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CHIP Enrollment June 2009:
An Update on Current Enrollment and Policy Directions

Prepared by
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Health Management Associates

and

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Kaiser Commission on Medicaid and the Uninsured

April 2010

THE HENRY J. KAISER FAMILY FOUNDATION

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

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Acknowledgements

This report is based on information provided by CHIP directors and other state officials responsible for data and statistical reporting. We thank these dedicated public servants for their timely responses to our survey, for confirming the accuracy of the data, and for quick responses to our follow-up questions.

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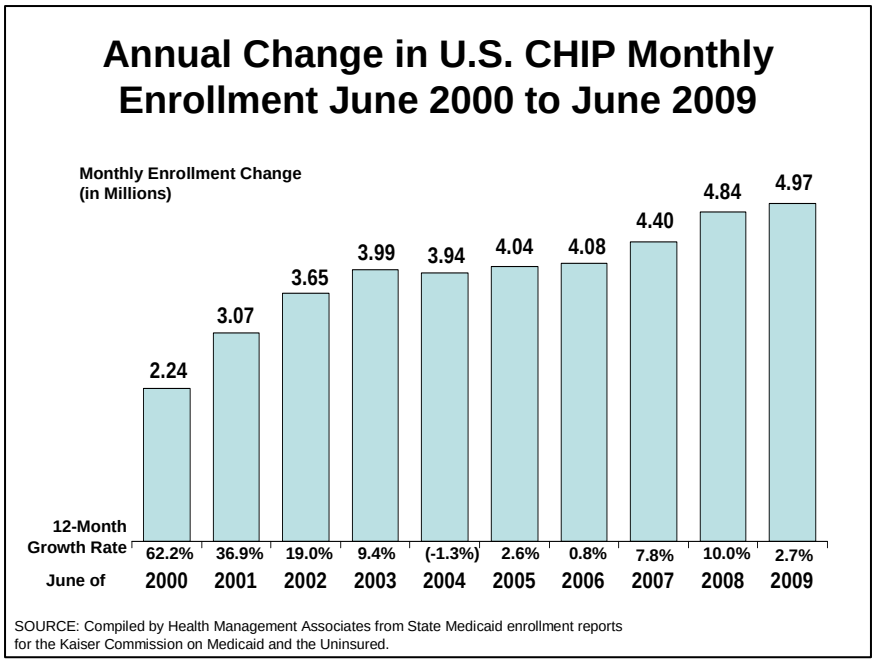
Executive Summary

In June 2009, the Children's Health Insurance Program (CHIP) enrolled nearly five million children in the 50 states and the District of Columbia, a 2.7% increase from the previous June. After years of flat enrollment from 2003 to 2006 resulting from state budget shortfalls and related reductions in program marketing and outreach, many states began to restore funding and increase eligibility levels in state fiscal year 2007. These renewed efforts combined with stronger state revenue pictures contributed to higher annual rates of enrollment growth beginning in 2007 (Figure ES-1). The beginning of the economic recession in December 2007 combined with uncertainty about the reauthorization of CHIP made it difficult for states to move forward with program changes. This led to a slowdown in enrollment growth in state fiscal year (SFY) 2009. In March 2009, the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) reauthorized CHIP for five years, breathing life back into the program. The enactment of national health reform in March 2010 extended CHIP funding through 2015 and continues the program through 2019.

Figure ES-1



Key Findings:

- The number of CHIP enrollees increased by 2.7% from June 2008 to June 2009, following a 10.0% growth in the year ending in June 2008 and a 7.8% growth in the year ending in June 2007.
- For SFY 2010, states project enrollment increases of approximately 8.0%.
- Twenty states enhanced eligibility or benefits in CHIP for SFY 2010, including 13 states that increased eligibility for children. No states cut eligibility levels.
- Coverage of adults under CHIP waivers is being phased-out by states. In June 2009, 273,600 adults had CHIP-financed coverage.
- CHIP directors remain most concerned about the impact of the economic downturn, implementation of CHIPRA requirements, and the effects of health reform.

Introduction and Background

The Children's Health Insurance Program (CHIP) provides health coverage for uninsured children in families with incomes too high to qualify for Medicaid but too low to afford private health coverage. CHIP is administered by individual states, and each state designs its program within federal guidelines. CHIP now provides health coverage for nearly five million children each month.

The original Congressional CHIP authorization in 1997 included funding for ten years, a period that expired on September 30, 2007. As the ten-year authorization neared its end, federal policymakers focused considerable attention on the reauthorization of CHIP. After two Presidential vetoes, Congress and the President reached an agreement in December 2007 on a temporary extension of funding to maintain existing enrollment levels through March 2009. In February 2009, Congress enacted the Child Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3), which fully reauthorized and funded the program for five years. The legislation also included incentives for states to find and enroll eligible children, and to simplify and streamline the enrollment process.

This report provides the latest data on CHIP enrollment and policy trends nationally and across the states through June 2009, based on survey responses and data provided from September through December 2009 by CHIP directors in all 50 states and the District of Columbia.

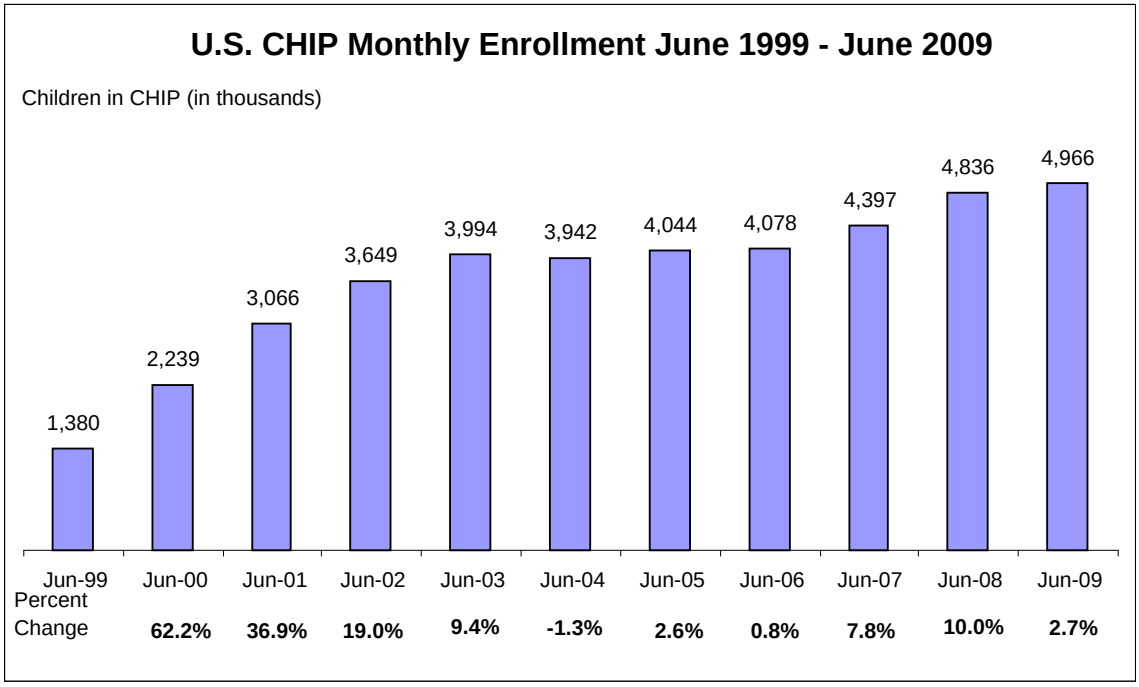
CHIP Enrollment and Policy Trends in State Fiscal Year 2009

CHIP reached a historically high monthly enrollment of 5 million children in June 2009. In the month of June 2009, a total of 4,966,000 children were enrolled in CHIP.[1] This enrollment number represents an increase of 130,400 children (2.7 percent) from June 2008. Although enrollment increased, annual rates of growth were substantially higher in each of the previous two years. From June 2007 to June 2008, CHIP enrollment increased by over 438,000 children, or ten percent (the largest annual growth in six years). From June 2006 to 2007, enrollment increased by more than 319,000 children, or 7.8 percent (Figure 1).

Given that CHIP enrollment remained relatively flat from June 2003 to June 2006, the annual enrollment increases in the subsequent three-year period are noteworthy. From June 2003 to June 2006, enrollment increased by only 85,000 children. In order to maintain eligibility levels and benefits during the economic downturn, many states chose to scale back or eliminate outreach activities. With states unable to afford outreach efforts, enrollment dropped in 26 states in at least one of these three years, and grew only slowly in other states (Table 1).

[1] This is a "point-in-time" monthly count of enrollment. See Appendix A in this report for comparison of point-in-time monthly enrollment with "ever-enrolled" annual enrollment counts.

Figure 1



Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2009.

As fiscal conditions improved in SFY 2007, many states began to restore funding for outreach and increased CHIP eligibility levels. This resulted in renewed enrollment growth, increasing by 7.8 percent in SFY 2007 and 10.0 percent in FY 2008. However, when the economy slipped back into a recession, enrollment growth slowed markedly to 2.7 percent in SFY 2009.

Three key factors contributed to the slower rate of growth in SFY2009. During this time period, many states maintained their CHIP programs but did not seek to expand their programs due to uncertainty surrounding the Congressional reauthorization of CHIP. Policy makers were reluctant to make major commitments to the program, especially given state fiscal conditions. States were also facing a bleak economic picture, which placed their budgets under severe pressure. In this fiscal environment, many programs were cut or eliminated. In several states, reductions occurred in CHIP outreach initiatives, and premiums were increased. In some states, CHIP programs bore the brunt of budget cuts since states were precluded from making cuts to Medicaid – but not to CHIP – as a condition of receiving enhanced Medicaid matching funds through the 2009 American Recovery and Reinvestment Act (ARRA). Lastly, the beginning of the economic recession put pressure on public programs as people began to lose jobs and income. However, the CHIP enrollment growth rate was not as high as expected in part because many children's family income fell below CHIP eligibility levels, leaving them eligible instead for their state's Medicaid program.

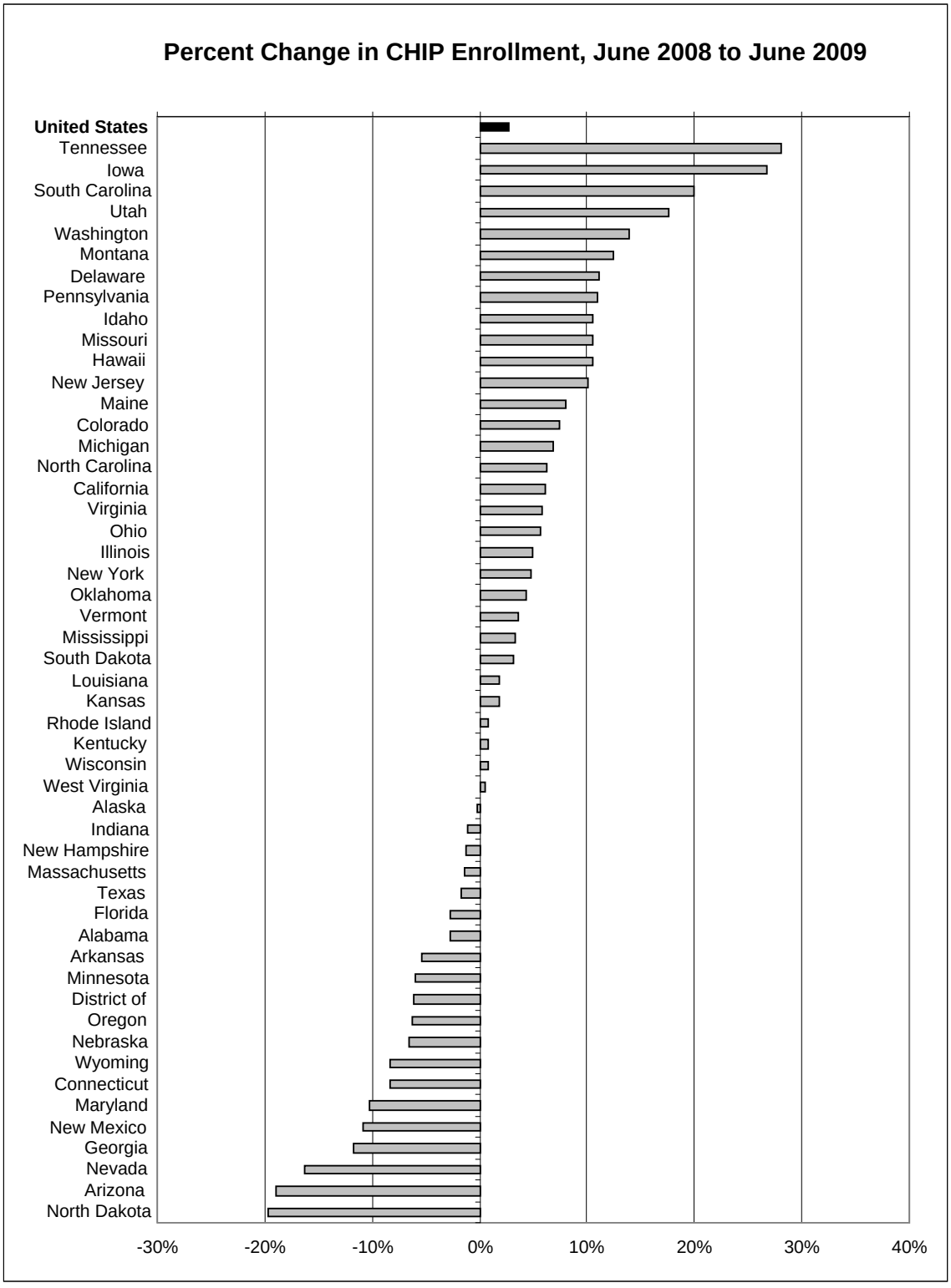
Table 1: Children Enrolled in CHIP by State, June 2004 – June 2009

	Program Type *	Monthly Enrollment						Percent Change				
		Jun-04	*Jun-05*	*Jun-06*	*Jun-07*	*Jun-08*	*Jun-09*	*Jun 04 to Jun 05*	*Jun 05 to Jun 06*	*Jun 06 to Jun 07*	*Jun 07 to Jun 08*	*Jun 08 to Jun 09*
United States		**3,941,608**	**4,043,863**	**4,078,163**	**4,397,495**	**4,835,639**	**4,966,030**	**2.6%**	**0.8%**	**7.8%**	**10.0%**	**2.7%**
Alabama	S	59,019	64,342	65,875	67,715	71,251	69,252	9.0%	2.4%	2.8%	5.2%	-2.8%
Alaska	M	14,243	11,366	9,582	7,793	8,743	8,721	-20.2%	-15.7%	-18.7%	12.2%	-0.3%
Arizona	S	50,373	50,638	59,250	64,453	65,837	53,408	0.5%	17.0%	8.8%	2.1%	-18.9%
Arkansas	C	54,273	62,141	67,170	69,349	67,832	64,213	14.5%	8.1%	3.2%	-2.2%	-5.3%
California	C	722,089	819,032	860,888	986,311	1,062,303	1,127,673	13.4%	5.1%	14.6%	7.7%	6.2%
Colorado	S	37,069	40,696	53,894	51,939	60,166	64,598	9.8%	32.4%	-3.6%	15.8%	7.4%
Connecticut	S	15,639	15,696	14,251	17,200	15,432	14,136	0.4%	-9.2%	20.7%	-10.3%	-8.4%
Delaware	C	3,461	4,360	4,844	5,069	5,484	6,090	26.0%	11.1%	4.6%	8.2%	11.1%
District of Columbia	M	4,391	4,573	4,750	5,146	6,720	6,307	4.1%	3.9%	8.3%	30.6%	-6.1%
Florida	C	331,716	203,983	193,639	224,575	231,226	225,028	-38.5%	-5.1%	16.0%	3.0%	-2.7%
Georgia	S	196,934	228,801	257,212	276,551	225,497	198,951	16.2%	12.4%	7.5%	-18.5%	-11.8%
Hawaii	M	12,261	14,108	15,569	17,226	18,787	20,763	15.1%	10.4%	10.6%	9.1%	10.5%
Idaho	C	11,780	13,787	14,287	19,352	26,811	29,652	17.0%	3.6%	35.5%	38.5%	10.6%
Illinois	C	119,857	135,984	151,253	175,145	186,107	195,233	13.5%	11.2%	15.8%	6.3%	4.9%
Indiana	C	64,403	68,939	69,787	68,394	71,253	70,496	7.0%	1.2%	-2.0%	4.2%	-1.1%
Iowa	C	32,157	34,913	36,286	33,412	34,580	43,830	8.6%	3.9%	-7.9%	3.5%	26.7%
Kansas	S	33,024	34,611	37,631	35,374	38,047	38,731	4.8%	8.7%	-6.0%	7.6%	1.8%
Kentucky	C	48,102	49,377	50,225	52,536	53,555	53,991	2.7%	1.7%	4.6%	1.9%	0.8%
Louisiana	C	100,925	107,914	107,777	107,828	124,310	126,657	6.9%	-0.1%	0.0%	15.3%	1.9%
Maine	C	13,967	13,989	14,705	13,346	13,839	14,955	0.2%	5.1%	-9.2%	3.7%	8.1%
Maryland	C	87,258	95,018	101,552	104,870	110,877	99,582	8.9%	6.9%	3.3%	5.7%	-10.2%
Massachusetts	C	56,208	70,198	75,019	87,492	105,094	103,605	24.9%	6.9%	16.6%	20.1%	-1.4%
Michigan	C	50,876	56,195	47,710	43,375	43,354	46,308	10.5%	-15.1%	-9.1%	0.0%	6.8%
Minnesota	C	1,982	2,122	2,229	2,458	2,368	2,226	7.1%	5.0%	10.3%	-3.7%	-6.0%
Mississippi	S	64,516	68,068	60,457	60,122	64,978	67,097	5.5%	-11.2%	-0.6%	8.1%	3.3%
Missouri	C	88,893	93,730	61,097	61,936	58,923	65,133	5.4%	-34.8%	1.4%	-4.9%	10.5%
Montana	S	10,914	10,908	13,165	13,289	16,576	18,639	-0.1%	20.7%	0.9%	24.7%	12.4%
Nebraska	M	22,188	23,132	23,194	24,491	25,397	23,744	4.3%	0.3%	5.6%	3.7%	-6.5%
Nevada	S	26,100	28,836	27,848	29,899	26,832	22,444	10.5%	-3.4%	7.4%	-10.3%	-16.4%
New Hampshire	C	6,532	7,022	7,688	7,415	8,009	7,905	7.5%	9.5%	-3.6%	8.0%	-1.3%
New Jersey	C	104,165	115,222	127,525	125,494	121,581	133,878	10.6%	10.7%	-1.6%	-3.1%	10.1%
New Mexico	M	10,706	10,647	10,598	8,072	9,706	8,647	-0.6%	-0.5%	-23.8%	20.2%	-10.9%
New York	S	438,892	426,529	388,689	394,164	365,311	382,803	-2.8%	-8.9%	1.4%	-7.3%	4.8%
North Carolina	S	115,571	130,467	109,466	113,667	122,379	129,973	12.9%	-16.1%	3.8%	7.7%	6.2%
North Dakota	C	3,586	4,136	4,454	4,553	5,785	4,644	15.3%	7.7%	2.2%	27.1%	-19.7%
Ohio	M	128,877	122,796	142,374	140,547	145,049	153,335	-4.7%	15.9%	-1.3%	3.2%	5.7%
Oklahoma	C	46,576	54,427	58,731	66,570	62,955	65,679	16.9%	7.9%	13.3%	-5.4%	4.3%
Oregon	S	20,443	25,014	29,430	39,586	50,736	47,575	22.4%	17.7%	34.5%	28.2%	-6.2%
Pennsylvania	S	134,426	136,511	143,501	161,166	172,662	191,497	1.6%	5.1%	12.3%	7.1%	10.9%
Rhode Island	C	11,459	11,756	12,412	12,612	12,348	12,454	2.6%	5.6%	1.6%	-2.1%	0.9%
South Carolina	C	51,479	52,561	40,161	36,001	45,332	54,406	2.1%	-23.6%	-10.4%	25.9%	20.0%
South Dakota	C	9,805	10,610	11,323	11,136	11,531	11,900	8.2%	6.7%	-1.7%	3.5%	3.2%
Tennessee	C	-	-	-	31,619	53,064	67,980	--	--	--	67.8%	28.1%
Texas	S	359,967	326,473	293,342	326,635	554,642	544,815	-9.3%	-10.1%	11.3%	69.8%	-1.8%
Utah	S	30,192	28,268	35,724	25,095	35,248	41,468	-6.4%	26.4%	-29.8%	40.5%	17.6%
Vermont	S	2,897	2,992	3,012	2,820	3,215	3,330	3.3%	0.7%	-6.4%	14.0%	3.6%
Virginia	C	58,676	73,187	78,745	82,731	90,907	96,163	24.7%	7.6%	5.1%	9.9%	5.8%
Washington	S	10,862	21,146	18,790	18,975	20,953	23,875	94.7%	-11.1%	1.0%	10.4%	13.9%
West Virginia	S	23,594	24,515	24,835	24,939	24,418	24,555	3.9%	1.3%	0.4%	-2.1%	0.6%
Wisconsin	C	34,957	28,006	30,954	31,368	71,590	72,153	-19.9%	10.5%	1.3%	128.2%	0.8%
Wyoming	S	3,328	4,121	5,263	5,684	6,039	5,532	23.8%	27.7%	8.0%	6.2%	-8.4%

* Program Type is as of June 2009.

Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2009.

Figure 2



Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2009.

From June 2008 to June 2009, the number of children enrolled in CHIP increased in 31 states. (Figure 2) Fourteen states experienced enrollment increases of at least ten percent or 10,000 children. Five of these states saw enrollment rise by at least 10,000 children, including *California, Pennsylvania, New York, Tennessee and New Jersey.* In *California*, the nation's largest CHIP program (known as "Healthy Families") increased by over 65,000 children (6.2 percent), reaching a total of 1,127,700 children. Two other states with large enrollment increases were *Pennsylvania*, where enrollment increased by 18,800 children (10.9 percent) and *New York*, where enrollment increased by 17,500 children (4.8 percent). Enrollment increased by almost 15,000 in Tennessee (up 28.1 percent, the largest annual percentage growth among all states for FY 2009). New Jersey enrollment increased by over 12,000 (10.1 percent).

Other states with enrollment growth of at least ten percent included: *Iowa* (up 26.7 percent), *South Carolina* (up 20.0 percent), *Utah* (up 17.6 percent), *Washington* (up 13.9 percent), *Montana* (up 12.4 percent), and *Delaware*, *Hawaii*, *Idaho*, *Missouri* and *Pennsylvania* (each up approximately 11 percent). (Table 2)

Following these increases in CHIP enrollment, state budget difficulties prompted three states *(California*, *Tennessee*, and *Arizona)* to freeze CHIP enrollment at some point during 2009 or 2010. Enrollment in *California* opened up on September 16, 2009, *Tennessee* will reopen enrollment in April 2010, and *Arizona* enrollment has been frozen since January 1, 2010.

Table 2: States with CHIP Enrollment Growth of at Least 10,000 Children or Ten Percent, June 2008 to June 2009

State	Monthly Enrollment		Enrollment Growth	Percent Change
	Jun-08	*Jun-09*	*Jun 08 to Jun 09*	*Jun 08 to Jun 09*
United States	**4,835,639**	**4,966,030**	**130,391**	**2.7%**
Tennessee	53,064	67,980	14,916	28.1%
Iowa	34,580	43,830	9,250	26.7%
South Carolina	45,332	54,406	9,074	20.0%
Utah	35,248	41,468	6,220	17.6%
Washington	20,953	23,875	2,922	13.9%
Montana	16,576	18,639	2,063	12.4%
Delaware	5,484	6,090	606	11.1%
Pennsylvania	172,662	191,497	18,835	10.9%
Idaho	26,811	29,652	2,841	10.6%
Missouri	58,923	65,133	6,210	10.5%
Hawaii	18,787	20,763	1,976	10.5%
New Jersey	121,581	133,878	12,297	10.1%
California	1,062,303	1,127,673	65,370	6.2%
New York	365,311	382,803	17,492	4.8%

Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2009.

Among the states that experienced CHIP enrollment increases in state FY 2009, CHIP directors indicated that the most significant factor by far was the economic downturn and rising unemployment, which caused higher demand and increased the number of applications for the program. In addition, five states identified recent eligibility expansions as a key contributor to enrollment growth.

From June 2008 to June 2009, the number of children enrolled in CHIP decreased in 19 states and the District of Columbia. In six of these states the drop in enrollment exceeded ten percent, including three states where the enrollment drop exceeded 10,000 children. The three states with the largest enrollment drops included: *Georgia*, where enrollment dropped by over 26,500 (11.8 percent); *Arizona*, where enrollment dropped by over 12,000 (18.9 percent); and *Maryland*, where enrollment decreased by over 11,000 (10.2 percent).

The three states with enrollment decreases that exceeded ten percent included: *North Dakota* (down 19.7 percent), *Nevada* (down 16.4 percent), and *New Mexico* (down 10.9 percent). (Table 3)

Table 3: States with CHIP Enrollment Drops of at Least 10,000 Children or Ten Percent, June 2008 to June 2009

State	Monthly Enrollment		Enrollment Growth	Percent Change
	Jun-08	*Jun-09*	*Jun 08 to Jun 09*	*Jun 08 to Jun 09*
United States	**4,835,639**	**4,966,030**	**130,391**	**2.7%**
North Dakota	5,785	4,644	(1,141)	-19.7%
Arizona	65,837	53,408	(12,429)	-18.9%
Nevada	26,832	22,444	(4,388)	-16.4%
Georgia	225,497	198,951	(26,546)	-11.8%
New Mexico	9,706	8,647	(1,059)	-10.9%
Maryland	110,877	99,582	(11,295)	-10.2%

Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2009.

Among states with enrollment declines, the most frequently mentioned factor was that a greater proportion of children were qualifying for Medicaid instead of CHIP, both at initial application and at annual renewals, due to reductions in family income. As a result, more children were transferring from CHIP to Medicaid when eligibility was re-determined. In addition, some states indicated that new verification requirements had depressed enrollment. (For example, this was the primary factor mentioned in *Georgia*, which experienced an annual enrollment drop of over 26,000 children). Outreach reductions and staffing shortages were also mentioned as factors that contributed to enrollment declines.

CHIP Policy Trends in State Fiscal Year 2009

State CHIP officials were asked to identify policy changes that had occurred from July 2008 through June 2009. For all but four states and the District of Columbia this period coincided with state FY 2008-2009.[2] The policy changes that were implemented related to eligibility levels, enrollment freezes, covered benefits, copayments, premiums and other policies. The following sections relate specifically to CHIP policy changes during the year ending in June 2009.

Eligibility: Eligibility levels for CHIP increased in five states and decreased in one state in state fiscal year 2009. On September 1, 2008, *New York* increased its CHIP eligibility level from 250 percent of the federal poverty level (FPL) to 400 percent FPL. On October 1, 2008, *Indiana* increased eligibility from 200 percent to 250 percent FPL, and *North Dakota* increased from 140 percent to 150 percent FPL. On January 1, 2009, *Washington* increased eligibility from 250 percent to 300 percent FPL, and *West Virginia* increased from 220 percent to 250 percent FPL.

Only one state implemented a reduction in its eligibility level over this annual period. On July 1, 2008, Rhode Island decreased eligibility for Title XXI-funded parents from 185 percent to 175 percent FPL.

Enrollment caps and freezes: As of June 2009, a total of five states had legislatively-established caps on the number of CHIP-funded child enrollees to ensure that enrollment would not cause program expenditures to exceed authorized levels. In four of the five states with enrollment caps, the caps were set at levels that were not reached in FY 2009 and program officials expected would not be reached in FY 2010. These four states included *Arkansas, Florida, Georgia* and *Wyoming*. For example, the enrollment cap in Georgia was set at 295,000 children but enrollment in June 2009 was less than 200,000. Instead of capping the number of enrollees, *North Carolina* has a cap on annual growth which was set at 6.0 percent for fiscal year 2009, although actual growth was 6.2 percent. A new 6 percent annual cap began on July 1, 2009. *Michigan* used an enrollment cap based on available funds in conjunction with an open enrollment period only for childless adults covered under a Title XXI waiver. Enrollment was allowed to exceed the cap (set at 62,000 for 2009) during the open enrollment period, but a new open enrollment period occurred only when enrollment dropped below the cap and available funds allowed new enrollments. In 2009, enrollment reached a high of 90,966 and a low of 41,000.

State budget difficulties prompted three states *(California, Tennessee,* and *Arizona)* to freeze CHIP enrollment at some point during 2009 or 2010. *California* froze enrollment on July 17, 2009 but was able to reopen the program on September 16, 2009 when additional state resources were identified. *Tennessee* froze CHIP enrollment on December 1, 2009 but will reopen enrollment in April 2010. *Arizona* has had a freeze on CHIP enrollment since January 1, 2010.

Premiums and Copayments: As of June 2009, there were a total of 45 states that operated a separate CHIP program, either as the entire state CHIP program (in 19 states) or along with a Medicaid expansion program (in 26 states). Medicaid programs (including Medicaid – expansion

[2] The state fiscal year begins on April 1 for New York, September 1 for Texas, and on October 1 for Alabama, Michigan and the District of Columbia.

CHIP programs) are precluded by federal law under Title XIX from charging premiums or copayments for children. However, federal law under Title XXI allows premiums and copayments for separate CHIP programs. Such premiums or copayments must meet a test of reasonableness to assure affordability.

Of the 45 states that operate a separate program as of June 2009, 36 states required premiums for enrollment in their separate CHIP program. During state FY 2009, 15 of these states made small upward adjustments in these premiums. The premium amounts for each state as of June 2009 are shown in Appendix B at the end of this report.

A total of 24 CHIP programs also require payment of nominal copayments at the time a child receives a covered medical service. In some cases, the copayments apply only for groups at higher income levels, such as between 200 and 250 percent FPL. (For example, in *Louisiana*, copayments are similar to those charged to children under the state employee health plan.) However in some states, copayments apply only to older children (such as in *Florida*, where copayments apply for children ages 5 to 18). Copayments may be tied to a benchmark plan, such as a public employee plan or a private plan. For example, during FY 2009, *Utah* changed its benchmark plan from the public employees plan to a private plan, resulting in copayment increases for some services. Copayments typically apply to prescription drugs, office or specialty visits, and non-emergency visits to an emergency room.

In addition, at least four states (*North Carolina*, *New Hampshire*, *Utah* and *Wyoming*) indicated that premiums are scheduled to increase during FY 2010.

Other policy changes in fiscal year 2009: Over the year ending in June 2009, six states made other policy changes in CHIP. In each case, the changes increased eligibility or the enhanced the eligibility determination process.

- *Alabama* began accepting electronic signatures through its online application process for both CHIP and Medicaid.
- *Alaska* changed from 6-month to 12-month continuous eligibility for all children in both Title XXI-funded CHIP and Title XIX-funded Medicaid.
- *Kentucky* lifted its face-to-face interview requirement and implemented a new mail-in application process.
- *New York* instituted a new process for children found not to be eligible for renewal of Medicaid due to excess income, in which their information is electronically transmitted to CHIP to expedite the eligibility and enrollment process.
- *Pennsylvania* instituted a number of simplifications, including removing requirements to verify income for households with income greater than 300 percent FPL, adding IRS Form 1099 as an acceptable document for income verification, no longer requiring a signed tax return as proof of income. In addition, Pennsylvania allowed otherwise-eligible individuals to purchase CHIP at-cost, if they were unable to verify their income.
- *Texas* rescinded its policy that required written verification of pregnancy for coverage under its program for the unborn. The applicant's statement can now be used.

Fiscal Year 2010 CHIP policy changes: The survey on which this report is based upon reflects information provided by CHIP directors from September through December 2009. As a result, CHIP officials were able to provide information on policy changes already implemented or planned for state FY 2010. The next survey will focus in more detail on policy changes in FY 2010. However, it was clear from actions already taken for FY 2010 that significant expansions were occurring, and that the primary reason was program reauthorization. CHIP reauthorization occurred in February 2009, just as state legislatures were making program and funding decisions for FY 2010. Reauthorization removed the uncertainty about future federal policy and funding that stifled state action in 2008 and 2009, and allowed state policy makers to respond with confidence to the new opportunities afforded by CHIPRA.

Twenty states listed eligibility or benefit enhancements they had implemented or planned to implement in their CHIP programs in FY 2010. These included 13 states that had expanded eligibility or adopted significant simplifications designed to improve the application and eligibility determination process, and nine states that expanded benefits covered under CHIP.

Most significant are the eligibility changes, particularly at a time of fiscal restraint across the states, which may signal a renewal of state actions to expand coverage for children through CHIP. Aside from the temporary enrollment freezes in state fiscal year 2010 described earlier in this report for Arizona, California and Tennessee, no state eligibility cutbacks were mentioned during this time period. A partial state list of eligibility level increases included:

- *Alabama* expanded CHIP eligibility for children from 200 percent to 300 percent FPL, effective October 1, 2009.
- *Arkansas* submitted a State Plan Amendment (SPA) to increase eligibility from 200 percent to 250 percent FPL.
- *Colorado* has plans to increase CHIP eligibility from 205 percent to 250 percent FPL, effective in April or June 2010.
- *Iowa* increased CHIP eligibility to 300 percent FPL.
- *Indiana* submitted a SPA to expand CHIP eligibility to 300 percent FPL.
- *Kansas* submitted a SPA to increase eligibility for CHIP to 250 percent FPL.
- *Montana* increased eligibility from 175 percent to 250 percent FPL, effective October 1, 2009.
- *Nebraska* increased CHIP eligibility from 185 percent to 200 percent FPL, effective September 1, 2009.
- *Oregon* submitted a SPA to increase eligibility to 200 percent FPL.
- *Texas* will begin covering additional qualified alien children under CHIP and Medicaid, effective May 2010.

In addition, in FY 2010 a number of states are implementing benefit expansions or are making other improvements in coverage, including easing restrictions on benefits. Some states expanded or reinstated dental coverage after the reauthorization of CHIP. A few states mentioned that a state budget shortfall might mean that benefit restrictions could occur during FY 2010.

CHIP enrollment of children over the next year: Over the next year, CHIP officials expect that their programs will continue to be affected by the economic downturn. This will likely be

due to a greater number of people applying for CHIP and an increase in the number who qualify for the program, along with shortfalls in the state revenues that help pay for it.

Of the 48 states that responded to this question, 34 states envisioned an upward trend in CHIP enrollment; nine expected enrollment to remain about the same; and five projected a drop in the number of enrolled children. Across the 48 states offering projections, the median projection for enrollment growth was eight percent in FY 2010. Among those states expecting enrollment to increase, half of them expected enrollment growth to exceed ten percent, with some states envisioning growth of 15 to 20 percent or more.

Early indications are that 2010 will mark a significant turning point for CHIP, with the reauthorization of the program being a key factor, together with preparation for health reform implementation. In many states, policy makers are now prepared to invest once again in the program, even when funds are scarce. The change in the policy environment is reflected in new efforts to find and enroll eligible children and expectations that an increasing number of children will be served by CHIP in FY 2010.

CHIP coverage of Unborn Children: Beginning in 2002, the Centers for Medicare and Medicaid Services (CMS) authorized states to use CHIP funds for prenatal care and other medical services for pregnant women. CMS defines this as "Unborn Child" coverage, which is authorized through a State Plan Amendment rather than a program waiver. CMS policy is to count these individuals as children enrolled in CHIP. This report uses the CMS definition and includes these individuals in the total number of enrolled children. In June 2009, 15 states reported that they used the Unborn Child option to provide coverage for 182,700 individuals, an annual increase of about 10,000 from the 172,700 reported for CHIP-financed unborn child coverage in June 2008.

Adults Covered by CHIP Funds: Until 2006, CMS authorized states to cover adults with CHIP funds with an approved waiver. Previously, CMS encouraged states with available funds within their CHIP allocation to obtain waivers to cover specific categories of uninsured adults, including pregnant women, parents, and childless adults. States granted such waivers had to assure coverage priority for children and could not restrict enrollment for children while a waiver for adult coverage was in effect. However, Congress prohibited further CHIP waivers for parents and other adults in the Deficit Reduction Act of 2005. States will be able to continue to finance coverage for parents under existing Title XIX waivers through September 2011. As of June 2009, a total of 12 states reported coverage for 273,600 adults under CHIP waivers. (Table 4)

Table 4: States with CHIP-Financed Coverage of Adults, June 2005 to June 2009

	Adults								
	Monthly Enrollment					% Change			
	Jun-05	*Jun-06*	*Jun-07*	*Jun-08*	*Jun-09*	Jun 05 to Jun 06	Jun 06 to Jun 07	Jun 07 to Jun 08	Jun 08 to Jun 09
United States	**331,068**	**349,433**	**374,709**	**250,897**	**273,627**	**5.5%**	**7.2%**	**-27.0%**	**9.1%**
Arizona	48,385	14,870	14,045	10,187	9,870	-69.3%	-5.5%	-29.7%	-3.1%
Arkansas	-	-	217	1,449	3,029	N/A	N/A	1295.9%	109.0%
Colorado	832	1,195	1,207	1,872	1,618	43.6%	1.0%	34.1%	-13.6%
Idaho	-	254	291	331	347	N/A	14.6%	19.2%	4.8%
Illinois	103,879	121,148	149,755	-	-	16.6%	23.6%	N/A	NA
Maine	-	-	-	13,954	11,135	N/A	N/A	N/A	-20.2%
Michigan	46,874	62,000	59,000	69,469	86,777	32.3%	-4.8%	47.1%	24.9%
Minnesota	23,954	20,896	17,195	16,572	16,572	-12.8%	-17.7%	-3.6%	0.0%
Nevada	-	-	107	127	196	N/A	N/A	83.2%	54.3%
New Jersey	51,149	73,401	86,725	101,422	94,530	43.5%	18.2%	9.0%	-6.8%
New Mexico	-	4,753	7,444	7,793	12,964	N/A	56.6%	74.2%	66.4%
Oregon	7,364	10,143	10,969	-	-	37.7%	8.1%	N/A	NA
Rhode Island	13,878	12,346	11,816	11,247	-	-11.0%	-4.3%	-100.0%	NA
Virginia	-	408	757	1,128	1,089	N/A	85.5%	43.9%	-3.5%
Wisconsin	34,753	28,019	15,181	15,346	35,500	-19.4%	-45.8%	133.8%	131.3%

Source: Data provided by state officials to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, 2009.

Coverage of Adults without Children under CHIP after December 2009: Of the parents, pregnant women and childless adults covered under Title XXI that totaled of 273,627 in June 2009, a total of 127,163 were childless adults in five states (*Arizona*, *Idaho*, *Michigan*, *New Jersey* and *New Mexico*). CHIPRA specified that after December 2009 states could no longer claim Title XXI funds to support coverage for childless adults. In each of these five states that covered childless adults in June 2009, officials indicated their state would use Title XIX funding to continue coverage in 2010.

CHIPRA: Outreach, Performance Bonuses, Citizenship Documentation and Other Issues

The 2009 CHIPRA legislation provided funding for CHIP through federal fiscal year 2013, providing assurance to states that federal matching funds would be available for their programs. Equally important were the provisions to improve benefits and quality of care for children and to encourage enrollment of eligible children, including a new performance bonus system to reward states that meet specified targets for increasing enrollment of children in Medicaid. In addition, CHIPRA extended the Medicaid citizenship documentation requirement to CHIP. However, these CHIPRA documentation changes did not go into effect until January 1, 2010, and therefore do not impact the June 2009 CHIP enrollment information that is highlighted in this report.

Outreach

CHIPRA specifically allocates $100 million to fund state and federal outreach activities for Medicaid and CHIP. Out of this total, $10 million is earmarked for a national campaign to improve enrollment in Medicaid and CHIP. The remaining $90 million is to be awarded to state and local governments and other qualifying organizations such as community-based organizations, school lunch, WIC and other programs that serve children, federally qualified health centers and DSH hospitals and other entities that are in a position to conduct outreach

campaigns and facilitate enrollment of eligible children into CHIP or Medicaid. Outreach initiatives targeting Native Americans are to receive $10 million of the total.

A total of 20 states indicated at the time of our survey that the state had applied for an outreach grant, or planned to do so. Even though the grants require no state matching funds, the state economic situations in this fiscal year clearly impacted not only the ability of states to conduct outreach, but also their ability to pursue outreach grants. A total of 28 states specifically indicated that state budget cutbacks had impacted their ability to fund and carry out outreach. Some states indicated that existing outreach contracts had been canceled. Other states indicated that the legislature did not fund any outreach for this fiscal year, or that funding was curtailed. Many states were struggling to fund unexpectedly high rates of growth in Medicaid spending due to enrollment growth, making this a difficult time to allocate additional spending for outreach.

On September 30, 2009, CMS announced the recipients of the first $40 million in grant funds. As shown in Table 5, 14 states either directly (11 states) or through formal partnership with community organizations (CA, FL, and KS) received nearly $11 million in outreach funding during this first wave.

Table 5: Federal Fiscal Year 2010 State CHIPRA Outreach Grants

State	FY 2010 CHIPRA Outreach Grant Funding to State
California	$399,900
Florida	$69,102
Kansas	$523,932
Lousiana	$955,681
Maine	$680,249
Maryland	$988,177
Montana	$971,868
New Jersey	$988,177
New Mexico	$957,221
Oklahoma	$988,177
Oregon	$988,177
Virginia	$988,154
Wyoming	$268,889
Wisconsin	$988,177
Total	$10,755,881.00

Note: Table includes only states where the grantee was a state entity or community organization in formal partnership with the state. Grants awarded to non-state entities such as non-profit organizations, individual counties, local school districts were not included.

Source: Centers for Medicare and Medicaid Services. CHIPRA Outreach and Enrollment Grants. Available online at: http://www.cms.hhs.gov/CHIPRA/11_outreachenrollmentgrants.asp

Overall, a total of 35 states in our survey indicated that they were funding outreach, although usually at a reduced level compared to previous years. Outreach included advertising on television and radio, on the web and in print. Initiatives are often carried out through community organizations or special contracts with a state university. In 41 states, officials indicated that community organizations played an important role in conducting outreach. Entities mentioned included Tribal organizations, Hispanic organizations, migrant organizations, FQHCs, advocacy groups, and universities. Many of these groups had applied for CHIPRA outreach grants. In California, for example, all outreach funding was eliminated in the state budget, making the state ineligible to apply for the CHIPRA outreach grants directly. They were however part of a formal partnership with a local community organization that was selected as a grantee. In Louisiana, officials indicated that more than 15 community and health care organizations applied for outreach grants. Due to the shortage of state funds, many states are relying on these community organizations to assist with outreach activities. Overall, CMS reported that more than 400 grant

applications were reviewed in this first wave, and that 69 grantees were selected, 20 of which consisted of groups of organizations – some of which included state agencies – working together.

CHIPRA Performance Bonuses

CHIPRA provides for special bonus payments to states based on the extent that enrollment of children in Medicaid increases over the period from 2009 through 2013. States that implement specified policies or procedures and achieve enrollment levels that exceed target levels will quality for federal payments intended to help defray the cost of coverage for the newly enrolled children. The federal payment can range between 15 percent and 62.5 percent of the average cost of coverage, depending on the extent enrollment exceeds the target levels. The targets are based on actual enrollment in 2007, adjusted by growth in child populations plus 4 percentage points in 2009; 3.5 percentage points in 2010 through 2012; 3 percentage points in 2013 through 2015; and 2 percentage points in 2016 and after.

To qualify for the bonus, a state must have implemented at least five of the following eight enrollment or retention policies or procedures for CHIP and Medicaid:

1. Adopt 12-month continuous eligibility for all children.
2. Eliminate an asset test for children, or allow self certification without the need for documentation to verify assets.
3. Eliminate face-to-face interview requirements at application or renewal of eligibility.
4. Use of a single application and verification processes for Medicaid and CHIP.
5. Allow administrative or passive renewal.
6. Allow presumptive eligibility.
7. Allow "Express Lane" eligibility, using eligibility from other programs such as school lunch in determining eligibility for Medicaid and CHIP.
8. Provide premium assistance to subsidize qualifying employer-sponsored health insurance.

These eight policies and procedures are widely regarded as actions that simplify enrollment and retention. Adopting these policies would reduce the hassle factors associated with eligibility determination, allowing a greater number of eligible children to enroll in Medicaid and CHIP and to maintain that coverage when eligibility is redetermined.

Of the eight policies, many states already did not require a face-to-face interview, had no asset test or a simplified asset test, and had already adopted a single application for Medicaid and CHIP.

At the time of the survey, a total of 16 states indicated that they already had in place five or more of the required policies. However, over a dozen states indicated that they were planning to implement one or more additional policies and procedures. When these states have implemented their new policies, a total of 26 states indicate that they will have implemented at least five of the eight required policies.

Performance Bonuses

Having at least five of the required policies in place is necessary for a state to qualify for a performance bonus, in addition to meeting the requirement for growth in the number of children enrolled in Medicaid. As of the time of the survey in the fall of 2009, most states did not know if they would qualify for a performance bonus. One quarter of states believed they would not qualify. Only a handful of states indicated at the time of the survey that they believed they would qualify for a performance bonus.

On December 16, 2009, CMS released the Federal Fiscal Year 2009 bonus payment awards. The awards allocated more than $72 million to Alaska, Alabama, Illinois, Louisiana, Michigan, New Jersey, New Mexico, Oregon, and Washington (Table 6).

Table 6: Federal Fiscal Year 2009 State Bonus Payment Awards

	Program Features (x = met; "No" = unmet; "blank" = State did not claim to implement)								
State	Continuous Eligibility	Liberalization of Asset Requirements	Elimination of In-Person Interview	Use of Same Application and Renewal Form	Automatic/ Administrative Renewal	PE	Express Lane	Premium Assistance Subsidies	**Calculated Bonus Payment Award**
AK	x	x	x	x	x				$788,505
AL	x	x	x	x	x				$39,107,910
IL	x	x	x	x	x	x	No		$9,108,140
LA	x	x	x	x	x				$1,545,368
MI	x	x	x	x		x			$3,713,892
NJ	x	x	x	x	x	x	No		$4,208,553
NM	No	x	x	x	x	x			$5,084,179
OR	x	x	x	x	x		No		$1,600,227
WA	x	x	x	x	x		No	No	$7,461,079
Total									**$72,617,853**

Source: Attachment to Dear State Health Official letter #09-015, Centers for Medicare and Medicaid Services, Available online at http://www.cms.hhs.gov/smdl/downloads/SHO09015ATT.pdf.

Citizenship Documentation

The Deficit Reduction Act of 2005 (DRA) imposed a new requirement that all U.S. citizens who apply for Medicaid and all ongoing beneficiaries had to provide documentation of citizenship and identity. CHIPRA extended the Medicaid requirement to CHIP, effective on January 1, 2010. CHIPRA also allows states to use electronic data matches with the Social Security Administration (SSA) to ascertain citizenship.

Two-thirds of states indicated that they would use the new data match with SSA; only four states said they did not plan to use the data match at this time, and 13 states did not yet know. States with Medicaid expansion programs have been applying the citizenship documentation requirements for CHIP children along with Medicaid children for several years.

Despite widespread adoption of the data match approach in Medicaid expansions programs, concerns were raised about applying the citizenship documentation requirements to CHIP by a number of states with separate programs. One state said: "It is an unnecessary barrier to enrollment for uninsured children and all national studies of the DRA requirements indicate that it has kept eligible U.S. citizens from access to benefits that they are entitled to." Other states

indicated that they used a mail in application and the new law will require applicants to deliver the documentation to the local health department, where space and staff are limited and they are not set-up for this type of interview. Others expressed concern about added administrative costs and delays in enrollment. Another concern related to the timing of the SSA data match and the ability to meet the required timelines.

Enrollment of Lawfully Residing Immigrant Children and Pregnant Women

Prior to CHIPRA, Medicaid and CHIP were not available to legally residing immigrant children and pregnant women during their first five years of residence. CHIPRA allows states to include these individuals in Medicaid and CHIP. In this survey, a total of 14 states indicated that they had this coverage using state-funds only prior to CHIPRA. More than half of states did not yet know whether their state would adopt this coverage, but a total of 21 states indicated that they plan to adopt this coverage under CHIP. Of the 21 states, nine indicated thy plan to adopt it only for children, and 12 states indicated they would adopt it for both children and pregnant women.

Dental Coverage Under CHIP

Unlike Medicaid, CHIP is prohibited from wrapping around or supplementing other insurance. By law, children are not eligible to enroll in CHIP if they have other insurance. CHIPRA provides an exception in the case of dental services, allowing states the option under CHIP to provide dental coverage for children who have other insurance.

In this survey, three states indicated that they would be adding this coverage for dental care, including *Iowa, Maryland* and *Oklahoma*.

Coverage of Pregnant Women Under CHIP

CHIPRA provides states with the option of covering pregnant women under CHIP with a standard State Plan Amendment. Previously, such coverage required a waiver. In general, the eligibility criteria and cost sharing must be similar to those for children. At the time of the survey, three states were planning on using this option under CHIP (*Maryland, New Jersey* and *West Virginia*).

Issues for CHIP in the Future

Without question, the most significant issue for CHIP program administrators in fiscal year 2010 is the economy, and the effect of the economic downturn on state revenues and the ability of the state to afford its share of program costs. At a time when more children and families are qualifying for Medicaid and CHIP, state revenues have been dropping, budget shortfalls are almost universal, and state programs and staff are being scaled back. Across the country, state officials referred to the fiscal challenges they face, which in some states translate into difficult program decisions driven by shortages in state funds. One CHIP director said the most significant issue facing CHIP is "…the impact that the economic downturn has had for families….The downturn has resulted and will continue to result in less tax revenue available for

the state to pay for programs that have seen huge increases in enrollment due to both increased unemployment and underemployment." In many states, there is concern that budget shortfalls will force program expansions and improvements to be put on hold until the fiscal situation improves, making it more difficult to enroll eligible children.

A second issue for CHIP administrators relates to implementation of the new CHIPRA requirements. States mentioned a number of mandatory provisions that require time to implement, including dental coverage, wrap-around services, employer contribution requirements, the citizenship documentation requirements, the premium grace period, mental health parity, disenrollment options in rural areas, working to implement eligibility policies to qualify for the performance bonuses, and new outreach strategies. One state commented: "Some of the CHIPRA provisions add financial burdens to the State CHIP budget at a time when [our] main financial concern is covering currently eligible children."

A third issue relates to ongoing uncertainty at the time of our survey about the role of CHIP in health reform. CHIPRA provided certainty for funding through 2013, but the future of the program and its potential role under health reform remained uncertain. CHIP directors expressed concern about what the role might be for a program that has demonstrated such success in covering children.

Conclusion

CHIP enrolled almost five million children in June 2009, an increase of 130,000 children or 2.7 percent above the 4.8 million enrolled a year earlier in June 2008. Increases in the number of children enrolled occurred in 31 states, with decreases occurring in 19 states and the District of Columbia. The relatively slow growth in the year ending in June 2009 was attributed to the fact that state policy makers were constrained by budget shortfalls and by the uncertainty caused by the program's temporary authorization during 2008 and early 2009. With the adoption of CHIPRA in February 2009, the program is now fully funded and authorized through federal fiscal year 2013, and many states are again acting to expand their programs and to find and enroll eligible children.

The focus of CHIP policy activity across states has been on the implementation of CHIPRA. There are new opportunities for outreach, as the federal government is awarding grants to states and community-based organizations to undertake outreach for Medicaid and CHIP. States can qualify for performance bonuses based on their adoption of specific policies and procedures that help streamline and simplify the eligibility process and growth in the number of children enrolled in Medicaid. These new federal policies in CHIPRA have created a new focus and priority on finding and enrolling eligible children, and an expectation that CHIP enrollment will increase in the future.

The economic downturn and its ongoing impact on state revenues continues to challenge state CHIP programs. However, even in difficult fiscal times, a total of 20 states listed eligibility or benefit enhancements they had implemented or plan to implement in state fiscal year 2010, including eligibility expansions in 13 states. States expect enrollment growth to accelerate in

2010, with average growth projected to be about eight percent, considerably greater than the 2.7 percent average growth in state fiscal year 2009.

States also face new opportunities and challenges with the passage of national health reform in March 2010. The health reform law provides funding for CHIP through 2015 (two years beyond funding provided by CHIPRA) and continues the program through 2019. The law also provides new protections for children who qualify for CHIP. For example, the law requires states to maintain Medicaid and CHIP eligibility through 2019, and by 2014 any child eligible for CHIP who cannot enroll due to the cap on federal CHIP funds will have to be screened for Medicaid eligibility or for comparable subsidized coverage in the newly created Health Insurance Exchanges. The health reform law ensures that CHIP will continue to play an important role in providing affordable coverage to low-income children and that it will be a key part of the continuum of coverage options available to families in the future.

Appendix A: Data Definitions and Methodology

The data in this report reflect the number of children and adults enrolled in CHIP programs in each state in the indicated month. For this report, state CHIP officials provided data specifically for the months of September and December 2008 and March and June 2009. States were encouraged to review data included in previous reports in this series and to update data as might be appropriate or previous periods. The data for this report were requested in September 2009 and responses were returned through December 2009.

The data in this report are "point-in-time," which means the number of individuals enrolled in a state program in a specific month, such as June 2009 for this report. A "point-in-time" count of enrollees is distinct from the "ever-enrolled" count, which is provided in reports issued by the federal Centers for Medicare and Medicaid Services (CMS). For example, the annual enrollment report from CMS for federal fiscal year 2007 (the year ending in September 2007, issued on February 7, 2008), reported a total of 7,144,794 children enrolled at any point in time and for any length of time during that year. In contrast, the number of children enrolled in the month of September 2007 per data provided by state officials for these reports was 4,494,200. A comparison of these two sets of data indicates that of the unduplicated count of 7,144,800 children enrolled at any point in time and for any length of time over the 12 months from October 2006 through September 2007, a total of 4,494,200 or 62.9 percent remained enrolled in September 2007, and 2,650,600 or 37.1 percent were no longer enrolled.

The annual count of children ever-enrolled will always exceed the number enrolled at any point-in-time, as long as new enrollments and disenrollments occur during the year. The greater the number of new enrollments and disenrollments, the greater will be the difference between the point-in-time and annual ever-enrolled counts. Recent experience is that over one-third of CHIP enrollees enrolled at any time and for any length of time during the year were not enrolled at the end of the year. The percentage has increased from about 30 percent in 2001 to 37 percent in 2007, indicating increasing rates of CHIP disenrollment over this period. The percentages calculated in the manner indicated above for federal fiscal years 2001 – 2007 are:

FFY 2001	29.9 percent
FFY 2002	31.5 percent
FFY 2003	33.3 percent
FFY 2004	35.1 percent
FFY 2005	34.1 percent
FFY 2006	37.3 percent
FFY 2007	37.1 percent

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

Appendix B: CHIP Premiums and Enrollment Fees as of June 2009

State	Requires Premiums or Enrollment Fees		Premium Amounts
	Yes	*No*	
U.S. Total	**36**	**15**	
Alabama	✓		$50 per child for families from 100-150% FPL $100 per child for families 151-200% FPL Maximum of 3 children per family pay premiums. Native Alaskans and Native Americans are excluded from paying premiums.
Alaska		✓	
Arizona	✓		100 -150% FPL: $10 for one child; $15 two or more children; Parents: 3% of monthly family income. 150-175% FPL: $40 for one child; $60 two or more children. Parents: 5% of monthly family income. 175-200% FPL: $50 one child, $70 two or more children; Parents: 5% of monthly family income.
Arkansas	✓		$25 per month. Premiums only for adults in HIFA waiver.
California	✓		Based upon income. Premiums range from $4-$17 per month per child with a family maximum of $51 per month. 25% discount for those using Electronic funds transfer.
Colorado	✓		151-200% FPL: $25 per year for one child, $35 per year for two or more children.
Connecticut	✓		Band 1 = 185-235% FPL: No premium Band 2 = 235-300% FPL: $30 per child per month, $50 per month two or more children. Band 3 = 300%+ FPL: based on group rate between $158-$230 per child per month.
Delaware	✓		$10, $15, $25 per family per month based upon income.
District of Columbia		✓	
Florida	✓		<150% FPL: $15 per month per family >150% FPL: $20 per month per family
Georgia	✓		FPL: One Child Family Cap 100-150%: $10.00 $15.00 151-160%: $20.00 $40.00 161-170%: $22.00 $44.00 171-180%: $24.00 $48.00 181-190%: $26.00 $52.00 191-200%: $28.00 $56.00 201-210%: $29.00 $58.00 211-220%: $31.00 $62.00 221-230%: $33.00 $66.00 231-235%: $35.00 $70.00
Hawaii	✓		No premiums up to 250% FPL; Sliding scale of up to $60 per child per month for families 250-300% FPL
Idaho	✓		133 – 150% FPL: $10 per child per month 150% of FPL and above: $15 per month per child in Separate program
Illinois	✓		150% of FPL and above: $15 for one child, $25 for

State	Requires Premiums or Enrollment Fees		Premium Amounts
	Yes	*No*	
			two, $30 for three; $35 for four; $40 for five or more children, per family per month.
Indiana	✓		150-175% FPL: $22 for one child, $33 two or more, per month, 175-200% FPL: $33 for one child, $50 two or more, per month. 200-225% FPL: $42 for one child, $53 two or more, per month, 225-250% FPL: $53 for one child, $70 two or more, per month.
Iowa	✓		> 150% FPL: $10 per child per month; $20 per family (more than one child) per month.
Kansas	✓		151-175% of FPL: $20 per month per 176-200% FPL $30 per month per family
Kentucky	✓		$20 per month per family with incomes > 150% FPL
Louisiana	✓		$50 per month per family with income from 201-250% FPL
Maine	✓		$8-$64 per month depending upon family size and income.
Maryland	✓		185-200% FPL: $0 PFPM 200-250% FPL: $48 PFPM 250-300% FPL: $60 PFPM
Massachusetts	✓		To 150% FPL: No premium. 150 - 200% FPL: $12 per child per month to family maximum of $36 201 – 250% FPL: $20 per child per month, to family maximum of $60 251 – 300% FPL: $28 per child per month, to family maximum of $84
Michigan	✓		$10 per family per month.
Minnesota	✓		Premiums are determined on a sliding scale based upon income and family size, and apply only to MinnesotaCare parents and caretakers covered under the Section 1115 waiver.
Mississippi		✓	
Missouri	✓		150-300% FPL: $13-$382 per month, based on income and family size.
Montana		✓	
Nebraska		✓	
Nevada	✓		Based upon family size and income: 0-35% FPL: $0 36 - 150% FPL: $25 per family per quarter 151-175% FPL: $50 per family per quarter 176-200% FPL: $80 per family per quarter Native Americans are exempt from all premiums.
New Hampshire	✓		185-250% FPL: $25 per child per month with $100 max per month 250-300% FPL: $45 per child per month with $135 max per month.
New Jersey	✓		150 - 200% FPL: $19 per month per family 201 - 250% FPL: $38.50 per month per family

State	Requires Premiums or Enrollment Fees		Premium Amounts
	Yes	*No*	
			251 - 300% FPL: $76.00 per month per family 301 - 350% FPL: $128 per month per family For parents: 150 – 200% FPL: $32.00 for first parent, plus $13.50 for second parent As of 7/1/09 premiums are no longer required for children between 150-200%. Premiums increased to: 201 - 250% FPL: $40.00 per month per family 251 - 300% FPL: $79.00 per month per family 301 - 350% FPL: $133 per month per family For parents: 150 – 200% FPL: $33.50 for first parent, plus $14 for second parent
New Mexico		✓	
New York	✓		< 160% FPL: $0 for individual and family 160 – 222% FPL: $9 individual, $27 family max. 223 – 250% FPL: $15 individual, $45 family max. 251 – 300% FPL: $30 individual, $90 family max. 301 – 350% FPL: $60 individual, $180 family max. American Indians/Native Americans exempt.
North Carolina	✓		Enrollment fee of $50 per child, or maximum of $100 per family for families between 150-200%FPL, no enrollment fee for families below 150% FPL.
North Dakota		✓	
Ohio		✓	
Oklahoma		✓	
Oregon		✓	
Pennsylvania	✓		>200% - 250% FPL: 25% of cost to state, approximately $43 per child per month >250% - 275% FPL: 35% of cost to state, approximately $60 per child per month >275% - 300% FPL: 40% of cost to state, approximately $69 per child per month >300% FPL: Families can buy CHIP benefit at the cost to the state, approximately $173 per child per month
Rhode Island	✓		150-185% FPL: $61 per family per month 185-200% FPL:$77 per family per month 200-250% FPL: $92 per family per month
South Carolina		✓	
South Dakota		✓	
Tennessee		✓	
Texas	✓		Enrollment fee for each six months. 133 – 150% FPL: $0 per family 151 – 185% FPL: $35 per family 186 – 200% FPL: $50 per family
Utah	✓		101-150% FPL: $30 per quarter per family 151-200% FPL: $60 per quarter per family
Vermont	✓		$60 per family per month
Virginia		✓	

State	Requires Premiums or Enrollment Fees		Premium Amounts
	Yes	*No*	
Washington	✓		$15 per child per month to maximum of $45 per month per household.
West Virginia	✓		200% FPL and above: $35 per month for one child; $71 per month for two or more children
Wisconsin	✓		Individual premium amounts for BadgerCare+: Children: 200-230% FPL: $10; 230-240% FPL: $15 240-250% FPL: $23; 250-260% FPL: $34 260-270% FPL: $$44; 270-280% FPL: $55 280-290% FPL: $68; 290-300% FPL: $82 Above 300% FPL: $97.53 Adult Caretakers: 150-160% FPL: $10; 160-170% FOL: $27 170-180% FPL: $68; 180-190% FPL: $122 190-200% FPL: $188; >200% FPL: $268 Total premiums for groups at or below 300% of FPL are capped at 5% of countable household income.
Wyoming		✓	

Note: Information in this table was provided by state CHIP officials in September through December 2009 in response to the survey question: "As of June 2009, were any CHIP enrollees required to pay a premium or enrollment fee?"

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