TESTIMONY OF

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BEFORE THE SENATE FINANCE SUBCOMMITTEE ON HEALTHCARE

HEARING ON

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Chairman Hatch, Senator Rockefeller, distinguished members of the subcommittee, thank you for the opportunity to discuss the State Children's Health Insurance Program (SCHIP). First, I would like to thank Chairman Hatch, Senator Rockefeller, and Senator Kennedy for the leadership they displayed in working to establish the SCHIP program. I also would like to acknowledge the contributions of Sen. Chafee's father, Sen. John Chafee, whose involvement in the SCHIP effort highlighted his dedication and commitment to children's health care needs.

SCHIP Nears 10-Year Anniversary

Next year marks the 10th anniversary of SCHIP, a program that provided health benefits to more than 6.1 million children in FY 2005. Enrollment of children now exceeds original expectations by more than 1 million, and the Administration remains committed to working with States to continue to serve children and families as effectively as possible, and to strengthen efforts to identify and enroll the many eligible but unenrolled children, as the President has made clear through his proposed "Cover the Kids" Initiative. As the Finance Committee works on the reauthorization of this important program, I want to work with you to build on the success of SCHIP.

Created as part of the Balanced Budget Act of 1997 (BBA), SCHIP reflected a bipartisan approach to address the growing number of children without health insurance. SCHIP is a partnership between the Federal and State government with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but cannot afford private coverage. SCHIP is the single largest expansion of

health insurance coverage for children since the initiation of Medicaid. The program provides each State with the flexibility to design its program within broad Federal guidelines in order to best meet the unique needs of the children and families it serves, and the circumstances of health insurance in the State. This flexibility has helped make SCHIP a clear success, because SCHIP took an innovative approach: flexibility for States to find the best way to provide coverage within broad Federal guidelines. SCHIP gives States the ability to adjust the program's coverage to reflect the particular needs and economic circumstances of the populations served, and to use new and creative approaches to provide health insurance coverage effectively.

SCHIP Enrollment Exceeds Original Goals

SCHIP funds became available to the States beginning October 1, 1997, and since then, the Centers for Medicare & Medicaid Services (CMS) has overseen the allocation of the approximately $40 billion the BBA appropriated to the program. As an incentive to expand coverage to reach low-income SCHIP children, the BBA provided States with the opportunity to receive an enhanced Federal matching rate of up to 85 percent for qualifying State SCHIP expenditures.

Enrollment of children in SCHIP programs has increased from 660,000 in FY 1998 to 6.1 million ever-enrolled for FY 2005. When the program began, CMS had estimated enrollment of only 5 million by FY 2005. CMS wants to build on the successful enrollment in SCHIP and is committed to finding and enrolling as many eligible children as possible. The President's proposed "Cover the Kids" initiative would provide $100 million annually for grants to the States, Tribes, schools, and faith-based and community organizations to increase enrollment of children in SCHIP at Medicaid.

CMS also is taking new steps to increase the quality of care in all SCHIP programs. As part of this effort, CMS is working with the States to develop long-term performance measures for SCHIP. CMS also is collaborating with the States to improve how performance measurement data are collected.

SCHIP Provides Coverage to Low-Income Children

SCHIP is designed to provide coverage to "targeted low-income children" and since September 1999 every State, the District of Columbia and all five territories has had a SCHIP plan in place. A "targeted low-income child" is one who resides in a family with income below 200% of the Federal Poverty Level (FPL) or whose family has an income up to 50 percent higher than the State's Medicaid eligibility threshold. Some States have expanded SCHIP eligibility beyond the 200% FPL limit, and others are covering entire families and not just children.

SCHIP provides States (including territories) with three options when designing a program. With their SCHIP allotment, States may expand Medicaid eligibility to children who previously did not qualify for the program (17 States and D.C.); design a children's health insurance program entirely separate from Medicaid (18 States); or, combine both the Medicaid and separate program options (21 States).

Typically, SCHIP benefits are available to uninsured children under age 19 who are not eligible for Medicaid and whose families have incomes below 200 percent of the Federal Poverty Level (FPL). The differences in populations and income levels covered have a significant impact on whether a State's SCHIP allotment is sufficient to cover the costs of its program.

SCHIP eligibility requirements vary by State and are based on the structure of the individual State's program. This flexibility allows States to use its SCHIP funding in the most appropriate way to respond to its unique demographics. Currently, 36 States have eligibility levels up to and including 200 percent of the FPL. An additional 14 States cover children above that level and five of those States set their eligibility up to and including 300 percent of the FPL. New Jersey has the highest eligibility limit and offers SCHIP to children up to 350 percent of the FPL (See Attachment 1).

In a State with a Medicaid expansion program, the requirements of the State Medicaid program apply to its SCHIP plan. There is greater flexibility for States that have

established separate SCHIP programs, including the option of placing certain limitations on enrollments. These States also have the discretion to determine if assets are considered, what income is counted, and whether income disregards are applied to reduce countable income.

When considering an enrollment application for SCHIP, States must have a process in place to screen for Medicaid eligibility and facilitate Medicaid enrollment as appropriate. States also have the discretion to allow for a period of presumptive eligibility during the application and enrollment process.

Another way that SCHIP ensures that only appropriate individuals gain access to the program is through the requirement that a State make sure that low-income individuals are not substituting SCHIP coverage for private, employer-sponsored coverage they previously had. This "crowd-out" requirement prohibits individuals from entering the program if they had employer-sponsored coverage within the past six months. This requirement is particularly meaningful for States covering higher-income SCHIP eligibles, who perhaps could not afford the entire share of the premium for employer-sponsored coverage without SCHIP assistance.

SCHIP Provides States with Flexible Benefit Design Options

While SCHIP is a partnership between the Federal and State governments, States have a high degree of flexibility in designing their programs, particularly those choosing to implement a separate program. Under the law, a State that opts for a Medicaid expansion must provide services under SCHIP that mirror the Medicaid services provided by that State in its State Medicaid Plan. States with a separate child health program have four options for structuring their benefit package: benchmark coverage, benchmark equivalent coverage, existing State-based comprehensive coverage, and Secretary-approved coverage.

Benchmark coverage is a coverage package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option

Service Benefit Plan or a health benefits plan offered by the State to its employees. A health plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the State also is considered benchmark coverage. This option allows States to model their program's coverage on mainstream private coverage, and to coordinate with or subsidize employer coverage rather than financing a separate system.

States that elect to provide benchmark equivalent coverage must provide coverage with an aggregate actuarial value at least equal to one of the benchmark plans. Benefits must include inpatient and outpatient hospital services, physician surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, including age-appropriate immunizations. Plans also must provide at least 75 percent of the actuarial value of coverage under the benchmark plan for prescription drugs, and mental health, vision and hearing services.

The third option applies only to States that offered comprehensive coverage packages before the enactment of SCHIP. New York, Pennsylvania and Florida had existing programs that met SCHIP coverage requirements and therefore were "grandfathered" into the program.

Finally, States may also choose to design their program to best serve their populations, provided the Secretary approves the program design. This option is one of the hallmarks of the flexibility the statute gives States. For example, States may design their program to include the same benefits as the State's Medicaid program. States also may elect to provide coverage under SCHIP that is offered under a SCHIP or Medicaid section 1115 demonstration project. Such coverage may also include coverage that includes benefits in addition to benchmark coverage or coverage that is equivalent to the New York, Florida or Pennsylvania programs.

Regardless of the type of health benefits coverage provided by a State, there are certain services that all States must cover, including coverage for well-baby and well-child care,

immunizations and emergency services. States generally cannot exclude preexisting conditions from coverage. If SCHIP plans provide coverage through group health plans, preexisting condition exclusions must adhere to ERISA rules. States opting for a separate child health program must ensure that coverage provided under the SCHIP program does not substitute for private group health plan coverage. These protections against crowd-out may include a required waiting period without group health plan coverage.

SCHIP Cost-Sharing Requirements

Federal law and regulations restrict the level of cost-sharing States may impose on their SCHIP beneficiaries. For States that opt to expand Medicaid coverage, co-payments are restricted to the levels allowed by the Medicaid program. For States that offer separate SCHIP programs, co-payments, premiums and other cost-sharing mechanisms cannot exceed five percent of the family income for all children in the family. In addition, cost-sharing is not permitted for well-baby, well-child care, immunizations, or preventive dental services. When implementing co-payments, States may not favor higher-income children over children from lower-income families. Additionally, States are prohibited under Federal SCHIP regulations from imposing any charge or cost-sharing requirements on American Indian or Alaskan Native children.

SCHIP Demonstration Process Encourages Innovation

To provide States with the ability to structure their SCHIP plans to improve coverage and the quality of services available to beneficiaries, the Secretary has the authority to waive aspects of the Federal statute and regulations governing SCHIP. This allows States to amend their programs to increase health insurance coverage and encourage innovation. Using section 1115 of the Social Security Act, States can more effectively tailor their programs to meet local needs and can experiment with new approaches to providing health care services. These demonstrations have been used to provide health insurance to uninsured children, parents, caretaker guardians, and pregnant women. For example, CMS recently extended a demonstration in Minnesota that allows the State to use SCHIP funds to provide coverage to those with incomes from 100 to 200 percent of FPL who are parents and relative caretakers of Medicaid- and SCHIP-eligible children. Extending

coverage to parents and caretaker relatives not only serves to cover additional uninsured individuals, but it may also increase the likelihood that they will take the steps necessary to enroll their children. Extending coverage to parents and caretakers may also increase the likelihood that their children remain enrolled in SCHIP. For example, in New Jersey, which covers parents through a section 1115 demonstration, the State found that having one parent enrolled increased the likelihood that a child remains enrolled.

CMS has promoted a relatively new section 1115 approach, the Administration's Health Insurance Flexibility and Accountability (HIFA) demonstrations, to help States to develop comprehensive insurance coverage for individuals with income at or below 200 percent of the FPL using currently available SCHIP and Medicaid funds. These demonstrations target vulnerable, uninsured populations, such as pregnant women, parents and children on Medicaid and SCHIP, and other adult caregiver-relatives. CMS places a particular emphasis on broad statewide approaches that maximize both private health insurance coverage and employer sponsored insurance. As of January 2006, CMS has approved 13 HIFA demonstrations: Arizona, Arkansas, California, Colorado, Idaho, Illinois, Maine, Michigan, New Jersey, New Mexico, Oklahoma, Oregon, and Virginia.

Although the coverage of expansion populations promotes the objectives of SCHIP by providing health insurance coverage to those who were previously uninsured, SCHIP 1115 demonstrations must assure that all necessary SCHIP (title XXI) funds are available for children. Under the demonstrations, States are not permitted to limit or cap children's enrollment, and are required to prioritize the availability of funds for children over funding adult expansion populations.

States are using HIFA demonstrations to offer premium assistance to uninsured individuals who have access to employer-sponsored health plans. This allows the States to cover more people while maximizing the use of limited public resources. Premium assistance helps families afford private coverage and enables families to enroll in a single health insurance plan. This approach to helping families afford health insurance not only provides more efficient coverage than separate plans for different family members; it also

minimizes the risk of crowd-out.

As required by the Deficit Reduction Act (DRA) of 2005, CMS will no longer, as of October 1, 2005, approve new demonstration requests that would use SCHIP funds to provide coverage to non-pregnant childless adults, other than caretaker relatives. This prohibition, however, does not apply to current demonstrations or to the extension, renewal or amendment of existing demonstrations.

SCHIP Financing Based on Annual Allotment and Federal Matching Funds

SCHIP is jointly financed by the Federal and State governments and is administered by the States. As previously mentioned, within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides a capped amount of funds to States on a matching basis for Federal fiscal years (FY) 1998 through 2007.

The amount of the Federal funds available for SCHIP is allocated based on a fiscal-year and on a State-specific basis. The statute appropriates the following amounts for allotment to States:

- $4,295,000,000 for FY 1998;
- $4,275,000,000 each year for FY 1999 through FY 2001;
- $3,150,000,000 each year for FY 2002 through FY 2004;
- $4,050,000,000 each year for FY 2005 through FY 2006; and,
- $5,000,000,000 for FY 2007.

State allotments for a fiscal year are determined in accordance with a statutory formula that is based on the "Number of Children" and the "State Cost Factor." For FY 2001 and succeeding years, the Number of Children factor is based on 50 percent of the low-income uninsured children in the State and 50 percent of the number of low-income children in the State. The State Cost Factor is a geographic cost factor that is based on annual wages in the health care industry for each State. Payment variability to the States

over time is limited by statutory floors and ceilings, which limit fluctuation from year-to-year and over the life of the program.

One of the primary data sources used in this formula is the Current Population Survey (CPS). The CPS provides data on the number of uninsured children in each State.

For qualifying expenditures, States receive an enhanced Federal matching rate that is equal to 70 percent of their Medicaid Federal Medical Assistance Percentage (FMAP) for the fiscal year plus 30-percentage points, not to exceed 85 percent. In addition to the limits imposed on the overall allotment amounts, there is a 10-percent limit on administrative expenditures (including expenditures for outreach) by each State that is applied on a fiscal year basis. This limit is referred to as the "10-percent administrative cap."

In general, State allotments for a fiscal year remain available for expenditure by that State for a 3-year period; the fiscal year of the award and the two subsequent fiscal years. For example, the 2004 allotment is available to States during Federal fiscal years 2004, 2005 and 2006. However, any allotment amounts for a fiscal year that a State fails to use within that 3-year period are subject to reallocation to States that spent their entire SCHIP allotment.

SCHIP Financing

At the beginning of SCHIP implementation, States were at various stages of providing coverage for children. Some States were already covering children at higher income levels prior to SCHIP. For example, Minnesota was covering children up to 275 percent of the Federal poverty level (FPL) before SCHIP was implemented. So, in order to reduce the rate of uninsurance in their State, Minnesota used title XXI funds to expand coverage to parents and later expanded coverage to unborn children. As a result, Minnesota and other States with similar approaches to reducing uninsurance became redistribution States, by maximizing title XXI funds that other States had not expended.

Also, at the beginning of SCHIP, States were growing their programs at various paces. Some States grew their programs very rapidly covering children up to higher income levels, while other programs grew incrementally in phases. For example, Massachusetts aimed at reducing the uninsured rate in the State by implementing MassHealth Family Assistance to uninsured children with family incomes from 150 to 200 percent of the FPL. In 2003 Massachusetts added presumptive eligibility for SCHIP as well as expanded coverage to unborn children up to 200 percent of the FPL. Most recently, Massachusetts expanded coverage to children up to 300 percent of the FPL. By expanding eligibility in the early years of SCHIP, States like Massachusetts took advantage of title XXI funds to reduce the rate of the uninsured in their State. Massachusetts became eligible and received redistribution funds for each year from 1998 through 2002.

Since fiscal year 2002, some States' total spending of title XXI funds has exceeded their annual original allotments. Shortfalls of Federal title XXI funds have been avoided by using leftover prior-year balances and by redistributing funds from States with unspent funds to States facing shortfalls. At the end of FY 2006 there is projected a total of $4.1 billion in unexpended allotments that will be available for expenditure in FY 2007. In addition $5 billion in FY 2007 allotments will become available in FY 2007. Therefore, a total of $9.1 billion will be available nationally to States in FY 2007. States' projected expenditures in FY 2007 are $6.4 billion. Therefore, from a national perspective, there are sufficient allotment funds available to address the States' total expected expenditures. However, even though the available expected SCHIP funds in FY 2007 will total over $9 billion, the shortfall for certain States in FY 2007 is projected to be about $906 million. This is because most of the $4.1 billion in unexpended SCHIP funds carried over from FY 2006 is unavailable for reallotment in FY 2007 to the States that may need it. The current law redistribution rules for title XXI funds mean that only a limited portion of these funds are available for reallocation. The President's FY 2007 Budget proposes to address projected shortfalls of any individual State and target SCHIP funds to States in a more timely manner.

In FY 2006, there are about $9.7 billion in available allotments in FY 2006 (not including the $283 million in DRA funds discussed below) which does include about $4 billion in FY 2006 allotments and about $5.7 billion in allotments carried over from FY 2005 (including $173 million in unexpended FY 2003 allotments). States projected expenditures in FY 2006 are about $5.8 billion.

However, even though from a national perspective there would be sufficient funds to meet the projected expenditures in FY 2006, there are 12 States that would have a total shortfall of about $456 million. The only funds available for redistribution in FY 2006 are the unexpended $173 million in FY 2003 allotments. Since amounts actually available for reallotment in 2006 do not prevent 2006 shortfalls, Congress appropriated $283 million ($456 million minus the $173 million in unexpended FY 2003 allotments) for purposes of providing additional allotments to shortfall States through the Deficit Reduction Act (DRA) of 2005. Shortfall States are those States that have insufficient Federal funding to fund the State's current title XXI programs. The 12 shortfall States are Illinois, Iowa, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, Rhode Island, and South Dakota.

Prior to FY 2006, Congress took several other actions to reallocate title XXI funds to prevent State shortfalls in previous years. The Benefits Improvement and Protection Act (BIPA) of 2000 revised the allocation process to provide both retained and redistributed funds from the 1998 and 1999 SCHIP allotments and make these funds available through 2002. Public Law 108-74, which was signed by President Bush on August 15, 2003, extended the availability of the 1998 and 1999 SCHIP allotments again through 2004. This law also permitted States to retain 50 percent of the total amount of unexpended 2000 and 2001 allotments through 2004 and 2005 respectively. Public Law 108-74 also authorized "qualifying States" to use up to 20 percent of 1998, 1999, 2000 and 2001 allotments for Medicaid payments. (Qualifying States included Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin.) Then 2002 unspent funds were reallocated to States that had fully expended their 2002 allotments per the Secretary's authority granted

under title XXI. There is no provision in current statute to allow States that did not fully expend funds to retain any unspent funds.

Six of the States that had expended their full 2002 allotments (Arizona, Minnesota, Mississippi, Nebraska, New Jersey, and Rhode Island) projected that their 2005 expenditures would exceed available SCHIP funding. CMS issued a final Federal Register notice in September 2005 that designated these States as "shortfall States" that would receive funding in the amount of the shortage.

This history illustrates that in the beginning of the SCHIP program States were still building their programs and some had unexpended funds available for redistribution.

However, as time progressed, the amount of available redistributed funds decreased and States began having shortfalls of SCHIP funds. The Administration and Congress have worked together successfully to address any State shortfalls. The FY 2007 Budget proposes to address State shortfalls for FY 2007 and we look forward to working with Congress on this issue.

Over the years, States have projected shortfalls for various reasons:

- Expansions under section 1115 authority to parents, childless adults or pregnant women;
- Coverage provided to children with SCHIP eligibility income thresholds above 200 percent of the Federal poverty level (FPL);
- Coverage to unborn children;
- Presumptive eligibility coverage provided through SCHIP; and/or
- The reduction in the availability of redistribution funds over time;

As we work to reauthorize the SCHIP program, we want to work with you to make sure that SCHIP allotments are distributed in a manner that meets State needs. We have an effective track record of assuring that available SCHIP funds are used where needed for coverage, to prevent any consequences from shortfalls in specific States.

Conclusion

Chairman Hatch, Senator Rockefeller, distinguished members of the subcommittee, thank you again for the opportunity to discuss the SCHIP program. The flexibility afforded under this program has allowed States to expand health care creatively to children nationwide. As we approach the 10-year anniversary of the program, I am excited for the opportunity to take stock of the success of SCHIP and begin the process of working with you to reauthorize this landmark health care program. I would be happy to answer any questions you may have.

Upper Income Thresholds for Pre-SCHIP Medicaid and State Children's Health Insurance Programs as of July 2006

	Percent of the Federal Poverty Level (FPL)					
	Traditional Medicaid Thresholds as of March 31, 1997				Thresholds as of July 2006[a]	
State	Ages 0-1	Ages 1-5	Ages 6-13	Ages 14-18	M-SCHIP	S-SCHIP
Alabama (S)	133%	133%	100%	15%	-	200%
Alaska (M)	133%	133%	100%	100%	175%	-
Arizona (S)	140%	133%	100%	30%	-	200%
Arkansas[b] (C)	133%	133%	100%	18%	200%	200%
California (C)	200%	133%	100%	82%	100%	250/300%[c]
Colorado (S)	133%	133%	100%	37%	-	200%
Connecticut (S)	185%	185%	185%	100%	185%	300%
Delaware (C)	133%	133%	100%	100%	200%	200%
District of Columbia (M)	185%	133%	100%	50%	200%	-
Florida (C)	185%	133%	100%	28%	200%	200%
Georgia (S)	185%	133%	100%	100%	-	235%
Hawaii[d] (M)	185%	133%	100%	100%	300%	-
Idaho (C)	133%	133%	100%	100%	134%[e]	185%
Illinois[f] (C)	133%	133%	100%	46%	133%	200%
Indiana (C)	150%	133%	100%	100%	150%	200%
Iowa (C)	185%	133%	100%	37%	200%[g]	200%
Kansas (S)	150%	133%	100%	100%	-	200%
Kentucky (C)	185%	133%	100%	33%	150%	200%
Louisiana (M)	133%	133%	100%	10%	200%	-

Program Type as of July 2006

Upper Income Thresholds for Pre-SCHIP Medicaid and State Children's Health Insurance Programs

	Percent of the Federal Poverty Level (FPL)					
	Traditional Medicaid Thresholds as of March 31, 1997				**Thresholds as of July 2006**	
State	**Ages 0-1**	**Ages 1-5**	**Ages 6-13**	**Ages 14-18**	**M-SCHIP**	**S-SCHIP**
Maine (C)	**185%**	**133%**	**125%**	**125%**	**150%**	**200%**
Maryland (C)	**185%**	**185%**	**185%**	**100%**	**200%**	**300%**
Massachusetts (C)	**185%**	**133%**	**114%**	**86%**	**150%[h]**	**300%[i]**
Michigan (C)	**185%**	**133%**	**100%**	**100%**	**150%**	**200%**
Minnesota (C)	**275%**	**275%**	**275%**	**275%**	**280%[j]**	**275%**
Mississippi (S)	**185%**	**133%**	**100%**	**34%**	**-**	**200%**
Missouri (M)	**185%**	**133%**	**100%**	**100%**	**300%**	**-**
Montana (S)	**133%**	**133%**	**100%**	**40.5%**	**-**	**150%**
Nebraska (M)	**150%**	**133%**	**100%**	**33%**	**185%**	**-**
Nevada (S)	**133%**	**133%**	**100%**	**31%**	**-**	**200%**
New Hampshire (C)	**185%**	**185%**	**185%**	**185%**	**300%[k]**	**300%**
New Jersey (C)	**185%**	**133%**	**100%**	**41%**	**133%**	**350%**
New Mexico (M)	**185%**	**185%**	**185%**	**185%**	**235%**	**-**
New York (S)	**185%**	**133%**	**100%**	**51%**	**-**	**250%**
North Carolina (C)	**185%**	**133%**	**100%**	**100%**	**200%[l]**	**200%**
North Dakota (C)	**133%**	**133%**	**100%**	**100%[m]**	**100%[n]**	**140%**
Ohio (M)	**133%**	**133%**	**100%**	**33%**	**200%**	**-**
Oklahoma (M)	**150%**	**133%**	**100%**	**48%**	**185%**	**-**
Oregon (S)	**133%**	**133%**	**100%**	**100%**	**-**	**185%[o]**

Program Type as of July 2006.

Upper Income Thresholds for Pre-SCHIP Medicaid and State Children's Health Insurance Programs

	Percent of the Federal Poverty Level (FPL)					
	Traditional Medicaid Thresholds as of March 31, 1997				Thresholds as of July 2006	
State	**Ages 0-1**	**Ages 1-5**	**Ages 6-13**	**Ages 14-18**	**M-SCHIP**	**S-SCHIP**
Pennsylvania (S)	**185%**	**133%**	**100%**	**41%**	**-**	**200%**
Rhode Island (C)	**250%**	**250%[p]**	**100%[q]**	**100%**	**250%[r]**	**250%**
South Carolina (M)	**185%**	**133%**	**100%**	**48%**	**150%**	**-**
South Dakota (C)	**133%**	**133%**	**100%**	**100%**	**140%**	**200%**
Tennessee[s] (M)	**-**	**-**	**-**	**16%**	**-**	**-**
Texas (S)	**185%**	**133%**	**100%**	**17%**	**-**	**200%**
Utah (S)	**133%**	**133%**	**100%**	**100%[t]**	**-**	**200%**
Vermont[u] (S)	**225%**	**225%**	**225%**	**225%**	**-**	**300%**
Virginia (C)	**133%**	**133%**	**100%**	**100%**	**133%**	**200%**
Washington (S)	**200%**	**200%**	**200%**	**200%**	**-**	**250%**
West Virginia (S)	**150%**	**133%**	**100%**	**100%**	**-**	**200%**
Wisconsin (M)	**185%**	**185%**	**100%**	**45%**	**185%[v]**	**-**
Wyoming (S)	**133%**	**133%**	**100%**	**55%**	**-**	**200%**

Source: CMS/Center for Medicaid and State Operations, information from SCHIP state plans.
See Notes on following page.

Program Type as of July 2006.

Notes: [a] Some numbers may differ in practice because of the operation of an income disregard that has not been taken into account.
[b] Arkansas increased Medicaid eligibility to 200 percent of the FPL, effective September 1997, through section 1115 demonstration authority. This expansion was effective September 1997, which is after the SCHIP maintenance effort date.
[c] California's county program expanded eligibility to 300 percent of the FPL in four counties. Coverage for the unborn child goes to 300 percent of the FPL
[d] Hawaii covers children 200-300 percent of the FPL under s section 1115 demonstration.
[e] Idaho covers children ages 6 through 18 only.
[f] Illinois' SCHIP Medicaid expansion covers infants up to 200 percent of the FPL when the child is born to a woman in the Moms and Babies program. The separate child health program, KidCare Share covers children from 133--150 percent of the FPL, with modest co-payments. KidCare Premium covers children from 150-200 percent of the FPL, with modest premiums and co-payments.
[g] Iowa's SCHIP Medicaid expansion program covers infants over 185 percent of the FPL through 200 percent of the FPL.
[h] Massachusetts' SCHIP Medicaid expansion program covers infants in families with income up to 200 percent of the FPL.
[i] In Massachusetts, only children under age 0 are covered above 200 through 225 percent of the FPL through the SCHIP unborn child/prenatal state plan amendment option.
[j] In Minnesota, only children ages birth through two are eligible for the SCHIP Medicaid expansion.
[k] In New Hampshire, infants are covered through the SCHIP Medicaid expansion and children ages one through 18 are covered through the separate child health program.
[l] In North Carolina, children ages 0-5 are covered in the Medicaid expansion program; children ages 6-18 are covered in the separate child health program.
[m] In North Dakota, the age range is 14-17.
[n] North Dakota's SCHIP Medicaid expansion consists of children who became eligible for Medicaid when the state eliminated the Medicaid asset tests on January 1, 2002.
[o] Oregon increased eligibility to 185 percent of the FPL through a HIFA section 1115 Medicaid and SCHIP demonstration.
[p] In Rhode Island, the age range is 1-7.
[q] In Rhode Island, the age range is 8-13.
[r] For Rhode Island, an amendment to increase the SCHIP Medicaid expansion income threshold to 300 percent of the FPL has been approved, but has not been implemented.
[s]Tennessee provides coverage to children above the Medicaid state plan levels under a section 1115 demonstration. The demonstration covers: (1) Children without access to group health insurance up to 200 percent of the FPL; (2) Children enrolled as of 12/31/01 who have access to group health insurance up to 200 percent of the FPL; and (3) Children who are medically uninsurable with no upper income limit. Therefore, TennCare has no upper limit. TennCare recipients with incomes above the poverty level are charged a monthly premium based on a sliding scale. There are no premium subsidies for families with incomes > 400 percent of the FPL. The SCHIP Medicaid expansion covered children born before October 1, 1983 who enrolled in TennCare on or after April 1, 1997.
[t] In Utah, the age range is 14-17.
[u]Vermont's SCHIP covers uninsured children between 225 and 300 percent of the FPL. Other children in this income range that are ineligible for SCHIP are covered under the state's Medicaid Section 1115 waiver, which was implemented October 1998.
[v] In Wisconsin, once a child is enrolled, eligibility is maintained as long as income stays below 200 percent of the FPL.