Frequently Asked Questions…

SCHIP

In This FAQ...

What is SCHIP?

The State Children's Health Insurance Program (SCHIP)[1] is a partnership between the federal government and the states and is designed to provide health insurance coverage for targeted low-income children under age 19 who are not eligible for Medicaid. SCHIP is a capped entitlement to states under which states receive an enhanced federal match rate. It was created as part of the Balanced Budget Act of 1997 (BBA-97; P.L. 105-33) and enacted as Title XXI of the Social Security Act. In the act, Congress allocated over $40 billion for SCHIP through 2007, making it the largest federal expansion of health insurance coverage since the passage of Medicaid in 1965. The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) has federal oversight authority for all state SCHIP programs, activities and expenditures.

How is SCHIP structured?

The law gives states significant freedom in designing their programs[2], allowing states to use SCHIP funds in three ways.

1) Medicaid Expansions broaden Medicaid to cover older children or children from families with incomes too high for them to qualify for regular Medicaid. In Medicaid expansion plans, all Medicaid rules apply. Service delivery occurs through the same providers and systems, benefits are the same as Medicaid benefits, Medicaid's restrictions on

cost sharing apply, and the state may not cap enrollment (turn away applicants who are eligible) after a certain number of children have enrolled or after the state has exhausted its funds. The state receives federal reimbursement for expenses at its regular Medicaid "match rate."

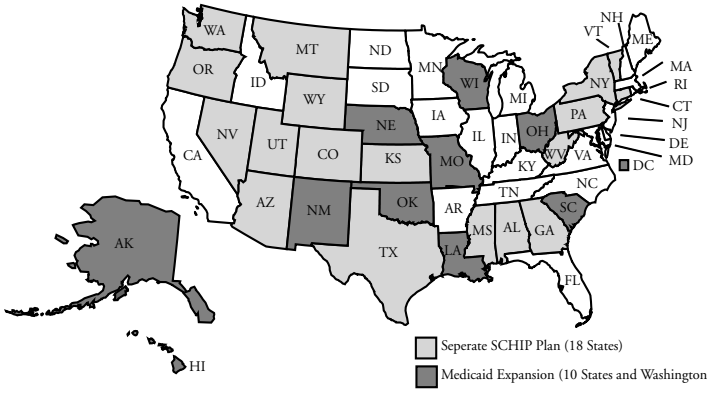
2) State-Designed or Private Plans create an entirely new program with a benefit package consistent with provisions of Title XXI (see *"What services does SCHIP cover?"*). In state-designed SCHIP programs, service delivery, quality assurance mechanisms, enrollment procedures, benefits and even the name of the program may be different from those of Medicaid. State-designed programs must be approved by the secretary of the Department of Health and Human Services. States have several benefit package options.

✦ *Benchmark coverage*. Benefit packages must be equivalent to either the Federal Employees' Health Benefit Package, the Blue Cross/Blue Shield plan in the state, the benefit package offered to state employees or the package offered by the HMO in the state with the largest non-Medicaid enrollment.

✦ *Benchmark-equivalent*. Benefits must have the same actuarial value as one of the benchmark benefit packages. Coverage must include inpatient and outpatient hospital services, physicians' services, lab and x-ray, and well-baby and well-child visits, including age-appropriate immunizations.

✦ *Existing state-based comprehensive coverage*. Benefits must be equivalent to other state-subsidized, non-Medicaid programs that existed before SCHIP.

Figure 1.
SCHIP Plan Structure



Source: CMS SCHIP Activity Map, January 18, 2007. Availabe at http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/SCHIPStatePlanActivityMap.pdf

3) Combination Plans both expand Medicaid and create a separate private plan, for different populations. In state-designed plans—or state-designed portions of combination plans—SCHIP is not an entitlement. Thus, the program is not required to accept new enrollees if its capacity has been reached or if the state has expended all available funds. States may choose to enroll kids in coverage after spending their full SCHIP allotment, although they are required to use their own funds to do so.

All states, territories and the District of Columbia have established SCHIP programs. Eighteen states operate a separate SCHIP program, 10 states plus the District of Columbia use their SCHIP funds only in Medicaid, and 22 states use a combination approach in which SCHIP funds are used to expand Medicaid and to cover a group of higher income children in a separate program[3] (see figure 1).

Who is covered by SCHIP?

As of April 2006, SCHIP covered about 4.4 million kids. State-by-state enrollment is listed in table 1.

SCHIP eligibility is limited to targeted low-income children under age 19 unless a state has obtained a waiver from CMS (see below). SCHIP allows coverage for children from families earning up to 200 percent of the federal

Table 1. Current Monthly SCHIP Enrollment, June 2005

Alabama	64,342	Nebraska	23,132
Alaska	11,366	Nevada	28,836
Arizona	50,638	New Hampshire	7,022
Arkansas	61,102	New Jersey	115,222
California	816,406	New Mexico	10,647
Colorado	40,696	New York	426,529
Connecticut	15,696	North Carolina	130,467
Delaware	4,360	North Dakota	4,136
Florida	203,983	Ohio	122,796
Georgia	228,801	Oklahoma	54,427
Hawaii	14,108	Oregon	25,014
Idaho	13,787	Pennsylvania	136,511
Illinois	135,984	Rhode Island	11,756
Indiana	68,939	South Carolina	52,561
Iowa	34,913	South Dakota	10,610
Kansas	34,611	Tennessee	0 *
Kentucky	49,377	Texas	326,473
Louisiana	107,914	Utah	28,268
Maine	13,989	Vermont	2,992
Maryland	95,018	Virginia	73,187
Massachusetts	65,289	Washington	12,956
Michigan	56,195	West Virginia	24,515
Minnesota	2,122	Wisconsin	28,006
Mississippi	68,068	Wyoming	4,121
Missouri	93,730	District of Columbia	4,573
Montana	10,908		

Note: *Tennessee phased out its Medicaid expansion program in September 2002.
Sources: Compiled by the Health Management Associates from state Medicaid enrollment reports, for the Kaiser Commission on Medicaid and the Uninsured. Data as of June 2005, published December 2006.

poverty level (FPL) ($20,650 per year for a family of four), or 50 percentage points higher than the state had previously covered under Medicaid. Some states have increased eligibility levels to an even higher level, while others have set maximum income levels below 200 percent of poverty. Twenty-five states and the District of Columbia have income limits at 200 percent of the FPL, 13 states exceeded 200 percent of the FPL, and the remaining 12 states set maximum income levels below 200 percent of the FPL. Applicants must be uninsured at the time of application, must not be eligible for Medicaid or state employee coverage through a parent, and must not be a resident of a state institution.

Although SCHIP is aimed mainly at covering children, states have obtained waivers to use SCHIP funds to cover adults. As of March 2006, for example, 15 states had obtained waivers that were financed at least in part by SCHIP appropriations. In 12 of these states, SCHIP coverage was extended to include one or more categories of adults with children, typically parents of Medicaid/SCHIP children, caretaker relatives, legal guardians, and/or pregnant women. At the end of 2006, four states had waivers to use SCHIP to cover childless adults, and nine states cover unborn children who will be eligible for SCHIP at birth as well as prenatal and childbirth services for the mother of the child.

The Deficit Reduction Act (DRA) of 2005 prohibits the secretary of the U.S. Department of Health and Human Services from granting new SCHIP waivers to states to cover nonpregnant, childless adults. This prohibition, however, does not apply to current demonstrations or to the extension, renewal or amendment of existing demonstrations.

What services does SCHIP cover?

As mentioned above, when designing their SCHIP programs, states may expand their Medicaid programs, create a separate program or combine both approaches.

All state SCHIP programs cover inpatient, outpatient and emergency care (although many states charge higher copayments for inappropriate use of the emergency room) and many kinds of specialist care. States are required to provide well-baby and well-child visits, as well as immunizations. Additionally, almost all states cover mental health and substance abuse services, although states may limit such services by, for example, capping the number of visits or total costs that may be incurred per year.

In states that use managed-care plans to deliver SCHIP benefits, mental health and substance abuse services often are delivered through a fee-for-service arrangement or through "carve-outs"—separately administered managed care groups that deliver only that type of specialty service.[4]

States that use their SCHIP programs to expand Medicaid coverage to more low-income children must provide all mandatory Medicaid benefits, as well as all optional services specified in their state Medicaid plans. Under the DRA of 2005, states have the option to enroll particular populations into new benchmark and benchmark-equivalent plans. Benchmark-equivalent plans must also include at least 75 percent of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category." These additional services include prescription drugs, mental health services, vision services and hearing services.

How does SCHIP differ from Medicaid?

SCHIP was designed to complement Medicaid by expanding access to low-income children. Key differences between Medicaid and SCHIP are summarized in table 2.

Table 2. Medicaid/SCHIP Characteristics

Category	Medicaid	SCHIP
Covered Groups	• Low-income children • Low-income parents and pregnant women • Low-income children and adults with disabilities • Low-income elderly	• Targeted low-income children with incomes above Medicaid eligibility levels who do not have private health insurance • "Unborn children" • Some parents and other adults through waivers, although the option to cover childless adults was removed in the 2005 DRA
Number of Enrollees	• 28 million children	• 4.4 million children
Funding	• Open-ended entitlement • Enrollment caps prohibited	• Entitlement to states, not individuals • The annual funding level is set by statute and is based on the number of low-income children and low-income uninsured children in the state; it includes a cost factor that represents the average health service industry wages in the state compared to the national average
Match Rate	• Federal match rates in Medicaid range from 50 percent to 76 percent	• States receive an enhanced match for SCHIP. Rates range from 65 percent to 83.2 percent (See table 3)
Scope of Coverage	• Comprehensive range of federally defined benefits, including EPSTD, dental, mental health, prevention or EPSTD wrap-around coverage for states opting to provide benchmark coverage	• States have flexibility in defining plans, although all benchmark plans must include basic benefits, as defined in statute • This flexibility applies to separate SCHIP programs, not to Medicaid expansion programs

COST SHARING

Cost sharing refers to out-of-pocket payment—such as premiums, deductibles, coinsurance, copayments, or other fees—made by health insurance enrollees. Federal law permits states to require some SCHIP beneficiaries to share costs.[5] Cost-sharing may not be required for preventive services such as well-child services, routine physical examinations, associated laboratory tests, immunizations, and routine preventive and diagnostic dental services.

States that cover targeted low-income children under Medicaid expansion plans must follow Medicaid's cost-sharing rules . Medicaid rules prohibit premiums for children in families with incomes between 100 percent and 150 percent of the FPL, but states can require service-related cost-sharing of up to 10 percent of the cost of the service rendered. For children in families with incomes above 150 percent of the FPL, states may charge premiums and can require cost-sharing of up to 20 percent of the cost of the service rendered.

States with separate state-designed SCHIP programs may charge children at or below 150 percent of the FPL a monthly premium of no more than $19 and nominal co-payments that generally are no more than $5. States may set their own premium and cost-sharing schedules for children in families with incomes above 150 percent of the FPL, as long as cost-sharing is not lower for higher income children than for lower income children.

Under both Medicaid and SCHIP rules, total cost-sharing obligations cannot exceed 5 percent of family income.

How is SCHIP funded?

SCHIP is an entitlement to states. The federal government shares the expense of the SCHIP program by paying a percentage of the costs of covering youngsters. The percentage of expenses that the federal government contributes to each state is equivalent to 70 percent of the federal government's match rate for the Medicaid program (known as the Federal Medical Assistance Percentage Matching Rate, or the FMAP) plus 30 percentage points, up to a maximum of 85 percent. The SCHIP match rate also is called the "enhanced FMAP" (see table 3).

Each state is entitled to a specific maximum allotment of federal funds each year, as established in statute. The first year for which Congress allocated money for SCHIP was federal fiscal year 1998 (beginning October 1, 1997). States are allowed three years (e.g., FY 2004, FY 2005, FY 2006) to spend their allotments. After that date, Title XXI provides that all remaining funds be reallocated to states that have used up their allotments.

In response to federal budget pressure, the allocation schedule included a decrease in federal funds in Fiscal Years 2002 to 2004, commonly referred to as the "SCHIP Dip." During the "dip," federal funds decreased by about 25 percent (ranging annually from $4.275 billion to $3.15 billion). The downturn in federal revenues and payments occurred at a difficult time for states, which were contending with their own budget crises and an increasing number of uninsured children and adults (see figure 2).

What is Reallocation?

The rules regarding reallocation vary by fiscal year. Generally, the year-specific rules divide states into two groups for the purpose of reallocation:

Table 3. Medicaid and State Children's Health Insurance Program Federal Match Rates (FMAP), FY 2007

State/Jurisdiction	Medicaid	SCHIP	State	Medicaid	SCHIP
Alabama	68.85%	78.20%	Nevada	53.93%	67.75%
Alaska	57.58%	70.31%	New Hampshire	50.00%	65.00%
Arizona	66.47%	76.53%	New Jersey	50.00%	65.00%
Arkansas	73.37%	81.36%	New Mexico	71.93%	80.35%
California	50.00%	65.00%	New York	50.00%	65.00%
Colorado	50.00%	65.00%	North Carolina	64.52%	75.16%
Connecticut	50.00%	65.00%	North Dakota	64.72%	75.30%
Delaware	50.00%	65.00%	Ohio	59.66%	71.76%
Florida	58.76%	71.13%	Oklahoma	68.14%	77.70%
Georgia	61.97%	73.38%	Oregon	61.07%	72.75%
Hawaii	57.55%	70.28%	Pennsylvania	54.39%	68.07%
Idaho	70.36%	79.25%	Rhode Island	52.35%	66.64%
Illinois	50.00%	65.00%	South Carolina	69.54%	78.68%
Indiana	62.61%	73.83%	South Dakota	62.92%	74.04%
Iowa	61.98%	73.39%	Tennessee	63.65%	74.56%
Kansas	60.25%	72.18%	Texas	60.78%	72.55%
Kentucky	69.58%	78.71%	Utah	70.14%	79.10%
Louisiana	69.69%	78.78%	Vermont	58.93%	71.25%
Maine	63.27%	74.29%	Virginia	50.00%	65.00%
Maryland	50.00%	65.00%	Washington	50.12%	65.08%
Massachusetts	50.00%	65.00%	West Virginia	72.82%	80.97%
Michigan	56.38%	69.47%	Wisconsin	57.47%	70.23%
Minnesota	50.00%	65.00%	Wyoming	52.91%	67.04%
Mississippi	75.89%	83.12%	District of Columbia	70.00%*	79.00%*
Missouri	61.60%	73.12%	**Average FMAP**	**60.16%**	**71.90%**
Montana	69.11%	78.38%	**Median FMAP**	**60.25%**	**72.18%**
Nebraska	57.93%	70.55%			

Note: *The values for the District of Columbia in the table were set for the state plan under titles XIX and XXI and for capitation payments and DSH allotments under those titles. For other purposes, including programs remaining in Title IV of the act, The District values are 50 percent.
Source: For FMAP and SCHIP rates see Federal Register at http://aspe.hhs.gov/health/fmap07.htm.

- Those states that fully exhaust the original allotment by the three-year deadline, called *redistribution states*; and
- Those states that did *not* exhaust the original allotment by the three-year deadline, called *retention states*.

Congress has adjusted the reallocation formula twice, extending the time frame for state use their original allotments, and preventing the funds from reverting to the U.S. Treasury. In 2000 and 2002, Congress took action to help states avoid losing approximately $3.46 billion.[6]

In September 2004, nearly $1.1 billion in unspent SCHIP funds reverted to the U.S. Treasury. That marked the first time Congress did not redistribute unspent funds to overspending states, but allowed the money to exit the program. To close the shortfalls in FY2005, Congress appropriated $283 million to states in the 2005 DRA .[7]

What is the SCHIP Shortfall?

Although excess funds were available in the early years of the program, the reverse is true now. The success of national and state efforts to enroll children, combined with rising health-care costs, have caused annual allotments to fall short of the amount needed to operate existing SCHIP initiatives. Many states relied on surpluses accumulated during

Table 4. Projected Federal SCHIP Shortfalls, FY 2006-2007, and Other SCHIP Characteristics, Among Shortfall States
(in millions of dollars)

Shortfall States	Projected Shortfalls		FY2005 Enrollment		FY2007	Upper-Income
	FY2006	FY2007	Children	Adults	FMAP	Eligibility
Alaska		$9.3	22,322		70.3%	175%
Georgia		$117.9	306,733		73.4%	235%
Illinois	$75.9	$244.6	281,432	175,994	65.0%	200%
Iowa		$16.1	46,562		73.4%	200%
Louisiana		$3.9	109,150		78.8%	200%
Maine		$0.6	30,654		74.3%	200%
Maryland		$67.4	120,316		65.0%	300%
Massachusetts	$12.0	$129.8	162,679		65.0%	300%
Minnesota		$31.7	5,076	35,011	65.0%	280%
Mississippi		$39.2	79,352		83.1%	200%
Missouri		$27.8	115,355		73.1%	300%
Nebraska	$0.4	$11.5	44,706		70.6%	185%
New Jersey	$9.6	$156.5	129,591	66,827	65.0%	350%
North Carolina		$17.7	196,181		75.2%	200%
Rhode Island		$43.3	27,144	24,169	66.7%	250%
South Dakota		$2.6	14,038		74.0%	200%
Wisconsin		$7.0	57,165	108,808	70.2%	185%
Shortfall States' Total	**$98.0**	**$926.9**	**1,748,456**	**410,809**		

Source: Congressional Research Service (CRS) SCHIP Projection Model, July 2006.

the early years of the program to avoid running out of funds, but those surpluses are dwindling.[8]

FY 2006 marked the first year in which numerous states faced SCHIP shortfalls, even after the redistribution of unspent SCHIP funds (see table 4).

Analysts anticipated that, in 2007, as many as 17 states would face a combined shortfall of $927 million, roughly the cost of covering 530,000 children.[9] Just prior to adjournment in 2006, however, Congress approved a law that includes a provision to redistribute existing unspent SCHIP funds to the states that are facing shortfalls in 2007.

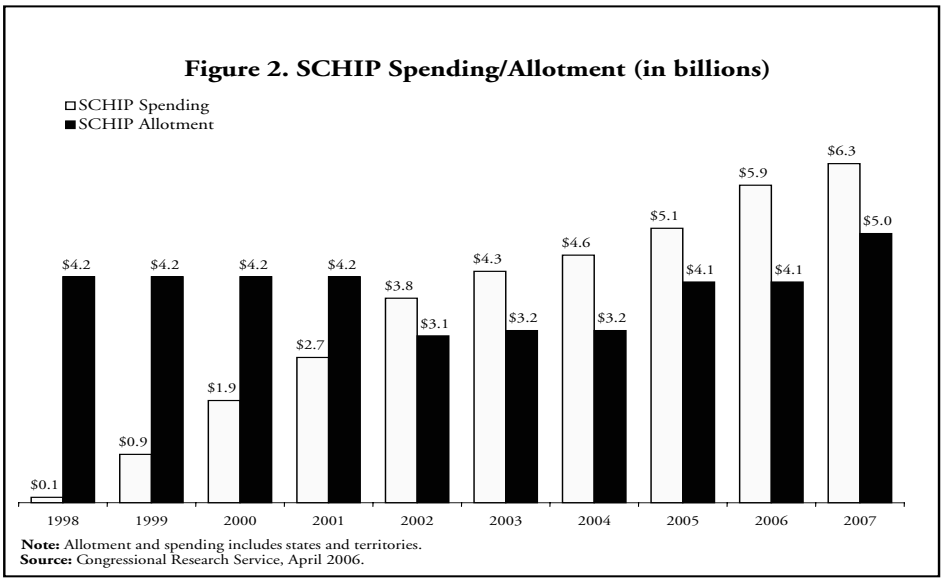
Under the National Institutes of Health Reform Act of 2006 (H.R. 6164), no state will endure a shortfall before May 4, 2007. The law directs the HHS secretary to allocate $146 million in expiring FY 2004 SCHIP funds to states that are experiencing shortfalls, spending down on a monthly basis in the order that states hit shortfalls.[10]

As of March 31, 2007, those states that have more than twice the total SCHIP funds that they need to meet projected demand in the remaining years of the program will give up half their remaining FY 2005 funds to a new redistribution pool. These redistribution funds, approximately $125 million, will be spent down by the HHS secretary to fill the shortfalls on a monthly basis, in the same manner as the FY 2004 funds are spent. No state will give up more than $20 million in FY 2005 funds.

Shortfall states that provide SCHIP coverage to adults will receive funds from the redistribution pool, but at the regular Medicaid matching rate instead of the enhanced federal match under SCHIP. The law makes children a priority for these SCHIP funds, but it does not exclude other populations that are eligible for coverage under SCHIP through waivers.

Under the new legislation, states that receive extra help for SCHIP will receive the enhanced rate only for children and pregnant women. Shortfall states covering adults in their SCHIP programs will received the lower Medicaid matching rate.

The legislation also allows the 11 states that expanded their Medicaid program before the SCHIP enactment (Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin) to spend up to 20 percent of their FY 2006 and FY 2007 allotments to provide Medicaid coverage to eligible children.



What is at stake for states during reauthorization?

FY 2007 marks the final year of SCHIP's original 10-year authorization. The federal budget baseline, developed by the Congressional Budget Office (CBO), assumes funding of $5.04 billion annually for the next 10 years. However, the Congressional Research Service estimates that $6 billion is required in FY 2007 to maintain services at their current level.

If SCHIP funding is frozen for the 2008-2012 period:[11]

- In 2008, states will face a combined shortfall of $1.1 billion, equivalent to the cost of insuring 700,000 low-income children; and
- By 2012, 34 to 36 states will face a combined funding gap of $2.9 billion to $3.7 billion.

Under current Congressional budget rules (unless CBO increases the federal budget baseline), in order for Congress to increase SCHIP funding, members would have to make cuts to other programs, such as Medicaid, Medicare, child welfare and the Supplemental Security Income. In addition to funding issues, Congress is likely to examine the funding formula used to determine each state's share of the annual federal SCHIP allotment, the amount of time states are permitted to retain their SCHIP funds and the method of distributing unspent funds from states that cannot use them to states that need additional funds.

Why is SCHIP important?

Since 1997, Medicaid and SCHIP have reduced the number of uninsured children by one-third, from 23 percent to 15 percent. As of December 2005, more than 4 million children received health benefits through SCHIP. The program has significantly affected the health status of children from low-income families. SCHIP-enrolled children are more likely to report a usual source of care when compared to their uninsured counterparts, are far less likely to have unmet health care needs, and are more likely to have well-child and regular dental and vision care.[12]

Moreover, the flexibility afforded to states in designing their SCHIP programs has allowed states to create well-received and popular programs, even in the absence of the mandates that exist in Medicaid. Outreach for SCHIP also has had a spillover effect on Medicaid programs. Many states report that families that apply for SCHIP have been found to be eligible for Medicaid; states are required to screen children for Medicaid and to enroll them in the program if they are eligible, before enrolling them in SCHIP. As a result, many states have enrolled as many or more children in Medicaid as they have in SCHIP.

Notes

1. Some sources refer to SCHIP as CHIP or CHIPS, but in 1999 Congress specified that all official sources must refer to "SCHIP" and the State Children's Health Insurance Program.

2. NCSL and the Forum for State Health Policy Leadership have many resources available on SCHIP in the 50 states. To view summaries of state programs and 50-state tables on key aspects of the program, visit www.ncsl.org/programs/health/health.htm and see the *State Children's Health Insurance Program Chartbook.*

3. C. Mann, R. Rudowitz, *Financing Health Coverage: The State Children's Health Insurance Program Experience* (#7252) (Washington, DC: Kaiser Family Foundation, #7252, 2005).

4. Note that the term "carve-out" can refer to carved out services, patients, or administrative practices, and is used differently by different sources. In some states, for example, children with special health care needs are enrolled in entirely separate plans, under which they receive all care, including primary care. In these states, children with special needs are a "carved-out population."

5. E. Herz, C. Peterson, *State Children's Health Insurance Program (SCHIP): A Brief Overview* (#RL30473) (Washington, DC:Congressional Research Service, July 2006).

6. C. Peterson, *Federal SCHIP Financing: Testimony Before the Senate Finance Health Subcommittee* (Washington, DC: Congressional Research Service, July, 2006).

7. Center for Children and Families, Georgetown University Policy Institue, *SCHIP's Financing Structure*, July 2006.

8. E. Herz, C. Peterson, *State Children's Health Insurance Program (SCHIP): A Brief Overview* (#RL30473) (Washington, DC: Congressional Research Service, , July 2006).

9. C Peterson, *SCHIP Financing: Funding Projections and Redistribution Issues* (#RL32807) (Washington, DC: Congressional Research Service, October 2006).

10.C. Peterson, SCHIP Provision of H.S. 6164 (NIH Reform Act of 2006) (#RS22553) (Washington, DC: Congressional Research Service Report for Congress, December., 2006).

11. C. Peterson, *Federal SCHIP Financing: Testimony Before the Senate Finance Health Subcommittee*.

12. C. Trenholm, et. al., *The Santa Clara County Healthy Kids Program: Impacts on Children's Medical, Dental and Vision Care.* (Washington, DC: Mathematica Policy Research, Inc., July 2005).

Glossary

Carve-out. This is a capitated system for delivery of a defined set of services that is separate from a managed care plan. Services provided under carve-outs usually are those that are expensive, difficult to manage or highly specialized, such as mental health, substance abuse, vision and dental.

Combination plan. An SCHIP plan that incorporates a Medicaid expansion to extend coverage under Medicaid to specific groups, along with a separate state-designed insurance plan to cover additional groups of children.

Cost-sharing. Financial contributions from participating families. These may include premiums, enrollment fees, deductibles, copayments, coinsurance or other out-of-pocket expenses. Cost-sharing is permitted in private and combination plans provided that it does not exceed 5 percent of family income. In Medicaid, copayments for children under age 18 are not permitted, but limited premiums based on family size and annual income may be imposed.

Enrollment cap. The cap limits the total number of enrollees in a state SCHIP program. Caps may be imposed if a state has expended all its available SCHIP funds. Enrollment caps are not permitted in Medicaid.

Entitlement. Medicaid is an entitlement program. This means that any person who is eligible must be enrolled, even if a state's appropriation for its portion of Medicaid expenses in a given year has been expended. SCHIP is not an entitlement and may be capped.

Federal Medical Assistance Percentage (FMAP). This is commonly referred to as the "match rate" or the percentage of total Medicaid expenses that the federal government contributes to each state. The federal government's contribution to SCHIP is an "enhanced FMAP," which is equivalent to 70 percent of the FMAP plus 30 percentage points, up to a maximum of 85 percent.

Fee-for-service. This is a traditional payment system for medical services in which physicians, hospitals and other providers are reimbursed for each service performed.

Medicaid look-alike. A state-designed SCHIP program that closely resembles that state's Medicaid program (in terms of benefits packages, eligibility requirements, etc.) but that is not considered an entitlement program and may have enrollment caps.

Targeted low-income children. SCHIP is designed to provide coverage to "targeted low-income children." A "targeted low-income child" is one who resides in a family with income below 200 percent of the federal poverty level (FPL) or whose family has an income 50 percent higher than the state's Medicaid eligibility threshold. Some states have expanded SCHIP eligibility beyond the 200 percent FPL limit.

State-designed plan. An SCHIP plan that is not a Medicaid expansion, but is a separate insurance program that conforms to SCHIP requirements. These also are called private plans.

Waivers. Under SCHIP, states apply to Centers for Medicare and Medicaid Services for a variance, or waiver, to use program funds to provide insurance coverage for families of eligible children. A state also may apply for an 1115 waiver for its SCHIP program (as in Medicaid) to make broad changes in eligibility, services and/or the service delivery system.

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Other Sources

NCSL's web site www.ncsl.org/programs/health/chiphome.htm contains a wealth of information, including summary descriptions of each state's program, charts and tables, issue briefs and reports, as well as links to other resources.

The **Centers for Medicare and Medicaid Services** (CMS) is the authoritative source of information about state plans and amendments, as well as program administration and regulation, at http://www.cms.gov/schip/

The **National Academy for State Health Policy** (www.nashp.org) and the **National Health Policy Forum** (www.nhpf.org) provide issue briefs and research on SCHIP programs and trends.

The Covering Kids and Families Program, funded by the **Robert Wood Johnson Foundation**, assists states with outreach and enrollment issues. Their web site is www.coveringkids.org.

The **Henry J. Kaiser Family Foundation** (www.kff.org) hosts a wealth of information on SCHIP and Medicaid, as well as many other health topics. The Foundation also operates two additional web sites, **Kaiser Network** (www.kaisernetwork.org) and State Health Facts Online (www.statehealthfacts.org).