

## SCHIP Turns Five: Taking Stock, Moving Ahead

Jennifer M. Ryan, *Senior Research Associate*

**OVERVIEW**—*This issue brief notes the five-year anniversary of the effective date of Title XXI of the Social Security Act, the State Children’s Health Insurance Program (SCHIP). It looks at the successes of the program, as well as some of the obstacles SCHIP will face as it moves from childhood into adolescence and attempts to maintain its effectiveness in providing health coverage to uninsured children and families. The paper explores the critical funding impasse created by the downturns in the economy and the financing structure of the SCHIP statute. It also highlights the emerging issue of program retention and the need to minimize unnecessary disenrollments. Finally, the issue brief considers the prospects for SCHIP’s continued success—through bipartisan support in Congress and states’ efforts to develop new and improved strategies to maintain and even expand their SCHIP programs in the coming years.*

## SCHIP Turns Five: Taking Stock, Moving Ahead

October 1, 2002, will mark the five-year anniversary of the effective date of the State Children's Health Insurance Program (SCHIP). The program was the result of a bipartisan agreement in the Congress to provide new funding for health insurance coverage for low-income uninsured children. SCHIP was generally targeted at children in families with incomes below 200 percent of the federal poverty level, which equals \$36,200 for a family of four in 2002. Therefore, children eligible for the program are often in working families who cannot afford coverage or whose employers do not offer health benefits. States had the opportunity to set up a new, free-standing SCHIP program, to expand their existing Medicaid programs, or to develop a combination of the two approaches. By July 2000, every state and territory had implemented a SCHIP plan and, today, 21 states are operating Medicaid expansion programs, 16 states have separate SCHIP programs, and 19 states are operating combination programs.<sup>1</sup>

States took great pride in the new opportunity to develop their SCHIP programs and reach out to low-income families. They set up marketing campaigns, held outreach events featuring their governors, and came up with catchy names—such as Healthy Kids, Peach Care, and Hoosier Healthwise—for their new programs. Behind the scenes, states also simplified their programs to make them more user friendly. They shortened applications, encouraged families to apply by mail rather than making them come in to the welfare office, and removed some of the burdensome eligibility verification requirements. The federal government did its share as well. President Clinton and other members of the administration hosted many SCHIP events, including the launch of a nationwide outreach campaign, Insure Kids Now, that includes a toll-free number and Web site where families can call and be linked directly with enrollment information for SCHIP in their state.

In addition, in 1997, the Robert Wood Johnson Foundation (RWJF) signaled its strong support for the new SCHIP program by creating a \$47 million initiative called "Covering Kids." The initiative was designed to help states reach out to families and provide them with information about the availability of health coverage through SCHIP and Medicaid. Administered by the Southern Institute on Children and Families, Covering Kids has provided grants to all 50 states and the District of Columbia and has conducted nationwide outreach events as well as large-scale advertising campaigns and an annual back-to-school enrollment drive.

**National Health Policy Forum**

2131 K Street NW, Suite 500  
Washington DC 20037

202/872-1390

202/862-9837 [fax]

nHPF@gwu.edu [e-mail]

www.nHPF.org [web]

**Judith Miller Jones**

*Director*

**Judith D. Moore**

*Co-Director*

**Michele Black**

*Publications Director*

NHPF is a nonpartisan education and information exchange for federal health policymakers.

## SUCSESSES AND CHALLENGES

### Enrollment Growth

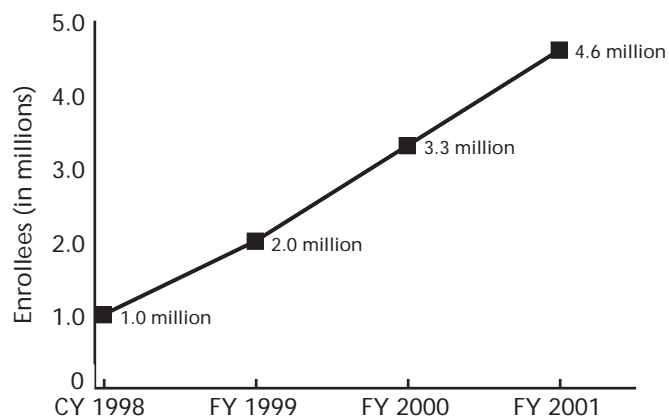
Despite initial delays and quandaries in some states about how to structure their new programs, states and their legislatures took a thoughtful approach toward the design and rollout of SCHIP. The result has been a steady trend of significant enrollment growth—over a million children each year—and a wide recognition of success by academics, advocates, and governments alike. The Centers for Medicare and Medicaid Services (CMS) reports that 4.6 million children were enrolled at some point during fiscal year (FY) 2001 (the year ending September 30, 2001)—an increase of 38 percent over the 3.3 million enrolled during the previous fiscal year (Figure 1).<sup>2</sup> These numbers are extremely encouraging, given the stated program goal of reducing the number of uninsured, and several studies have substantiated SCHIP's positive impact on the overall rate of uninsurance in the nation. As early as 2000, the Census Bureau's report on the Current Population Survey noted that the decrease in uninsured children was largely due to the outreach efforts resulting from SCHIP implementation.<sup>3</sup>

In addition, research is beginning to substantiate the anecdotal evidence from states that SCHIP outreach efforts have also resulted in significant increases in regular Medicaid enrollment. Outreach strategies and simplification efforts have not only made the SCHIP program user friendly, they have encouraged states to streamline their Medicaid programs in ways that begin to step away from the "welfare stigma" from which many states' programs still suffer. Covering Kids has played a significant role in encouraging state innovations with outreach and eligibility simplification activities for both SCHIP and Medicaid. In fact, on May 1, 2002, RWJF announced a new initiative, Covering Kids and Families, and provided an additional \$55 million in grants to support and enhance states' outreach and retention efforts over the next four years.

### Economic Downturn

The current economic situation has caused states to slow or even reverse some of those efforts in an attempt to control Medicaid spending and enrollment. A few states have considered or implemented similar changes to their SCHIP programs, including capping enrollment for extended periods of time. On the whole, however, states are committed

**FIGURE 1**  
Number of Children Ever Enrolled in SCHIP,  
Calendar Year 1998 through Fiscal Year 2001



Source: Centers for Medicare and Medicaid Services, "State Children's Health Insurance Program: Fiscal Year 2001 Annual Enrollment Report," U.S. Department of Health and Human Services, Washington, D.C., February 6, 2002.

to maintaining their programs and the streamlined processes that have helped them find and enroll uninsured children over the past four years.

These successes must be considered in the context of the number of uninsured children that have not yet been reached, the size of SCHIP compared to that of states' Medicaid programs, and the current fiscal environment. For more than a year, the economy has been a major cause for concern across the board, and nearly all states have reported shortfalls in their budgets. While the direct effect on program enrollment is just beginning to be documented, declines in the economy logically result in more families becoming unemployed, uninsured, and therefore eligible for Medicaid or SCHIP. This influx of eligibles could prove to be problematic for states in a time of even tighter budgets than usual. The Medicaid program already serves 21 million children, and federal funding accounted for an average of 15 percent of states' general revenues in 2001.<sup>4</sup> In addition, even though the SCHIP allotments are a separate and additional funding stream for states, they must contribute a portion of their own funds in order to draw down the federal enhanced match. When there is no state money to be had, the availability of federal matching funds is a small consolation. Finally, while several studies have indicated that SCHIP has had a positive impact on Medicaid enrollment, as well as the overall rate of uninsurance in the nation, the Census Bureau reports that there were still 8.4 million uninsured children in 2000, many of whom are eligible for Medicaid or SCHIP.<sup>5</sup> There is clearly much more work to be done.

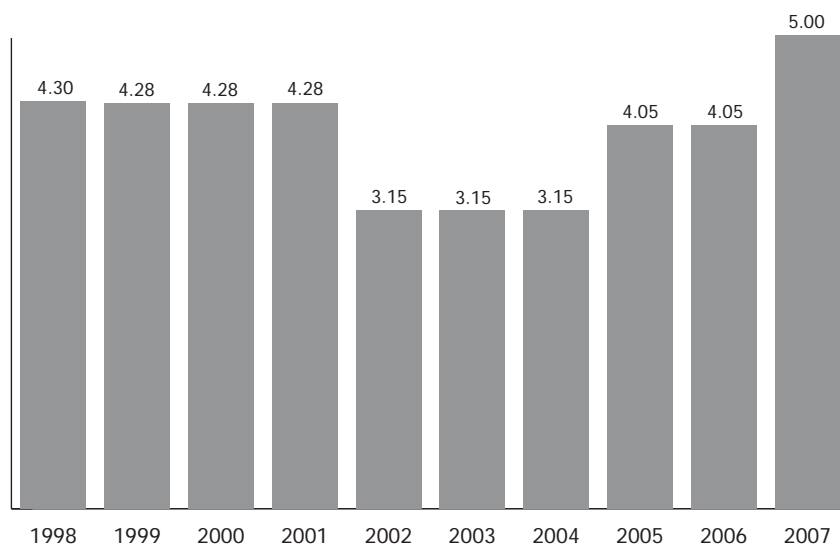
### The "SCHIP Dip"

When it was authorized as part of the Balanced Budget Act of 1997, the SCHIP program was funded as a block grant to states, providing them \$40 billion over ten years to expand health coverage to low-income uninsured children. However, as part of the budget balancing effort, the SCHIP funding was not distributed equally over the ten years. Instead, Congress allocated almost \$4.3 billion for each of the first four years of the program—1998 through 2001—but then decreased the funding by more than \$1 billion to \$3.15 billion for each of the following three years (Figure 2). So, between 2002 and 2004, states will experience a 26 percent decline in the amount of federal funding that is available to them for the maintenance (or unlikely expansion) of their SCHIP programs. Done with the sole purpose of helping to balance the overall federal budget, this "SCHIP dip" could mean a loss of SCHIP coverage for nearly 1 million children over the next three years.<sup>6</sup>

SCHIP funding is made available to the states through an allocation formula specified in the statute. The statute also includes a provision that requires any unspent SCHIP funds to be redistributed to states that fully expend their allotments at the end of a three-year period. These states would then have one additional year to spend the redistributed funds. In 2001, Congress amended this provision to allow for the redistribution

**When there is no state money to be had, the availability of federal matching funds is a small consolation.**

**FIGURE 2**  
**The SCHIP Dip:**  
**State Children's Health Insurance Program Allotments to States,**  
**FY 1998–FY 2007 (in billions of dollars)**



Source: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2002," Notice (CMS-2133-N), *Federal Register*, 66, no.208 (October 26, 2001); accessed August 13, 2002, at <http://cms.hhs.gov/schip/2133n.pdf>.

and retention of unused funds for FY 1998 and FY 1999. Any remaining unused funds from these years are scheduled to return to the U.S. treasury at the end of this fiscal year (September 30, 2002). Currently a total of \$2.8 billion of unspent federal funding is scheduled to revert to the treasury at the end of FY 2002 and FY 2003.<sup>7</sup>

On August 5, 2002, Sens. Jay Rockefeller (D-W.Va.), Lincoln D. Chafee (R-R.I.), Edward M. Kennedy (D-Mass.), and Orrin G. Hatch (R-Utah) introduced the Children's Health Improvement and Protection Act of 2002 (S.2860), legislation designed to correct the SCHIP dip and help avoid the reduction in SCHIP caseloads that has been anticipated under the current law. The bill would provide additional funding to restore SCHIP allotments for FY 2003 and FY 2004 to the FY 2001 level. The bill would also enable the expiring unspent SCHIP funds to remain with the states, rather than return to the U.S. treasury and continue to allocate unspent SCHIP funds equitably among the states.<sup>8</sup>

In addition to extending the availability of the existing funds, the legislation would also develop a "caseload stabilization pool" that would target the states most likely to have funding shortfalls in the coming years.<sup>9</sup> Analysis suggests that this approach could provide sufficient funding to

keep SCHIP caseloads from dropping and may even allow more children to receive coverage over the next five years of the program.<sup>10</sup> Although the future of this bill is uncertain, the administration has supported, in the president's 2003 budget, the goal of keeping SCHIP funding with the program and allowing it to continue to reach more uninsured children and families.

### Medicaid Budget Woes

As noted earlier, states' Medicaid budgets have become extremely tight as the economy has faltered over the past year. In response, the Senate, on July 25, 2002, approved a fiscal relief amendment that would provide a total of \$5.7 billion in additional Medicaid funding to temporarily increase the Medicaid matching rate for states that stand to have their federal medical assistance percentages (FMAPs)<sup>11</sup> decreased as a result of the strong economy of the late 1990s.<sup>12</sup> The FMAP recalculations are based on a Department of Health and Human Services (DHHS) analysis of three years of Census Bureau data on per capita income growth. Because they are based on the three-year average of these data, the adjustments are not immediately responsive to economic conditions. Consequently, the updated FMAPs, which will take effect on October 1, 2002, will reflect the tremendous economic growth between 1998 and 2000 (rather than states' current budgetary restrictions) and will only further compound their problems. Although the bill passed the Senate with very strong bipartisan support, there is no comparable bill in the House, so the future of this measure is not yet clear.

If these two bills eventually become law, states will gain some additional funds to help them sustain their Medicaid and SCHIP programs. However, the economy will continue to be the deciding factor in determining whether states will be able to further expand their programs to reach more uninsured children and families.

### Health Insurance Family Style

The theory that reaching out to and enrolling parents in health coverage will result in more children enrolled has become widely accepted over the past two years. Several states have made this assertion as a basis for an SCHIP Section 1115 demonstration and a means to access unspent SCHIP allotment funds. The Urban Institute looked at the first four states—New Jersey, Minnesota, Rhode Island, and Wisconsin—that received approval to use SCHIP funds to cover parents of children enrolled in the program and found that parents, and indeed their children, are enrolling readily in Medicaid and SCHIP. In fact, enrollment has even exceeded projected targets in some states. And state officials concluded that enrolling parents has led to substantial gains in child enrollment in both Medicaid and SCHIP, with child enrollment growing more rapidly than it did during the Medicaid child-only coverage expansions of the 1990s.<sup>13</sup>



More recently, states have been afforded even more flexibility to cover new populations and modify benefit packages and cost-sharing structures through a new approach to Section 1115 demonstrations and the new Health Insurance Flexibility and Accountability Initiative (HIFA) announced by DHHS in August 2001. In the past year, three states have received approval to expand coverage to adults using a Section 1115 waiver—California, Utah, and Arizona.<sup>14</sup>

Recently, questions and concerns have been raised regarding the additional flexibility the administration is providing states in using their SCHIP allotments. In particular, Arizona's demonstration, which uses SCHIP funding to provide coverage for childless adults, prompted strong criticism from the General Accounting Office (GAO). The concern is that allowing states to use unspent SCHIP funding to cover childless adults is not consistent with the statutory objective of expanding health coverage to low-income children. In a July 2002 report to the Senate Finance Committee, GAO asserted that DHHS has not, with its recent approvals of waivers under the new flexibility initiatives, consistently ensured that waivers are in line with program goals and are budget neutral. In fact, it concluded that the use of SCHIP funding for adults "is not authorized" under the statute.<sup>15</sup> GAO is further concerned that allowing coverage of childless adults could eventually prevent the redistribution of SCHIP funds to other states that have exhausted their allocations by covering children. The report recommends that the secretary of health and human services amend the approval of the Arizona waiver to prevent future use of SCHIP funds on childless adults and deny any pending proposals from other states. In addition, GAO recommends that Congress consider amending Title XXI, the SCHIP statute, to specify that SCHIP funds are not available for coverage of childless adults.<sup>16</sup>

In its comments on the GAO report, DHHS disagreed with the assertion that the Arizona waiver is inconsistent with the intent of the SCHIP statute. The agency argued that the Arizona waiver "must be viewed as a comprehensive approach in providing health insurance coverage to those who were previously uninsured, including parents and childless adults, some of whom may indeed be former Medicaid recipients."<sup>17</sup> It is not yet clear whether the administration will accept the GAO's recommendations or how it might respond to further criticisms from Congress. By making the request to GAO for an investigation, Congress does appear to be taking seriously the original intent of the SCHIP statute and the need to protect the funding that accompanies it.

## RETENTION: THE KEY TO THE FUTURE

While upward SCHIP enrollment trends have earned the states a reputation for innovation and commitment to the goal of reaching out to the uninsured, very little is known about what happens to families after they reach the end of their initial period of eligibility. Indeed, during

**Very little is known about what happens to families after they reach the end of their initial period of eligibility.**

the first few years of SCHIP, the main focus was on enrollment strategies: outreach, marketing, eligibility simplification, and cultural competency. Retention has always been a stated goal of SCHIP, but until recently monitoring disenrollment rates and eligibility renewal processes has generally taken a back seat to increasing enrollment.

Keeping eligible children enrolled in health care coverage is important, both administratively for states and in terms of health outcomes for children. Disruptions in health coverage can reduce continuity of care, result in missed preventive visits and place families in the tenuous position of trying to pay out-of-pocket for health care costs incurred during periods of uninsurance. In addition, since a significant number of children who are disenrolled return to public coverage within two months, (suggesting that they did not have access to other coverage), the costs of re-establishing eligibility and re-enrolling children in health plans can be burdensome for all involved.<sup>18</sup>

Retention has been an elusive issue, both semantically and in practice. States are free to design their renewal processes to best suit their own administrative structures and budgets, so comparing policies across states has been difficult. A few common themes have emerged, however, and several terms should be defined in order to clarify the discussion:

*Redetermination* is the process through which a family's SCHIP or Medicaid eligibility is reassessed. States have flexibility to decide how much information to request and how frequently to conduct redeterminations. Forty-two states have established a 12-month eligibility period in both their Medicaid and SCHIP programs,<sup>19</sup> but only a handful have significantly reduced the information required to redetermine eligibility. Of late, many states have begun to refer to redeterminations as *renewals* to help the program sound more like a commercial insurance product.

*Continuous eligibility* is a policy that allows families to remain enrolled in SCHIP or Medicaid for the entire eligibility period, regardless of a change in financial or other circumstances. Seventeen states currently provide children with 12 months of continuous eligibility.<sup>20</sup> (Many states have a 12-month eligibility period, but require families to report changes in income to the SCHIP or Medicaid agency, which would lead to an earlier eligibility redetermination and possible discontinuation of coverage.)

*Passive renewal* is a policy that a few states have implemented that allows families to stay enrolled in the program without being required to actively submit new income or other eligibility information to the state. Instead, the state sends the family a preprinted renewal form and asks them to return the form only if information needs to be updated. Passive renewal is often done in combination with a monthly premium. In this case, at the point of redetermination, states assume the family is still financially eligible and living in the state as long as they continue to make the premium payment.

**Keeping eligible children enrolled in health care coverage is important, both administratively for states and in terms of health outcomes for children.**



## NASHP and CHIRI— First Looks at Retention

In 2001, with funding from the David and Lucile Packard Foundation, the National Academy for State Health Policy (NASHP) established a SWOT (Strengths, Weaknesses, Opportunities and Threats) Team made up of seven states operating stand-alone SCHIP programs (Alabama, Arizona, California, Georgia, Iowa, New Jersey, and Utah) that agreed to take an in-depth look at their eligibility renewal processes and corresponding retention rates. NASHP contracted with a national research firm to conduct a study from the families' perspective. Lake Snell Perry and Associates conducted focus groups and a telephone survey with parents of current and past SCHIP enrollees. The study focused on two groups, current enrollees who have been enrolled in SCHIP for at least 6 months and "lapsed families" who had been terminated from the program either for nonpayment of their premiums or for failure to complete the renewal process.

The findings of the survey and focus group discussions include the following:

- Parents appreciate SCHIP and consider it a "high-quality" program. They want to keep their children enrolled (or would like to re-enroll them).
- Both programs and parents play a role in the effectiveness of the retention process—while it is clear that states could do more to make the renewal process more user friendly and less burdensome, many parents reported that they just had not gotten around to sending in the paperwork.
- Most parents consider the premium to be reasonable and say they feel good about contributing toward their children's coverage, but they sometimes have trouble finding the money to pay the premiums.<sup>21</sup>

While the results highlight positive aspects of the programs, they also indicate a few areas for concern and, perhaps most importantly, make it clear that very little is really known about retention at this point. There will undoubtedly be continuing lessons—similar to those states have been able to learn from each other about enrollment and outreach strategies—in finding the most effective and efficient retention strategies.

The Child Health Insurance Research Initiative (CHIRI), led jointly by the federal Agency for Health Care Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA) and funded

## Florida – Healthy Kids

Florida's Healthy Kids program is highlighted in the CHIRI study as having the most success with retention to date. This success is largely attributed to the use of a passive renewal process in which the state simply sends out a form preprinted with the family's information and asks the family to return it only if information needs to be updated. The state's use of a "universal premium" of \$15 per month for all SCHIP families provides a second check on eligibility for the state. Families who move out of the state, purchase other coverage, or do not want to continue with the program simply stop paying their premiums and the state discontinues coverage after three months. Consequently, 58 percent of children were enrolled in Healthy Kids at the two-year anniversary of their initial enrollment date and, although the state does not have a 12-month continuous eligibility policy, disenrollment rates were no greater at redetermination than at any other time.<sup>22</sup>

by AHRQ, HRSA, and the David and Lucile Packard Foundation, looked at renewal and disenrollment policies in four states—Kansas, Oregon, New York, and Florida. The study examined state policies in more detail and attempted to measure how each state's combination of strategies affected their overall retention rates. The study yielded many interesting findings, some dos and don'ts, and opportunities for further thinking and experimentation by states.

■ More than half of the children in New York and Florida were enrolled in SCHIP at the two-year anniversary of their initial enrollment; however, many of these children had been disenrolled at least once during that time.

■ Complex and administratively burdensome redetermination requirements can generate large numbers of disenrollments (as many as 50 percent). While some represent transfers to Medicaid or other coverage, 25 percent of those who were disenrolled re-enrolled in SCHIP after two months. This suggests that these children did not obtain other coverage and had likely been disenrolled inappropriately.

■ Longer periods of continuous eligibility result in better program retention, but requiring additional paperwork and concrete verification of income still results in spikes in disenrollment at the end of the continuous eligibility period.

■ Even in the absence of 12-month continuous eligibility, a passive renewal policy seems to have the most positive effect on program retention.<sup>23</sup>

These two studies and other anecdotal information from states provide interesting opportunities for other states to think about ways to improve their renewal processes and keep children enrolled in SCHIP for as long as they are eligible.

## THE FUTURE OF SCHIP: MOVING AHEAD

As SCHIP moves from childhood into adolescence, the successes and challenges, but also the lessons learned, will undoubtedly continue. In the grand scheme of things, federal funding for the program is secured by the statute until 2007, and SCHIP and Medicaid will likely play a role in the continuing debate over universal health coverage. On a more local scale, states will continue to refine their programs and learn from each other about what works best. They will share ideas about enrollment and

### North Carolina – Health Choice for Children

North Carolina enacted a freeze on new enrollment in Health Choice for Children from January until October of 2001, with some interesting and unexpected results. During the 10-month period, children were placed on a waiting list and remained there until the state determined that enough children had disenrolled from the program. The state began to enroll children off the waiting list in July 2001 and by October had enrolled a total of 36,000. The state found that negative publicity about the freeze, combined with its efforts to remind families of the importance of re-enrolling in order to keep their coverage for an indefinite period of time, resulted in more families taking the renewal process seriously and staying enrolled in the program; only 25 percent of families coming up for renewal during the freeze period did not re-enroll in Health Choice.<sup>24</sup>

retention strategies, cost-sharing and benefit structures, and creative financing mechanisms. States will also continue to have opportunities to experiment with their SCHIP and Medicaid programs—expand them to (some) new populations, work with the private sector to blend funding and benefit packages, and continue to reach out to low-income families whose children are in great need of health care coverage.

---

## ENDNOTES

1. Centers for Medicare and Medicaid Services, "State Child Health Insurance Program Plan Activity Map," updated as of August 6, 2002; accessed August 13, 2002, at <http://www.cms.hhs.gov/schip/chip-map.asp>.
2. Centers for Medicare and Medicaid Services, "State Children's Health Insurance Program Annual Enrollment Report: Fiscal Year 2001: October 1, 2000–September 30, 2001," February 6, 2002; accessed July 30, 2002, at <http://www.cms.hhs.gov/schip/schip01.pdf>. These data indicate the number of children "ever enrolled" during the course of the year, not to be confused with "point-in-time" enrollment numbers that indicate enrollment during a given month. For example, Vernon Smith, Ph.D., has conducted an ongoing survey of states' enrollment counts for December of each year, finding that 3.5 million children were enrolled in SCHIP in December 2001.
3. U.S. Census Bureau, "Health Insurance Coverage: Consumer Income—1999," Estimates based on the March 2000 Current Population Survey, September 29, 2000, 9; accessed August 12, 2002, at <http://www.census.gov/prod/www/abs/popula.html#income>. Mathematica Policy Research, Inc., and the Urban Institute have also done analysis to further quantify this effect.
4. Kaiser Commission on Medicaid and the Uninsured, "Medicaid 'Mandatory' and 'Optional' Eligibility and Benefits," Washington, D.C., July 2001, 1.
5. U.S. Census Bureau, "Health Insurance Coverage: Consumer Income—2000," Based on the March 2001 Current Population Survey, Washington, D.C., September 2001, 3; accessed August 13, 2002 at <http://www.census.gov/prod/www/abs/popula.html#income>. There are a range of estimates regarding the numbers of uninsured children that are actually eligible for Medicaid or SCHIP, but are not enrolled. Urban Institute analysis has estimated that 6.8 million uninsured children are eligible but unenrolled, with 4.6 million eligible for Medicaid and 2.3 million eligible for SCHIP (these estimates account for immigrant children as well). See Lisa Dubay, Jennifer Haley, and Genevieve Kenney, "Children's Eligibility for Medicaid and SCHIP: A View from 2000," Urban Institute, Washington, D.C., March 2002, 3; accessed August 13, 2002, at <http://www.urban.org/uploadedPDF/310435.pdf>. Another recent analysis, by John Holohan at the Urban Institute, has estimated that nearly 5 million children are eligible for the programs but have not been reached. See also Robert Wood Johnson Foundation, "New Data: Nearly 5 Million Children in America Are Needlessly Uninsured," press release, Washington, D.C., August 1, 2002; accessed August 6, 2002, at <http://www.rwjf.org/newsEvents/index.jsp>.
6. Office of Management and Budget, *Analytic Perspectives, Budget of the United States Government, Fiscal Year 2003*, 297; accessed August 13, 2002, at <http://www.whitehouse.gov/omb/budget/fy2003/pdf/spec.pdf>. See also Edwin Park, Leighton Ku, and Matthew Broaddus, "OMB Estimates Indicate that 900,000 Children Will Lose Health Insurance Due to Reductions in Federal SCHIP Funding," Center on Budget and Policy Priorities, Washington, D.C., July 15, 2002; accessed August 8, 2002, at <http://www.cbpp.org/7-15-02health.htm>.
7. On September 20, 2002, \$1.2 billion is scheduled to expire and revert to the treasury; an additional \$1.6 billion is expected to expire on September 30, 2003.
8. Office of Sen. Jay Rockefeller, "Fact Sheet on Rockefeller-Chafee-Kennedy-Hatch Children's Health Improvement and Protection Act of 2002, August 1, 2002; accessed August 6, 2002, at <http://www.rockefeller.senate.gov/2002/pr080102b.html>.

9. Ku, Park, and Broadus, "OMB Estimates."
10. Leighton Ku, telephone conversation with author, August 12, 2002.
11. Medicaid is jointly funded by the states and the federal government. The federal government matches state Medicaid expenditures at a specified Federal Medical Assistance Percentage (FMAP). The Medicaid statute established federal matching rates for each state based on a calculation of the ratio of the average per capita income of individuals residing in the state to the average per capita income for the United States as a whole. Based on this formula, FMAPs range from 50 percent in Colorado to 77 percent in Mississippi.
12. Vic Miller, "Senate Approves Temporary Fiscal Relief Amendment," Issue Brief 02-43, Federal Funds Information for States, Washington, D.C., July 31, 2002.
13. Embry Howell, Ruth Almeida, Lisa Dubay, and Genevieve Kenney, "Early Experience with Covering Uninsured Parents under SCHIP," Series A, No. A-51, Urban Institute, Washington, D.C., May 2002, 5; accessed August 12, 2002, at [http://www.urban.org/UploadedPDF/310498\\_A51.pdf](http://www.urban.org/UploadedPDF/310498_A51.pdf).
14. It should be noted that Utah's demonstration is not technically a HIFA waiver, because it does not meet all of the specific criteria outlined in the August 2001 HIFA guidance. For more information on HIFA and on Section 1115 demonstrations in general, see Jennifer M. Ryan, "1115 Ways to Waive Medicaid and SCHIP Rules," Issue Brief No. 777, National Health Policy Forum, June 13, 2002; available at [http://www.nhpf.org/pdfs/8-777+\(web\).pdf](http://www.nhpf.org/pdfs/8-777+(web).pdf). See also, Cindy Mann, "The New Medicaid and CHIP Waiver Initiatives," Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., February 2002; available at <http://www.kff.org/content/2002/4028/4028.pdf>.
15. U.S. General Accounting Office (GAO), "Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns," Report to the Committee on Finance, U.S. Senate (GAO-02-817), Washington, D.C., July 2002, 4, 14; accessed August 14, 2002, at <http://www.gao.gov>.
16. GAO, "Medicaid and SCHIP," 5.
17. GAO, "Medicaid and SCHIP," Appendix IV: Comments from the Department of Health and Human Services, 52.
18. Karen VanLandeghem and Cindy Brach, "SCHIP Disenrollment and State Policies," Issue Brief No.1, Child Health Insurance Research Initiative, Washington, D.C., June 2002, 3. The study looked at redetermination policies in four states—Florida, Kansas, New York, and Oregon—and found that in the latter three states up to 50 percent of children were being disenrolled at redetermination and estimated that up to 25 percent of them returned to the program within two months.
19. Donna Cohen Ross and Laura Cox, "Enrolling Children and Families in Health Coverage: The Promise of Doing More," Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., June 2002, 34.
20. Cohen Ross and Cox, "Enrolling Children," 34. A few states offer six months of continuous eligibility as well.
21. Trish Riley, Cynthia Pernice, Susan Kannel, and Michael Perry, "Technical Report: Why Eligible Children Lose or Leave SCHIP," National Academy for State Health Policy, Portland, Maine, May 2002, 6.
22. K. VanLandeghem and C. Brach, "SCHIP Disenrollment and State Policies," Issue Brief No. 1, Child Health Insurance Research Initiative, Washington, D.C., June 2002, 2; based on Andrew W. Dick et al., "The Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review*, 23, no. 3 (Spring 2002), 67–69.
23. Van Landeghem and Brach, "SCHIP Disenrollment, 1"; Dick et al., "Consequences."
24. State of North Carolina, "Federal Fiscal Year 2001 State Children's Health Insurance Program Annual Report," section 1.1 - 1.2, as submitted to the Health Care Financing Administration, U.S. Department of Health and Human Services, September 17, 2001; accessed August 4, 2002, at <http://www.cms.hhs.gov/schip/charnc01.pdf>.