIP during the fiscal year.[8]

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[7] Enrollment data for FY 1999 were not required for three States, Hawaii, Washington and Wyoming, because their plans were not in operation during FY 1999.

[8] Some States, such as New York, submitted SCHIP enrollment data for its separate program but estimated the number of SCHIP-funded children enrolled in Medicaid.

These enrollment data begin to tell us how well SCHIP is meeting its intended objectives. As more data on SCHIP and Medicaid enrollment become available, more will be learned about trends, State performance, and the impact of SCHIP on the number of uninsured children.

When interpreting these data, it is important to note some of the factors that will affect a State's SCHIP enrollment, particularly at this stage in the implementation of SCHIP.

- ***What is the income range of children covered by SCHIP?***

Some States use SCHIP to cover a broader group of children than other States. The breadth of the SCHIP-funded coverage in a State depends *both* on the upper and the lower eligibility boundaries of the State's SCHIP-funded coverage. Table 2 shows that the current upper income limits for SCHIP-approved plans range between 100 percent and 350 percent of the FPL.[9]

Since SCHIP funds may only be used to cover previously uninsured children, States cannot use SCHIP funds to cover children who would have been eligible under the standards in effect for their Medicaid programs as of March 1997. Thus, the

Medicaid income standards in place in each State as of March 1997 establish the lower boundary for that State's SCHIP-funded coverage. Table 2 shows the lower boundary of the SCHIP-covered group for each State and indicates that there was considerable variation across States with respect to this lower boundary.[10]

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[9] The upper income levels of SCHIP coverage do not necessarily reflect the upper income limits of a State's publicly-funded coverage for children. In part because of section 1115 demonstration programs, some States have expanded coverage for children under Medicaid but SCHIP funds are only used for a limited part of this coverage. Other States may offer State-funded coverage to higher income children. In addition, while most states do not consider assets when establishing eligibility for SCHIP, in some States the range of children covered by SCHIP will depend on the asset limit applied in Medicaid and in their separate SCHIP program.

[10] It should be noted that the upper and lower boundaries of SCHIP coverage may mix net income standards with gross income standards. For most States, the Medicaid income standards are net standards; that is, they are the income standards used by States to determine eligibility for children *after* deductions and exclusions from income are taken into account. In contrast, under the federal SCHIP law, the income standards for separate SCHIP programs may be either gross income standards

An example may help illustrate the importance of looking at both the upper and lower eligibility boundaries of a State's SCHIP coverage. Alabama and Georgia have used SCHIP funds to cover children with family incomes up to 200 percent of the FPL. However, because Alabama's Medicaid income eligibility standards were lower than Georgia's in March 1997 for some of its children, the breadth of Alabama's SCHIP-funded coverage is greater than Georgia's. Georgia had previously expanded coverage under Medicaid for some of its children, so its SCHIP-funded coverage for those children begins at higher income levels than Alabama's SCHIP-funded coverage.

- ***How many uninsured children are eligible for SCHIP-funded coverage in a State?***

Enrollment also will vary depending on the number of uninsured children residing in the State whose family income falls within the income group covered by SCHIP in that State. For example, Kansas and Michigan each use SCHIP funds to cover children with incomes up to 200 percent of the federal poverty line. Kansas has enrolled 14,400 children and Michigan has enrolled 26,700 children, but Michigan has many more low-income uninsured children than Kansas. Thus, differences in enrollment numbers may be explained in part by the disparity in the size of States' populations of low-income uninsured children.

- ***How long have States been enrolling children in SCHIP?***

As discussed in the program implementation section of this report, the implementation of SCHIP is still evolving; States have been enrolling children in SCHIP for different lengths of time. While this report provides enrollment data for all States that had a program in operation during FY 1999, not all States had programs in effect during the entire fiscal year.

- Sixteen of the 24 programs in States and Territories with Medicaid expansions were in operation for the full fiscal year, while seven of the

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or net income standards. The reporting forms ask States to identify their method for computing income, but not all States have reported this information.

15 programs in States with separate SCHIP programs were implemented for the full year.

- In the 17 States with combination programs, the Medicaid expansion portion of the program was implemented for the entire fiscal year in 16 States and the separate program was implemented for a full year in nine of those States.

The implementation dates for States' initial SCHIP plans are noted in Table 1.

Additionally, some States had been enrolling children in SCHIP for several months prior to the start of FY 1999; and three States -- New York, Pennsylvania and Florida -- had created State-funded separate child health programs in operation prior to the enactment of SCHIP.

- ***Do families with eligible children know about the availability of health care coverage through Medicaid and SCHIP and can they enroll their children into coverage without difficulty or delay?***

The offer of health care coverage alone is not sufficient to assure robust enrollment. Studies show that millions of uninsured children have been eligible for Medicaid but are not enrolled. This underscores the need for outreach as well as simple, family-friendly enrollment procedures. The implementation of SCHIP has significantly increased the range of activities and the level of commitment to outreach and program simplification under Medicaid and SCHIP.
Every State is now engaged in some kind of outreach effort, and in many communities there are multiple, complementary strategies ongoing to inform families about the availability of SCHIP and Medicaid. Most States are involving community-based organizations, schools and health providers in their outreach campaigns, and some States are providing grants to counties and local organizations to fund these outreach efforts. Federal, State, local and private funds have all been used to conduct outreach and to promote enrollment among eligible children. Ongoing coordinated efforts are needed to find and enroll eligible children in Medicaid and SCHIP-funded expansions.

The Administration is committed to providing leadership to sustain and enhance these outreach efforts. In a February 1998, Executive Memorandum, President Clinton asked eight federal departments to work together to develop ways to educate families and enroll children in Medicaid and SCHIP. This Interagency Taskforce on

Children's Health Insurance Outreach is led by the Department of HHS and includes other federal departments and agencies, as well as private sector organizations that serve children who are potentially eligible for coverage. Among other efforts, in February 1999, the Administration, along with the National Governors' Association, launched the Insure Kids Now campaign. The campaign includes:

- A national toll-free number (1-877-KIDS NOW) to refer families to information about Medicaid and SCHIP programs in their State; and

- The **insurekidsnow.gov** web site**,** which offers State-specific eligibility information and examples of successful outreach efforts for use by States, community-based organizations and other interested parties.

In addition, SCHIP has focused federal and State attention on the importance of simplifying application procedures. Lengthy and confusing application forms, requests for multiple documents, and in-person interviews at welfare offices have all been shown to create barriers to coverage and dampen progress toward the goal of decreasing the number of uninsured children.

In general, States have sought to avoid imposing burdensome application procedures in their new separate SCHIP programs, and virtually all States have taken steps to reduce these barriers in their Medicaid programs as well, although more work in this area needs to be done. The Administration has encouraged the use of streamlined enrollment procedures through guidance and technical assistance to States. For example, in September 1998, HCFA prepared and distributed a model shortened application that could be used to apply for both SCHIP and traditional Medicaid coverage. While there are no data correlating the ease of the application process with enrollment numbers, it is generally agreed that simplified, streamlined and non-stigmatizing procedures promote enrollment among eligible children.

- ***Will SCHIP accomplish the goal of reducing the number of uninsured children?***

In addition to the factors that affect these enrollment numbers, other factors will affect the extent to which new federal and State initiatives result in fewer children lacking health insurance coverage. For example, more study needs to be done to determine whether expansions of publicly-funded coverage are contributing to declines in private coverage. States are looking at this issue as part of the annual evaluation.

Another area that is receiving increased attention is the issue of retention of coverage. These enrollment data report the number of children ever enrolled in SCHIP in FY 1999, but do not report on disenrollments or indicate the time period during which a child was enrolled in SCHIP. (States are required to collect data on disenrollments in SCHIP, and these data will be available in later reports released by the Department.) There is evidence of considerable "churning" in the Medicaid program; that is, children moving in and out of Medicaid coverage. Frequent changes in coverage also occur in the private sector when children move in and out of group health coverage as their parents' employment status changes.

One way to reduce unnecessary churning in SCHIP and Medicaid is to assure that eligible children do not lose coverage due to burdensome redetermination procedures. Many States have begun to carry over to the redetermination process the strategies they have used to simplify the application process. In addition, according to States' SCHIP plans, 23 States offer children 12 months of continuous eligibility in their separate SCHIP programs (including the separate portion of combination programs), and, according to a recent survey of States, 15 States provide 12-month continuous coverage to children in Medicaid.[11]

Medicaid participation rates will also have a significant impact on the number of children who lack health insurance. Many States have anecdotally reported that they are enrolling more children in regular Medicaid because their outreach and coordination procedures, as well as their efforts to simplify enrollment, have had the effect of promoting enrollment among children who have been eligible for Medicaid but have not been enrolled. Although it is difficult for States to accurately measure this "woodwork" effect, in part because there are many factors influencing Medicaid enrollment among children, it is clear that in many States SCHIP is having a positive impact on regular Medicaid enrollment.

Conclusion

The SCHIP enrollment data for fiscal year 1999 show that SCHIP is making a significant contribution toward the goal of reducing the number of uninsured children in the United States. Nearly two million children were served by SCHIP between October 1, 1998, and September 30, 1999. Close to 700,000 children were served by State expansions of existing Medicaid programs and over 1.2 million children have

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[11] Medicaid data compiled by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. (December 15, 1999).

been covered through separate SCHIP-funded child health programs. It appears that the number of children served by SCHIP has nearly doubled from a year ago.

Furthermore, as SCHIP programs continue to expand and mature, it is likely that enrollment will continue to grow. This report is the first in a series of releases on SCHIP and Medicaid program implementation that will rely primarily on State-generated data to provide Congress, the States, and the public with the information needed to evaluate SCHIP and to consider how to continue to move the nation closer to the goal of assuring that all children have access to quality, affordable health care.

Table 1 -- State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for FY 1999

STATE	Type of SCHIP Program	Date Implemented 1\	Upper Eligibility 2\	State Reported FY '99 SCHIP Enrollment 3\ (Total children ever served in FY 99) Separate Program	Medicaid Expansion	FY 1999 Total SCHIP Enrollment
TOTAL: 56 PLANS				1,284,387	695,063	
Alabama 4\	Combo	02/01/98	200%	25,738	13,242	38,980
Alaska	Medicaid	03/01/99	200%		8,033	8,033
American Samoa ~	Medicaid	04/01/99	Not Applicable			0
Arizona	Separate	11/01/98	200%	26,807		26,807
Arkansas	Medicaid	10/01/98	100%		913	913
California	Combo	03/01/98	250%	187,854	34,497	222,351
Colorado	Separate	04/22/98	185%	24,116		24,116
CNMI ~ +	Medicaid	10/01/97	Not Applicable			0
Connecticut	Combo	07/01/98	300%	5,277	4,635	9,912
Delaware	Separate	02/01/99	200%	2,433		2,433
District of Colombia	Medicaid	10/01/98	200%		3,029	3,029
Florida #	Combo	04/01/98	200%	116,123	38,471	154,594
Georgia	Separate	11/01/98	200%	47,581		47,581
Guam ~ +	Medicaid	10/01/97	Not Applicable			0
Hawaii ^	Medicaid	07/01/00	185%		N/I	N/I
Idaho	Medicaid	10/01/97	150%		8,482	8,482
Illinois 5\	Medicaid	01/05/98	133%	7,567	35,132	42,699
Indiana ^	Combo	10/01/97	200%	N/I	31,246	31,246
Iowa	Combo	07/01/98	185%	2,694	7,101	9,795
Kansas	Separate	01/01/99	200%	14,443		14,443
Kentucky ** ^	Combo	07/01/98	200%	N/I	18,579	18,579
Louisiana	Medicaid	11/01/98	150%		21,580	21,580
Maine	Combo	07/01/98	185%	3,786	9,871	13,657
Maryland	Medicaid	07/01/98	200%		18,072	18,072
Massachusetts	Combo	10/01/97	200%	24,408	43,444	67,852
Michigan	Combo	05/01/98	200%	14,825	11,827	26,652
Minnesota **	Medicaid	10/01/98	280%		21	21
Mississippi ^	Combo	07/01/98	200%	N/I	13,218	13,218
Missouri	Medicaid	09/01/98	300%		49,529	49,529
Montana	Separate	01/01/99	150%	1,019		1,019
Nebraska	Medicaid	05/01/98	185%		9,713	9,713
Nevada	Separate	10/01/98	200%	7,802		7,802
New Hampshire	Combo	05/01/98	300%	3,700	854	4,554
New Jersey	Combo	03/01/98	350%	43,824	31,828	75,652
New Mexico**	Medicaid	03/31/99	235%		4,500	4,500
New York # 6\	Combo	04/15/98	192%	519,401	1,900	521,301
North Carolina **	Separate	10/01/98	200%	57,300		57,300
North Dakota ^	Combo	10/01/98	140%	N/I	266	266
Ohio	Medicaid	01/01/98	150%		83,688	83,688
Oklahoma**	Medicaid	12/01/97	185%		40,196	40,196
Oregon	Separate	07/01/98	170%	27,285		27,285
Pennsylvania #	Separate	05/28/98	200%	81,758		81,758
Puerto Rico 7\	Medicaid	01/01/98	200%		20,000	20,000
Rhode Island 8\	Medicaid	10/01/97	300%		7,288	7,288
South Carolina 9\	Medicaid	10/01/97	150%		45,737	45,737
South Dakota	Medicaid	07/01/98	140%		3,191	3,191
Tennessee**	Medicaid	10/01/97	100%		9,732	9,732
Texas ^	Combo	07/01/98	200%	N/I	50,878	50,878
Utah 10\	Separate	08/03/98	200%	13,040		13,040
Vermont**	Separate	10/01/98	300%	2,055		2,055
Virgin Islands ~ 11\	Medicaid	04/01/98	Not Applicable		120	120
Virginia	Separate	10/22/98	185%	16,895		16,895
Washington ^	Separate	02/01/00	250%	N/I		N/I
West Virginia	Combo	07/01/98	150%	6,656	1,301	7,957
Wisconsin	Medicaid	04/01/99	185%		12,949	12,949
Wyoming ^	Separate	12/01/99	133%	N/I		N/I

Table 1 -- Notes

1999 Caveats and Data Limitations:

(Note: FY 1999 enrollment statistics reflect unedited, unduplicated data as submitted by States to HCFA)

1\ Implementation date of the initial SCHIP plan as reported by States. In some States the initial SCHIP plan involved a modest expansion of coverage and was followed by a plan amendment to further expand coverage. As of January 1, 2000, there are 37 States with approved amendments, and another 13 States have pending State plan amendments.

2\ Reflects upper eligibility level of SCHIP plans and amendments approved as of January 1, 2000. Upper eligibility is defined as a percent of the Federal poverty level (FPL). In 1999, FPL was $16,700 for a family of 4. In general, States with Medicaid expansion SCHIP programs must establish their upper eligibility levels net of income disregards. States with separate SCHIP programs can establish their upper eligibility levels on a gross income basis or net of income disregards. Puerto Rico defines the upper eligibility limit as 200 percent of Puerto Rico's poverty level.

3\ State reported enrollment in FY 1999 reflects formal State quarterly electronic statistical data submissions and estimates by States in cases where electronic State quarterly data submissions were not available.

4\ Alabama's enrollment for Medicaid expansion SCHIP is estimated.

5\ Illinois is covering children under its proposed separate SCHIP program; although the amendment is pending.

6\ New York's enrollment for Medicaid expansion SCHIP is estimated.

7\ Puerto Rico's SCHIP allotment funded 20,000 children; another 44,324 children were funded with Territorial funds.

8\ Rhode Island has implemented their program to 250 percent FPL. In addition, Rhode Island has an approved amendment (February 5, 1999) to further expand the program to 300 percent FPL.

9\ South Carolina's enrollment for SCHIP reflects estimated enrollment from October 1998 - July 1999.

10\ Utah SCHIP enrollment for FY1999 reflects the total number of children ever enrolled in the fourth quarter.

11\ Virgin Island's SCHIP enrollment reflects the number of children for which health care claims were paid during the period from July 1998 through April 1999.

^ These States have plans or amendments approved, but these programs were not implemented as of September 30, 1999. Therefore, the enrollment counts do not correspond fully to the upper eligibility levels reported in this table since these eligibility levels reflect plans and plan amendments approved as of January 1, 2000.

** State reported SCHIP enrollment is estimated.

N/I "Not Implemented" denotes States with approved SCHIP plans or amendments with implementation dates after FY 1999.

~ Due to the unique nature of their SCHIP plans, these U.S. Territories and Jurisdictions may cover existing Medicaid populations with SCHIP funds, but only after their Medicaid funding caps are reached.

+ Guam and the Commonwealth of the Northern Mariana Islands (CNMI) did not exceed their Medicaid funding caps, and therefore could not claim any SCHIP funding in FY 1999.

Florida, New York and Pennsylvania had State-funded programs prior to SCHIP. Title XXI permitted children previously in the State-funded program to be covered under SCHIP and requires these

States to maintain at least the previous levels of spending.

Table 2: Eligibility Standards in States with Approved Title XXI Plans
(By Percentage of the Federal Poverty Level)

State (1)	**Medicaid standards in effect 3/31/97** (2) (lower income boundary for SCHIP)				**Medicaid SCHIP - Expansion Approved as of 01/01/00**	**Separate SCHIP Program Approved as of 01/01/00** (3)
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
Alabama	**133%**	**133%**	**100%**	**15%**	**100%**	**200%**
Alaska	**133%**	**133%**	**100%**	**100%**	**200%**	**n/a**
Arizona	**140%**	**133%**	**100%**	**30%**	**n/a**	**200%**
Arkansas (4)	**133%**	**133%**	**100%**	**18%**	**100% (born after 9/3/82 and before 10/1/83)**	**n/a**
California	**200%**	**133%**	**100%**	**82%**	**100%**	**250%**
Colorado	**133%**	**133%**	**100%**	**37%**	**n/a**	**185%**
Connecticut	**185%**	**185%**	**185%**	**100%**	**185%**	**300%**
Delaware	**133%**	**133%**	**100%**	**100%**	**n/a**	**200%**
District of Columbia	**185%**	**133%**	**100%**	**50%**	**200%**	**n/a**
Florida (5)	**185%**	**133%**	**100%**	**28%**	**100%**	**200%**
Georgia	**185%**	**133%**	**100%**	**100%**	**n/a**	**200%**
Hawaii	**185%**	**133%**	**100%**	**100%**	**185% (ages 1 thru 5) (7)**	**n/a**
Idaho	**133%**	**133%**	**100%**	**100%**	**150%**	**n/a**
Illinois	**133%**	**133%**	**100%**	**46%**	**133%**	**n/a**
Indiana	**150%**	**133%**	**100%**	**100%**	**150%**	**200% (7)**
Iowa	**185%**	**133%**	**100%**	**37%**	**133%**	**185%**
Kansas	**150%**	**133%**	**100%**	**100%**	**n/a**	**200%**
Kentucky	**185%**	**133%**	**100%**	**33%**	**150%**	**200% (7)**
Louisiana	**133%**	**133%**	**100%**	**10%**	**150%**	**n/a**
Maine	**185%**	**133%**	**125%**	**125%**	**150%**	**185%**
Maryland	**185%**	**185%**	**185%**	**100%**	**200%**	**n/a**
Massachusetts	**185%**	**133%**	**114%**	**86%**	**150%**	**200%**
Michigan	**185%**	**133%**	**100%**	**100%**	**150%**	**200%**
Minnesota	**275%**	**275%**	**275%**	**275%**	**280% (below age 2)**	**n/a**
Mississippi	**185%**	**133%**	**100%**	**34%**	**100%**	**200% (7)**
Missouri	**185%**	**133%**	**100%**	**100%**	**300%**	**n/a**
Montana	**133%**	**133%**	**100%**	**40.5%**	**n/a**	**150%**
Nebraska	**150%**	**133%**	**100%**	**33%**	**185%**	**n/a**

State (1)	Medicaid standards in effect 3/31/97 (2) (lower income boundary for SCHIP)				Medicaid SCHIP - Expansion Approved as of 01/01/00	Separate SCHIP Program Approved as of 01/01/00 (3)
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
Nevada	**133%**	**133%**	**100%**	**31%**	**n/a**	**200%**
New Hampshire	**185%**	**185%**	**185%**	**185%**	**300% (ages 0- 1)**	**300% (ages 1 thru 18)**
New Jersey	**185%**	**133%**	**100%**	**41%**	**133%**	**350%**
New Mexico	**185%**	**185%**	**185%**	**185%**	**235%**	**n/a**
New York (5)	**185%**	**133%**	**100%**	**51%**	**100%**	**192%**
North Carolina	**185%**	**133%**	**100%**	**100%**	**n/a**	**200%**
North Dakota	**133%**	**133%**	**100%**	**100% (thru age 17)**	**100% (18 year olds)**	**140%**
Ohio	**133%**	**133%**	**100%**	**33%**	**150%**	**n/a**
Oklahoma	**150%**	**133%**	**100%**	**48%**	**185% (thru age 17)**	**n/a**
Oregon	**133%**	**133%**	**100%**	**100%**	**n/a**	**170%**
Pennsylvania (5)	**185%**	**133%**	**100%**	**41%**	**n/a**	**200%**
Rhode Island	**250%**	**250% (thru age 7)**	**100% (ages 8 thru 14)**	**100%**	**300%(8)**	**n/a**
South Carolina	**185%**	**133%**	**100%**	**48%**	**150%**	**n/a**
South Dakota	**133%**	**133%**	**100%**	**100%**	**140%**	**n/a**
Tennessee (6)	**---**	**---**	**---**	**16%**	**100%**	**n/a**
Texas	**185%**	**133%**	**100%**	**17%**	**100%**	**200% (7)**
Utah	**133%**	**133%**	**100%**	**100% (thru age 17)**	**n/a**	**200%**
Vermont	**225%**	**225%**	**225%**	**225%**	**n/a**	**300%**
Virginia	**133%**	**133%**	**100%**	**100%**	**n/a**	**185%**
Washington	**200%**	**200%**	**200%**	**200%**	**n/a**	**250% (7)**
West Virginia	**150%**	**133%**	**100%**	**100%**	**150% (ages 1 thru 5)**	**150% (ages 6 thru 18)**
Wisconsin	**185%**	**185%**	**100%**	**45%**	**185%**	**n/a**
Wyoming	**133%**	**133%**	**100%**	**55%**	**n/a**	**133%**

Table 2 -- Notes

1\ The Territories are not included in this table. Due to the unique nature of their SCHIP plans, the U.S. Territories and jurisdictions may cover existing Medicaid populations with SCHIP funds, but only after their Medicaid funding caps are reached.

2\ Title XXI contains a provision that a child's family income must exceed the Medicaid income level that was in effect on March 31, 1997 in order for that child to be eligible for SCHIP-funded coverage.

3\ Reflects upper eligibility level of SCHIP plans and amendments approved as of January 1, 2000. Upper eligibility is defined as a percent of the Federal Poverty Level (FPL), which, in 1999, is $16,700 for a family of 4. In general, States with Medicaid expansion SCHIP programs must establish their upper eligibility levels net of income disregards. States with separate SCHIP programs can establish their upper eligibility levels on a gross income basis or net of income disregards.

4\ Arkansas increased Medicaid eligibility to 200% FPL effective September 1997 though section 1115 demonstration authority.

5\ These States had state-funded programs that existed prior to SCHIP. Title XXI permitted children previously in these State-funded programs to be covered under SCHIP and requires these States to maintain their previous level of State spending.

6\ Under its section 1115 demonstration, Tennessee has no upper eligibility level. The currently approved title XXI plan covers children born before October 1, 1983 in the expansion group and who enrolled in TennCare on or after April 1, 1997.

7\ Approved but not implemented as of January 1, 2000.

8\ Rhode Island has implemented their program to 250 percent of the FPL. The State also has an approved amendment (February 5, 1999) in place to further expand the program to 300 percent of the FPL.