
# State Children's Health Insurance Program (SCHIP): A Brief Overview

**Elicia J. Herz**
Specialist in Health Care Financing

**Chris L. Peterson**
Specialist in Health Care Financing

**Evelyne P. Baumrucker**
Analyst in Health Care Financing

March 12, 2008

**Congressional Research Service**
7-5700
www.crs.gov
RL30473

**CRS Report for Congress**
*Prepared for Members and Committees of Congress*

# Summary

The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels. The highest upper income eligibility limit for children in SCHIP is 350% of the federal poverty level, in one state, New Jersey.

Under SCHIP, states may enroll targeted low-income children in an SCHIP-financed expansion of Medicaid, create a new separate state SCHIP program, or devise a combination of both approaches. States choosing the Medicaid option must provide all Medicaid mandatory benefits and all optional services covered under the state plan. In addition, they must follow the nominal Medicaid cost-sharing rules or apply the new state plan option for premiums and service-related cost-sharing as allowed under the Deficit Reduction Act of 2005 (DRA). In general, separate state programs must follow certain coverage and benefit options outlined in SCHIP law. While some cost-sharing provisions vary by family income, the total annual aggregate cost-sharing (including premiums, copayments, and other similar charges) for a family may not exceed 5% of total income in a year. Preventive services are exempt from cost-sharing.

Nearly $40 billion was appropriated for SCHIP for FY1998 through FY2007 in BBA 97, with the annual allotments to states determined by a formula using a combination of the estimated number of low-income children and low-income *uninsured* children in the state, adjusted by a state health cost factor. Four continuing resolutions provided appropriations through December 31, 2007, for SCHIP allotments in FY2008. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173, enacted December 29, 2007) appropriated funds to ensure no state's SCHIP program runs out of federal SCHIP funds before March 31, 2009.

All states, the District of Columbia, and five territories have SCHIP programs. The territories, the District of Columbia, and 8 states use Medicaid expansions; 18 states use separate state programs; and 24 states use a combination approach. At the national level, approximately 7.1 million children were enrolled in SCHIP during FY2007, up from 6.7 million in FY2006. In addition, 14 states reported enrolling about 587,000 adults in SCHIP through program waivers in FY2007.

Spending was slow in the early years of SCHIP, but that trend changed in more recent years and led some states to exhaust their federal SCHIP funds. Congress appropriated additional SCHIP funds to address states' shortfalls in FY2006 ($283 million) and FY2007 ($650 million). Congress passed two bills that would "reauthorize" SCHIP—providing SCHIP funding through FY2012 and making other changes to both SCHIP and Medicaid. Both H.R. 976 and H.R. 3963 were vetoed by the President, with the Congress unable to override these vetoes. MMSEA was enacted to provide federal SCHIP funds through March 31, 2009, and did not make changes to the program.

# Contents



## Tables



## Contacts

The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act.[1] The program offers federal matching funds to states and territories to provide health insurance to certain low-income children. Although specific requirements apply to eligibility, benefits, and beneficiary cost-sharing, as described below, these rules can be modified via waiver authority provided in Section 1115 of the Social Security Act.[2]

## Eligibility and Enrollment

In general, Title XXI defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. States can set the upper income level for targeted low-income children up to 200% of the federal poverty level (FPL),[3] or 50 percentage points above the applicable pre-SCHIP Medicaid income level. However, "(u)nder current statutory and regulatory authority, States are able to effectively expand eligibility of all children under 19 years of age to whatever level they choose."[4]

Within these general rules, states may provide assistance to qualifying children in two basic ways. They may cover such children under their Medicaid programs and/or they may create a separate SCHIP program for this purpose. (More details on available benefits under each approach are described in the next section.) When states provide Medicaid coverage to targeted low-income children, Medicaid rules typically apply. When states provide coverage to targeted low-income children through separate SCHIP programs, Title XXI rules typically apply. In both cases, the federal share of program costs comes from federal SCHIP funds (also described in further detail below).

Title XXI does not establish an *individual* entitlement to benefits. Instead, Title XXI entitles *states* with approved state SCHIP plans to pre-determined federal allotments based on a distribution formula set in the law (explained further below). However, targeted low-income children covered under a SCHIP-financed expansion of Medicaid are entitled to the benefits offered under that program as dictated by Medicaid law. No such individual entitlement exists for targeted low-income children covered in separate SCHIP programs.

States may cover targeted low-income children by expanding their Medicaid programs in the following ways: (1) by establishing a new optional eligibility group for such children as authorized in Title XXI, and/or (2) by liberalizing the financial rules[5] for any of several existing

[1] A complete legislative history of the SCHIP program is contained in CRS Congressional Distribution Memorandum *SCHIP Legislative History*, by Elicia J. Herz and Chris L. Peterson, available upon request.

[2] See CRS Report RS21054, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers*, by Evelyne P. Baumrucker.

[3] In 2007, the poverty guideline in the 48 contiguous states and the District of Columbia is $20,650 for a family of four. ("Annual Update of the HHS Poverty Guidelines," 72 *Federal Register* 3147, January 24, 2007.)

[4] 66 *Federal Register* 2320, January 11, 2001. For additional information on states' flexibility in counting income for purposes of determining SCHIP eligibility, see CRS Congressional Distribution Memorandum, *Overview of Medicaid and Medicaid-Expansion SCHIP Eligibility for Children and Rules for Counting Income*, by April Grady, November 29, 2007, available upon request. This flexibility may now be limited, per a letter to State Health Officials from Dennis G. Smith, Director of the Center for Medicaid and State Operations of the Centers for Medicare and Medicaid Services (CMS), SHO #07-001, August 17, 2007, available at http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf.

[5] Under Medicaid law, Section 1902(r)(2) authority may be used to liberalize income and resource methodologies for a (continued...)

Medicaid eligibility categories. Many states with Medicaid-expansion SCHIP programs chose the latter, opting to cover targeted low-income children under existing Medicaid eligibility pathways, especially Medicaid's poverty-related child groups, rather than by establishing the Title XXI optional coverage group.[6] Such a strategy reduces the administrative burden of creating and implementing a new coverage group.[7]

States may also provide coverage to targeted low-income children by creating a separate SCHIP program. States define the group of targeted low-income children who may enroll in separate SCHIP programs. Title XXI allows states to use the following factors in determining eligibility: geography (e.g., sub-state areas or statewide), age (e.g., subgroups under 19), income, resources, residency, disability status (so long as any standard relating to that status does not restrict eligibility), access to or coverage under other health insurance (to establish whether such access/coverage precludes SCHIP eligibility), and duration of SCHIP enrollment.

**Table 1** shows every state's SCHIP program type as well as upper-income eligibility and enrollment data by population group. Ten states and the District of Columbia (plus four counties and certain children up to age two in California) have SCHIP coverage above 250% FPL. An additional eight states (including California) have income thresholds greater than 200% FPL but less than or equal to 250% FPL. Twenty-five states have upper income limits at 200% FPL. Seven states set maximum income levels below 200% FPL.[8]

The highest upper income eligibility limit for children in SCHIP is 350% of the FPL, in New Jersey.[9] New York submitted a state plan amendment (SPA) to expand SCHIP eligibility to children up to 400% FPL, but it was denied.[10] The basis of the disapproval was that New York did

(...continued)

number of groups, including, for example, poverty-related children (i.e., those under age 6 in families with income up to 133% FPL and those between ages 6 and 18 in families with income up to 100% FPL). That same authority can be used to liberalize financial rules for SCHIP purposes. Family coverage is provided under Section 1931. This section has its own provisions for liberalizing income and resource standards.

[6] Personal communication with Judy Rhoades, Centers for Medicare and Medicaid Services, June 5, 2003.

[7] Because individuals can have other health insurance and still be covered by Medicaid, this approach also allows states to bring into Medicaid otherwise ineligible higher-income children *regardless* of their other health insurance status. Under this strategy, for example, states can provide Medicaid benefits to additional children whose existing health insurance is limited (sometimes referred to as under-insured). When states liberalize the financial rules for existing Medicaid eligibility groups, the federal share of the costs for services provided to the subset *without* other health insurance—the targeted low-income children—is paid for out of SCHIP funds (described in further detail below). The federal share of the costs for services delivered to the remaining children *with* other health insurance is paid for by Medicaid. Under the fourth sentence of Section 1905(b) and Section 2105(a)(2) of the Social Security Act, states are required to exhaust their SCHIP allotments before using Medicaid funds to pay for those who meet the definition of a targeted low-income child.

[8] States may apply resource, or asset, tests in determining financial eligibility, but are not required to do so. In states with a resource test, individuals must have resources for which the dollar value is less than a specified standard amount in order to qualify for coverage. States determine what items constitute countable resources and the dollar value assigned to those countable resources. Assets may include, for example, cars, savings accounts, real estate, trust funds, tax credits, etc. In 2005, asset/resource tests were an eligibility criteria in only four states—Idaho, Missouri, Oregon and Texas (see N. Kaye, et al., *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs*, National Academy for State Health Policy (NASHP), September 2006, http://www.chipcentral.org/Files/Charting_CHIP_III_9-21-6.pdf, pp. 42-43).

[9] For determining financial eligibility for SCHIP and Medicaid, certain types and/or amounts of income are not counted. These are called "income disregards." For example, specified dollar amounts may be subtracted from gross income to calculate net income, which is then compared to the applicable income criterion.

[10] Centers for Medicare and Medicaid Services, *New York Title XXI Fact Sheet*, http://www.cms.hhs.gov/
(continued...)

not meet criteria set forth in a letter to state health officials, published by CMS on August 17, 2007.[11] The letter lists specific requirements for states that have or seek to expand SCHIP coverage to children in families with "effective family income levels" above 250% FPL.

The latest official numbers show that SCHIP enrollment reached a total of 7.1 million children in FY2007. Of this total, about 5.1 million were covered in separate state programs, and 2.1 million were targeted low-income children under Medicaid.

One of the primary uses of waiver authority under SCHIP has been to expand coverage for adult populations, which has proven controversial.[12] (See below for further discussion of adult coverage under SCHIP.) Fourteen states reported enrollment of about 587,000 adults in SCHIP in FY2007 (see **Table 1**). A substantial share of these adults (487,000, about 83%) were parents. Roughly 93,000 were childless adults, and the remainder (6,500) were pregnant women.

The number of SCHIP-enrolled adults in FY2007—587,000—is lower than in FY2006, when it was 701,000. Adult enrollment in FY2008 will likely be even lower, because the adult-coverage waivers in Illinois and Oregon were not renewed. As shown in **Table 1**, FY2007 adult enrollment was nearly 251,000 in Illinois and 15,000 in Oregon. Adult SCHIP enrollment in these two states made up nearly half of all adult SCHIP enrollment nationally.

From FY2006 to FY2007, most of the 14 states with adult SCHIP coverage experienced enrollment increases. However, those were overshadowed by large declines in four states. By FY2007, Arizona completed its transition of 85,000 SCHIP-enrolled childless adults into Medicaid. Michigan's enrollment of childless adults under 35% of poverty fell, from 102,000 in FY2006 to 78,000 in FY2007. Minnesota's enrollment of parents also fell, from 34,000 in FY2006 to 29,000 in FY2007. Finally, Wisconsin's parental enrollment declined from 110,000 in FY2006 to 48,000 in FY2007.

The only state in FY2007 with more adult SCHIP enrollment than child enrollment was Minnesota. Prior to the enactment of SCHIP more than a decade ago, Minnesota expanded its Medicaid program to cover children up to 275% of poverty. As a result, federal SCHIP funds in Minnesota could be used only to cover children above 275% of poverty. In order to have an operational SCHIP plan, Minnesota began its SCHIP program by covering 0- to 2-year-olds between 275% and 280% of poverty. With this limited eligibility group, Minnesota spent only $706,910 of the nearly $126 million in federal SCHIP funds it had been allotted between FY1998 and FY2001. In June 2001, the Bush Administration approved the state's waiver to cover parents of Medicaid/SCHIP children with family income between 100% and 200% of poverty.[13] As a result, the state's SCHIP funding position reversed, with the state receiving an FY2002 allotment of $30 million but having federal SCHIP spending of $65 million. Since then, its annual federal SCHIP spending has exceeded its annual allotment by $16 million to $42 million. Minnesota has

(...continued)

LowCostHealthInsFamChild/downloads/NYCurrentFactsheet.pdf.

[11] Letter to State Health Officials from Dennis G. Smith, Director of the Center for Medicaid and State Operations of CMS, SHO #07-001, August 17, 2007, available at http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf.

[12] For example, see the hearing webcast and written testimony for *Covering Uninsured Kids: Missed Opportunities for Moving Forward*, held by the Subcommittee on Health, House Energy and Commerce Committee, January 29, 2008, at http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.012908.CoveringUninsured.shtml.

[13] The state's SCHIP waiver was extended in December 2005 and is set to expire in June 2009.

been considered a shortfall state since FY2005. In FY2007, the state had 29,225 parents enrolled, along with 62 0- to 2-year-olds and 5,346 unborn children, a concept discussed later.

## Benefits

As noted above, when designing their SCHIP programs, states may cover targeted low-income children under their Medicaid program, create a new separate SCHIP program, or devise a combination of both approaches.

States that use Medicaid-expansion SCHIP programs must provide the full range of mandatory Medicaid benefits, as well as all optional services specified in their state Medicaid plans. As an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (P.L. 109-171; DRA) gives states the option to enroll state-specified groups, including children in SCHIP Medicaid expansions, in new benchmark and benchmark-equivalent benefit plans. These plans are nearly identical to the benefit packages offered through separate SCHIP programs (described below). For any child under age 19 in one of the major mandatory and optional Medicaid eligibility groups, including targeted low-income children, the benefits available through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program must be provided. Under EPSDT, children receive well-child care, immunizations, and other screening services, as well as medical care necessary to correct or ameliorate identified defects, illnesses, or conditions, including optional services states may not otherwise cover in their Medicaid programs.

States that choose to create separate SCHIP programs may elect any of three benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other health benefits plan that the Secretary of Health and Human Services determines will provide appropriate coverage to the targeted population of uninsured children.[14]

A benchmark benefit package is one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage that is offered and generally available to state employees in the state involved, and (3) the health coverage that is offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved.

Benchmark-equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A state choosing to provide benchmark-equivalent coverage must cover each of the benefits in the "basic benefits category." The benefits in the basic benefits category are inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray services, and well-baby and well-child care, including age-appropriate immunizations. Benchmark-equivalent coverage must also include at least 75% 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. States are encouraged to cover other categories of service

[14] When the law establishing SCHIP was enacted, existing programs financed entirely by the state in Florida, New York, and Pennsylvania were designated as meeting the minimum benefit requirements under SCHIP (i.e., these programs were grandfathered into SCHIP).

not listed above. Abortions may not be covered, except in the case of a pregnancy resulting from rape or incest, or when an abortion is necessary to save the mother's life.

All 50 states, the District of Columbia, and five territories have SCHIP programs. The territories, the District of Columbia, and 8 states use Medicaid expansions; 18 states use separate state programs; and 24 states use a combination approach. Three states received authority under the Balanced Budget Act of 1997 to operate previously existing comprehensive state-based plans as their separate SCHIP program. Among other types of separate SCHIP programs, data from 2005[15] indicate that most of the benchmark and benchmark-equivalent plans are based on the state employees' health plan, and most secretary-approved plans are modeled after Medicaid.

## Cost-Sharing

Cost-sharing refers to the out-of-pocket payments made by beneficiaries of a health insurance plan. Cost-sharing may include monthly premiums, enrollment fees, deductibles, copayments, coinsurance and other similar charges.

Federal law permits states to impose cost-sharing for some beneficiaries and some services under SCHIP. States that cover targeted low-income children under Medicaid must follow the nominal cost-sharing rules of the Medicaid program. Under these rules, the majority of such children are exempt. Children who are 18 years of age and enrolled in Medicaid expansions under SCHIP may be subject to service-related cost-sharing (e.g., copayments) at state option.

DRA[16] provides states with a new option for premiums and service-related cost-sharing that may be applied to targeted low-income children under SCHIP Medicaid-expansion programs. For children in families with income under 100% FPL, no premiums are allowed and service-related cost-sharing is limited to nominal amounts. For children in families with income between 100%-150% FPL, no premiums may be imposed; however, service-related cost-sharing may be applied up to 10% of the cost of the item or service rendered. For children in families with income above 150% FPL, premiums are allowed (no limit is specified), and service-related cost-sharing may be applied up to 20% of the cost of the item or service rendered. For all individuals, the total aggregate amount of all cost-sharing cannot exceed 5% of family income (on a quarterly or monthly basis as specified by the state). Preventive services for children are exempt from DRA cost-sharing. The nominal Medicaid cost-sharing amounts in regulation will be indexed by medical care inflation. Special rules apply to cost-sharing for prescription drugs, and for emergency room copayments for non-emergency care. DRA also allows states to condition continuing Medicaid eligibility on the payment of premiums. Providers may also be allowed to deny care for failure to pay service-related cost-sharing.

If a state implements SCHIP through a separate state program, premiums or enrollment fees for program participation may be imposed, but the maximum allowable amount is dependent on family income. For all families with incomes under 150% FPL and enrolled in separate state

[15] CRS analysis of unpublished data from a 2005 survey of state SCHIP programs conducted by the National Academy for State Health Policy (NASHP). For more information about this survey, see http://www.chipcentral.org/Files/Charting_CHIP_III_9-21-6.pdf.

[16] P.L. 109-432 modified DRA by specifying cost-sharing rules for individuals in families with income under 100% FPL. For additional information, see CRS Report RS22578, *Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)*, by Elicia J. Herz.

programs, premiums may not exceed the amounts set forth in federal Medicaid regulations. Additionally, these families may be charged service-related cost-sharing, but such cost-sharing is limited to (1) nominal amounts defined in federal Medicaid regulations for the subgroup with income below 100% FPL, and (2) slightly higher amounts defined in SCHIP regulations for families with income between 100%-150% FPL. For a family with income above 150% FPL, cost-sharing may be imposed in any amount, provided that cost-sharing for higher-income children is not less than cost-sharing for lower-income children.

Under SCHIP law, the total annual aggregate cost-sharing (including premiums, deductibles, copayments, and any other charges) for all children in separate SCHIP programs may not exceed 5% of total family income for the year. In addition, states are required to inform families of these limits and provide a mechanism for families to stop paying once the cost-sharing limits have been reached.

Preventive services are exempt from cost-sharing for all SCHIP families regardless of income. The Centers for Medicare and Medicaid Services (CMS) defines preventive services to include the following: all healthy newborn inpatient physician visits, including routine screening (inpatient and outpatient); routine physical examinations; laboratory tests; immunizations and related office visits; and routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays).

## The Evolution of SCHIP—Program Changes Via State Plan Amendments and Waiver Authority

SCHIP programs across states are evolving rapidly, as evidenced by the numerous changes states have made to their original state plans over time. As of August 2007, 289 amendments to original state plans had been approved and 14 more were in review.[17] Most states have multiple amendments. The content of the plan amendments varies among states. For example, some states use amendments to extend coverage beyond income levels defined in their original state plans. Others define new copayment standards for program participants. Still others modify benefit packages.

In addition to the amendment process, states that want to make changes to their SCHIP programs that go beyond what the law will allow may do so through what is called a Section 1115 waiver (named for the section of the Social Security Act that defines the circumstances under which such waivers may be granted). The Secretary of Health and Human Services may waive certain statutory requirements for conducting research and demonstration projects under SCHIP that allow states to adapt their programs to specific needs as long as those changes further the goals of the SCHIP program. As of September 21, 2007, CMS granted 22 SCHIP Section 1115 demonstrations in 20 states.[18, 19] As described below, states have turned to the waiver authority to

[17] The source for this information can be found online at http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/SCHIPStatePlanActivityMap.pdf.

[18] The Centers for Medicare & Medicaid Services, CMSO, FCHPG, Division of State Children's Health Insurance (DSCHI), *State Children's Health Insurance Program (SCHIP) Section 1115 Demonstration Projects as of September 21, 2007*, available at http://www.cms.hhs.gov/LowCostHealthInsFamChild

[19] These states include Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Michigan, Minnesota, Missouri, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Texas, Utah, Virginia, and Wisconsin. Two of these states, Arkansas and New Mexico, each have 2 operational SCHIP Section 1115 demonstration waivers.

expand coverage for certain adult populations and loosen the requirements surrounding the state option to extend family coverage under an employer-sponsored health insurance plan, among other purposes.

## SCHIP Coverage Expansions Parents and Childless Adults Under the HIFA Initiative

On August 4, 2001, the Bush Administration announced the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. Using Section 1115 waiver authority, this initiative was designed to encourage states to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches that maximize private health insurance coverage options and target populations with income below 200% FPL. In other words, states were permitted and encouraged to direct their unspent SCHIP funds towards coverage expansions under the HIFA initiative.[20]

While coverage expansions under Section1115 waiver authority were common before the HIFA initiative, this initiative dramatically increased states' coverage of adults with children (typically parents of Medicaid/SCHIP children, caretaker relatives, or legal guardians) and childless adults.[21] Of the 20 states with SCHIP waivers, 13 states have SCHIP waivers that were granted under the HIFA initiative.[22] Currently, 12 states have CMS approval to finance at least some of their adult coverage groups with unspent SCHIP funds (see **Table 1**).[23]

A population added under an 1115 waiver is only SCHIP-eligible for the five-year waiver period (or specified waiver extension period). Recently, the Administration has not renewed existing waivers that permitted coverage of adults through SCHIP. Illinois's waiver to cover adults in SCHIP expired September 30, 2007. Oregon's waiver to cover adults in SCHIP also expired, on October 31, 2007. Wisconsin's waiver for adult SCHIP coverage recently came up for renewal, but was only permitted to keep some adults in SCHIP.[24]

## SCHIP Coverage for Pregnant Women and Unborn Children

In addition to parents and childless adults, SCHIP permits states to cover adult pregnant women (aged 19 and older) in one of three ways: (1) states may apply for Section 1115 waivers to extend coverage to such pregnant women (as described above); (2) states may provide health benefits coverage, including prenatal care and delivery services, to unborn children of adult pregnant women through an SCHIP state plan amendment (SPA) as permitted through regulation;[25] or (3)

---

[20] *Medicine and Health*, "CMS Administrator: McClellan on Value Purchasing, SCHIP, DSH, and Specialty Hospitals," March 22, 2004.

[21] The Deficit Reduction Act of 2005 (P.L. 109-171) prohibits the use of SCHIP funds for coverage of non-pregnant childless adults in any new waivers approved after February 8, 2006.

[22] SCHIP HIFA waiver states include Arizona, Arkansas, California, Colorado, Idaho, Illinois, Michigan, Nevada, New Jersey, New Mexico, Oregon, Utah, and Virginia.

[23] Arkansas and New Mexico each have 2 operational SCHIP Section 1115 demonstration waivers.

[24] Under its prior waiver, parents of Medicaid-or SCHIP-enrolled children from 100% to 185% FPL were eligible for SCHIP; under the renewal, parents from 100% up to 130% FPL are in Medicaid, with parents from 130% to 185% FPL in SCHIP. Although family income cannot exceed 185% FPL for initial eligibility, parents may continue enrollment as long as family income does not exceed 200% FPL.

[25] Although CMS requires the care to be directed at the unborn child, the SCHIP unborn child SPA option effectively (continued...)

states may offer a "family coverage option" through a group health plan that may include maternity care to adult females in eligible families. As of October 2007, 17 states offered pregnancy-related services to adults using SCHIP funds. Of those, 6 states used the §1115 waiver authority, and 12 states extended coverage to unborn children of adult pregnant women through unborn child SPAs (Rhode Island extends coverage to adult pregnant women through both authorities).[26]

Of the 12 states that offer pregnancy-related services to unborn children under the SCHIP SPAs,[27] all but Tennessee extended coverage to the unborn children of undocumented aliens who otherwise would not have access to federally funded pregnancy-related services, except through emergency Medicaid.[28]

In FY2007, there were 262,366 unborn children enrolled in SCHIP, most of whom (179,779, 68.5%) were in California.[29]

## SCHIP Employer-Sponsored Insurance Coverage

Finally, under SCHIP states may purchase "family coverage" through an employer-sponsored health insurance plan if it is cost-effective relative to the amount paid to cover only the targeted low-income children and does not substitute for coverage under group health plans otherwise provided to the children. States using SCHIP funds for employer-based plan premiums, often referred to as "premium assistance," must ensure that (1) SCHIP minimum benefits are provided, (2) SCHIP cost-sharing ceilings are met, and (3) the children to be enrolled have not had group coverage for a specified period of time (typically four to six months). Because of these requirements, implementation of such premium assistance programs under SCHIP is not widespread; only two states—New Jersey and Massachusetts—have operational family coverage variance programs.[30] Also, as part of the HIFA initiative, states have used both Medicaid and SCHIP funds to pay premium costs for waiver enrollees who have access to employer-sponsored insurance (ESI). ESI programs approved under this waiver authority are not subject to the comprehensiveness, cost-effectiveness, and waiting period tests otherwise applicable to SCHIP's family coverage option. As of September 21, 2007, 10 states reported operating a premium

(...continued)

enables states to provide prenatal care to adult pregnant women including those with incomes at or above the Medicaid income eligibility thresholds and for individuals who do not qualify for Medicaid (or SCHIP) for other reasons, such as immigration status or incarceration.

[26] For more information see CRS Report RS22785, *SCHIP Coverage for Pregnant Women and Unborn Children*, by Evelyne P. Baumrucker.

[27] Arkansas, California, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Rhode Island, Tennessee, Texas, Washington and Wisconsin.

[28] Illegal immigrants are barred from Medicaid and SCHIP eligibility; legal immigrants who have not been granted lawful permanent residency status are ineligible for Medicaid or SCHIP for five years. Such women who otherwise qualify but for their documentation status have access to emergency care under Medicaid, which includes labor and delivery costs (Section 1903(v) of the Social Security Act).

[29] Centers for Medicare and Medicaid Services (CMS) analysis of SEDS FY2007 master file, "Age Groups Report 2007.xls," February 11, 2008, among those in age group "under 0."

[30] E-mail correspondence (from June 7, 2007) with Kathleen Farrell, the CMS Director of the SCHIP program.

assistance program under SCHIP or Medicaid through waiver authority.[31] (Other states may also be providing premium assistance through state plan amendments.)

## Financing and Expenditures

Federal financing of SCHIP includes three major components: (1) total federal appropriations for states' annual SCHIP allotment of federal funds among the states and territories, (2) reallocation of unspent federal funds and appropriations for eliminating states' shortfalls, and (3) other factors affecting federal financing including the federal matching rate and caps on administrative expenses.

### Federal Appropriations and Allotment Among the States and Territories

BBA 97 appropriated a total of approximately $40 billion for SCHIP for FY1998 to FY2007.[32] The funding level by fiscal year varied across time. The total annual appropriation for each of FY1998-FY2001 was a little more than $4.2 billion. This annual total dropped to under $3.2 billion in FY2002-FY2004. Then the appropriation rose to about $4.1 billion for FY2005 and FY2006, with a further increase to roughly $5.0 billion in FY2007. The drop in funding for FY2002-FY2004, sometimes referred to as the "SCHIP dip," was written into SCHIP's authorizing legislation due to budgetary constraints applicable at the time the legislation was drafted.

The 110th Congress passed two bills to "reauthorize" SCHIP—providing SCHIP funding for FY2008 through FY2012 and making other changes to both SCHIP and Medicaid. Both H.R. 976 and H.R. 3963 were vetoed by the President, with the Congress unable to override these vetoes.[33] In lieu of reauthorization, four continuing resolutions (P.L. 110-92, P.L. 110-116, P.L. 110-137, and P.L. 110-149) provided $5 billion for FY2008 federal SCHIP allotments through December 31, 2007.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173, enacted December 29, 2007) extended the availability of the FY2008 SCHIP allotment through March 31, 2009. MMSEA appropriated $5 billion for FY2009 allotments, also available through March 31, 2009. Because shortfalls of federal SCHIP funds were still projected to occur in certain states, additional funds were appropriated, as discussed in the next section.

---

[31] States with Employer-Sponsored Insurance programs granted under the Section 1115 waiver authority include Arkansas, Colorado, Idaho, Illinois, Nevada, New Mexico, Oregon, Rhode Island, Virginia, and Wisconsin. Source: The Centers for Medicare & Medicaid Services, CMSO, FCHPG, Division of State Children's Health Insurance (DSCHI), *State Children's Health Insurance Program (SCHIP) Section 1115 Demonstration Projects as of September 21, 2007*, available at http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/Section1115ReportApprovedUnderReview.pdf

[32] From the original appropriated amounts specified in BBA 97, the law set aside 0.25% of SCHIP funds for five territories (Puerto Rico, Guam, Virgin Islands, American Samoa, and the Northern Mariana Islands). Later, funds were added to the total annual appropriation and earmarked for the territories for each year beginning in FY1999. For FY1998-FY2002 only, $60 million annually was set aside for special diabetes grants.

[33] For more information on the vetoed H.R. 976 and H.R. 3963, see CRS Report RS22746, *SCHIP: Differences Between H.R. 3963 and H.R. 976*, by Evelyne P. Baumrucker et al.

The allotment of funds among the states is determined by a formula set in law. This formula is based on a combination of the number of low-income children and the number of *uninsured* low-income children in the state, adjusted by a cost factor that reflects average wages in the states' health service industry compared to the national average.

Annual original allotments are basically separate, sequential funding accounts. For each state and territory, the account for a given fiscal year is made available at the beginning of that year and remains available for up to three years (except for the new allotments for FY2008 and FY2009 under MMSEA). For example, the FY2004 original allotments were available to states until the end of FY2006. Typically, SCHIP payments are taken out of the earliest active account. Once that fiscal year allotment is fully expended, the state can begin drawing from the next available allotment.

## Redistribution of Unspent Federal Funds and Appropriations to Address Shortfalls

At the end of the applicable three-year period of availability, unspent allotments are redistributed to other states. The rules vary by fiscal year. Since FY2005, only states that exhausted the relevant allotment within three years were eligible to receive unspent funds from other states.

For FY2006, the amount available for redistribution was inadequate for covering projected federal SCHIP spending in 12 states. In DRA, Congress appropriated an additional $283 million to cover the projected shortfalls. Two states (Illinois and Massachusetts) ultimately had higher FY2006 SCHIP spending than anticipated, so they experienced shortfalls totaling approximately $100 million, almost all of that from Illinois.

In FY2007, $147 million in unspent FY2004 original allotments was available for redistribution. In the closing hours of the 109th Congress, a bill was passed to specify how those funds would be redistributed. The National Institutes of Health (NIH) Reform Act of 2006 (H.R. 6164, P.L. 109-482, NIHRA) required that the funds go to states "in the order in which such [shortfall] States realize monthly funding shortfalls ... for fiscal year 2007." The purpose was to delay any state facing a shortfall as far into the year as possible with the available funds. CRS projections indicated that this particular provision would delay shortfalls until the end of March 2007. To delay shortfalls even further, the SCHIP provisions of NIHRA called for an initial redistribution of up to half of unspent FY2005 original allotments as of March 31, 2007 (capped at $20 million per state)—after 2½ years of availability. For a state to forgo unspent FY2005 funds on that date, NIHRA required not only that the state have unspent FY2005 balances but that the state's *total* SCHIP balances (from the FY2005-FY2007 original allotments) as of March 31, 2007, were at least double what the state projected to spend in federal SCHIP funds in FY2007. This was projected to provide an additional $138 million for shortfall states, delaying any state facing a shortfall of federal SCHIP funds until May 2007. The shortfalls remaining for the rest of the fiscal year were projected at just over $600 million in 12 states.

On May 25, 2007, P.L. 110-28 (the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007; UTRA) was enacted. In it, Congress appropriated up to $650 million to cover state shortfalls of federal SCHIP funds for the remainder of FY2007. The final UTRA appropriations that went to 10 states[34] for FY2007 are shown in Column E of

[34] Georgia, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Mississippi, New Jersey, and Rhode Island. (continued...)

**Table 2**, along with other details about states' and territories FY2007 federal SCHIP financing, based on finalized data. **Table 3** shows cumulative federal SCHIP financing from 1998 through FY2007.

For FY2008, MMSEA required that unspent FY2005 allotments be redistributed to shortfall states on a monthly basis in the order in which these states experience shortfalls. In addition to this redistribution, MMSEA appropriated up to $1.6 billion for states' remaining shortfalls in FY2008. Current projections are that less than $1.2 billion of this appropriation will be necessary. Thus, the total federal SCHIP funds now available for states in FY2008 are expected to cover every state's projected expenditures.[35]

For FY2009, MMSEA also required that unspent FY2006 allotments be redistributed to states projected to face shortfalls in FY2009 before March 31, 2009, on a monthly basis in the order in which these states experience shortfalls. In addition to this redistribution, MMSEA appropriated up to $275 million for states' remaining shortfalls through March 31, 2009. Based on states' latest projections, the total FY2009 shortfalls through March 31, 2009, are projected at approximately $200 million.

## Other Factors Affecting Federal Financing

Like Medicaid, SCHIP is a federal-state matching program. For each dollar of state spending, the federal government makes a matching payment drawn from SCHIP accounts. A state's share of program spending for Medicaid is equal to 100% minus the federal medical assistance percentage (FMAP). The enhanced SCHIP FMAP is equal to a state's Medicaid FMAP increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the FMAP is less than 100%.[36] For example, in states with a Medicaid FMAP of 60%, the enhanced FMAP equals the Medicaid FMAP increased by 12 percentage points (60% + [30% multiplied by 40 percentage points] = 72%.) In this example, the state share is 100% -72% = 28%.

In other words, the enhanced FMAP means a state's share of expenditures is 30% lower than under the regular FMAP. In the previous example, with the federal government paying 60% of Medicaid expenditures, the state's share was 40%. Under the enhanced FMAP in SCHIP, the state's share is 28% (i.e., 40% x 0.7).

Compared with the Medicaid FMAP, which ranges from 50% to 75.89% in FY2007, the enhanced FMAP for SCHIP ranges from 65% to 83.12%. All SCHIP assistance for targeted low-income children, including coverage provided under Medicaid, is eligible for the enhanced FMAP. The Medicaid FMAP and the enhanced SCHIP FMAP are subject to a ceiling of 83% and 85%, respectively.

(...continued)

Alaska and Wisconsin ultimately did not face shortfalls.

[35] For more information, see CRS Report RS22739, *FY2008 Federal SCHIP Financing*, by Chris L. Peterson.

[36] The federal medical assistance percentage (FMAP) and the enhanced federal medical assistance percentage (enhanced FMAP) are calculated and published annually by the Secretary of DHHS. FMAP is a measure of the per capita income in each state, squared, compared to that of the nation as a whole. This formula is designed to provide a higher FMAP to states with lower per capita income.

There is a limit on federal spending for SCHIP administrative expenses, which include activities such as data collection and reporting, outreach and education, and other activities. For federal matching purposes, a 10% cap applies to state non-benefit expenses. This cap is tied to the dollar amount that a state draws down from its annual allotment to cover benefits and these non-benefit costs under SCHIP, as opposed to 10% of a state's total annual allotment. In other words, no more than 10% of the federal funds that a state draws down for SCHIP benefit and non-benefit expenditures combined can be used for non-benefit costs including administrative expenses.

## Forthcoming SCHIP Issues

Last year's debate over SCHIP "reauthorization" raised a variety of policy considerations about the program's federal financing, states' flexibility in program design, and target populations. Reauthorization legislation also provided a vehicle for Congress to consider changes to Medicaid. However, in the wake of two vetoed bills, many issues were left unresolved for both programs—including the level and availability of federal funding for SCHIP past March 31, 2009; limits on eligibility for higher income individuals; crowd-out prevention (i.e., preventing the substitution of public coverage for private coverage); premium assistance for those with access to employer-sponsored health insurance; and citizenship documentation rules.

The federal cost of any Medicaid or SCHIP proposal is likely to be a concern, depending on the additional funding that might be included in the forthcoming FY2009 budget resolution and how much spending would have to be offset under PAYGO rules. For example, proposed changes to citizenship documentation[37]—which received considerable attention in last year's SCHIP debate—could cost $1 billion or more over five years. The direction and scope of any proposed changes to Medicaid and SCHIP during the second session of the 110th Congress is unknown at this time.

[37] For more information on this issue, see CRS Report RS22629, *Medicaid Citizenship Documentation*, by Ruth Ellen Wasem.

## Table 1. SCHIP Enrollment and Eligibility Information for the 50 States and the District of Columbia

| State and Program Type as of 3/12/08 | Upper Income Level for Children (% FPL) as of 3/12/08 | Number of Children Ever Enrolled during FY2007 | | | Number of Adults Ever Enrolled in SCHIP Demonstrations during FY2007 (and Income Level by Group) | | | |
|---|---|---|---|---|---|---|---|---|
| | | Medicaid Expansions | Separate SCHIP Programs | Total Children | Pregnant Women | Parents of Medicaid and/or SCHIP children | Childless Adults | Total Adults |
| Alabama (S) | 200% | | 106,691 | 106,691 | | | | |
| Alaska (M) | 175% | 17,558 | | 17,558 | | | | |
| Arizona (S) | 200% | | 104,209 | 104,209 | — | 25,774 (100%-200%)[a] | — | 25,774[a] |
| Arkansas (C) | 200% | 85,863 | 3,779 | 89,642 | | 639 (0%-200%)[b] | | 639[b] |
| California (C) | 250%[c] | 265,057 | 1,273,359 | 1,538,416 | | | | |
| Colorado (S) | 200% | | 84,649 | 84,649 | 3,173 (185%-200%)[d] | — | — | 3,173[d] |
| Connecticut (S) | 300% | | 23,632 | 23,632 | | | | |
| Delaware (C) | 200% | 145 | 10,998 | 11,143 | | | | |
| District of Columbia (M) | 300% | 6,566 | | 6,566 | | | | |
| Florida (C) | 200% | 1,594 | 321,935 | 323,529 | | | | |
| Georgia (S) | 235% | | 356,285 | 356,285 | | | | |
| Hawaii (M) | 300% | 23,958 | | 23,958 | | | | |
| Idaho (C) | 185% | 19,019 | 14,041 | 33,060 | — | 380 (0%-185%)[e] | 152 (0%-185%)[e] | 532[e] |
| Illinois (C) | 200% | 157,120 | 188,456 | 345,576 | — | 250,570[f] | | 250,570[f] |
| Indiana (C) | 200% | 95,836 | 34,532 | 130,368 | | | | |
| Iowa (C) | 200% | 17,926 | 32,312 | 50,238 | | | | |
| Kansas (S) | 200% | | 49,536 | 49,536 | | | | |
| Kentucky (C) | 200% | 43,470 | 25,306 | 68,776 | | | | |
| Louisiana (C) | 250% | 151,953 | 1,710 | 153,663 | | | | |

| State and Program Type as of 3/12/08 | Upper Income Level for Children (% FPL) as of 3/12/08 | Number of Children Ever Enrolled during FY2007 | | | Number of Adults Ever Enrolled in SCHIP Demonstrations during FY2007 (and Income Level by Group) | | | |
|---|---|---|---|---|---|---|---|---|
| | | Medicaid Expansions | Separate SCHIP Programs | Total Children | Pregnant Women | Parents of Medicaid and/or SCHIP children | Childless Adults | Total Adults |
| Maine (C) | 200% | 21,966 | 9,071 | 31,037 | | | | |
| Maryland (M) | 300% | 120,357 | 12,530 | 132,887 | | | | |
| Massachusetts (C) | 300% | 93,922 | 90,561 | 184,483 | | | | |
| Michigan (C) | 200% | 60,508 | 53,517 | 114,025 | — | — | 77,713 (0-35%)[g] | 77,713[g] |
| Minnesota (C) | 280% | 62 | 5,346 | 5,408 | — | 29,225 (100%-200%)[h] | — | 29,225[h] |
| Mississippi (S) | 200% | | 81,565 | 81,565 | | | | |
| Missouri (C) | 300% | 81,764 | | 81,764 | | | | |
| Montana (S) | 175% | | 20,115 | 20,115 | | | | |
| Nebraska (M) | 185% | 46,199 | | 46,199 | | | | |
| Nevada (S) | 200% | | 41,862 | 41,862 | 476 (133-185%)[i] | 5 (0%-200%)[i] | | 481[i] |
| New Hampshire (C) | 300% | 621 | 11,467 | 12,088 | | | | |
| New Jersey (C) | 350% | 49,286 | 100,991 | 150,277 | 275 (185%-200%[j]) | 99,629 (above Medicaid -115%)[i] | — | 99,904[i] |
| New Mexico (M) | 235% | 16,525 | | 16,525 | — | 4,304 (37%-200%)[k] | 7,891 (0%-200%)[k] | 12,195[k] |
| New York (S) | 250% | | 651,853 | 651,853 | | | | |
| North Carolina (C) | 200% | 67,197 | 172,955 | 240,152 | | | | |
| North Dakota (C) | 140% | 1,808 | 3,661 | 5,469 | | | | |
| Ohio (M) | 200% | 231,538 | | 231,538 | | | | |
| Oklahoma (M) | 200% | 117,084 | | 117,084 | | | | |

| State and Program Type as of 3/12/08 | Upper Income Level for Children (% FPL) as of 3/12/08 | Number of Children Ever Enrolled during FY2007 | | | Number of Adults Ever Enrolled in SCHIP Demonstrations during FY2007 (and Income Level by Group) | | | |
|---|---|---|---|---|---|---|---|---|
| | | Medicaid Expansions | Separate SCHIP Programs | Total Children | Pregnant Women | Parents of Medicaid and/or SCHIP children | Childless Adults | Total Adults |
| Oregon (S) | 185% | | 63,090 | 63,090 | — | 7,856 (100%-185%)[l] | 7,378 (100%-185%)[l] | 15,234 |
| Pennsylvania (S) | 300% | | 227,367 | 227,367 | | | | |
| Rhode Island (C) | 250% | 24,234 | 1,833 | 26,067 | 360 (185%-250%)[m] | 20,588 (100%-185%)[m] | — | 20,948[m] |
| South Carolina (M) | 150% | 59,920 | | 59,920 | | | | |
| South Dakota (C) | 200% | 11,561 | 3,421 | 14,982 | | | | |
| Tennessee (C) | 250% | 35,589 | 5,774 | 41,363 | | | | |
| Texas (S) | 200% | | 710,690 | 710,690 | | | | |
| Utah (S) | 200% | | 44,785 | 44,785 | | | | |
| Vermont (S) | 300% | | 6,132 | 6,132 | | | | |
| Virginia (C) | 200% | 68,075 | 76,088 | 144,163 | 2,175 (133%-185%)[n] | — | — | 2,175[n] |
| Washington (S) | 250% | | 14,734 | 14,734 | | | | |
| West Virginia (S) | 220% | | 38,582 | 38,582 | | | | |
| Wisconsin (C) | 250% | 56,904 | 5,619 | 62,523 | — | 48,271 (100%-185%)[o] | — | 48,271 |
| Wyoming (S) | 200% | | 8,570 | 8,570 | | | | |
| **TOTALS** | | **2,051,185** | **5,093,609** | **7,144,794** | **6,459** | **487,241** | **93,134** | **586,834** |

**Sources:** Table prepared by CRS based on several sources. For SCHIP upper income levels for children, unpublished set of tables provided by CMS via e-mail on August 8, 2007. For program type, see http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/SCHIPStatePlanActivityMap.pdf and http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/MOCurrentFactsheet.pdf. For number of children ever enrolled, see *FY 2006 Number of Children Ever Enrolled Year -SCHIP by Program Type*, at http://www.cms.hhs.gov/NationalSCHIPPolicy/downloads/FY2006StateTotalTable.pdf, plus more recent unpublished information from CMS on the number of children enrolled for Arkansas, New Jersey and Virginia. For the number of adults enrolled in SCHIP demonstrations, *Adult SCHIP Chart FY2006 (030107).xls*, provided by CMS via e-mail on March 8, 2007. For upper income eligibility limits for adults in SCHIP and associated waiver expiration dates, see the CRS Congressional Distribution

Memorandum, *Chronological Analysis of Populations added to the State Children's Health Insurance Program (SCHIP) Under the Section 1115 Waiver Authority*, by Evelyne P. Baumrucker (available upon request); additional information obtained directly from states or CMS.

**Notes:** S—Separate child health program. M—Medicaid expansion program. C—Combination program. FPL—federal poverty level.

a. Arizona adult SCHIP expiration date: 9/30/11.

b. Arkansas adult SCHIP expiration date: 9/30/11.

c. California also provides coverage up to 300% in four select counties and for infants covered under the Access for Infants and Mothers (AIM) program.

d. Colorado adult SCHIP waiver expiration date: 9/30/09.

e. Adult SCHIP waiver is for employees of small businesses and their families with access to job-based health insurance. Idaho adult SCHIP expiration date: 11/3/09.

f. Illinois' adult SCHIP waiver expired 9/30/07.

g. Michigan adult SCHIP waiver expiration date: 1/15/09.

h. Minnesota adult SCHIP waiver expiration date: 6/12/09.

i. SCHIP coverage of parents uses their job-based health insurance. Nevada adult SCHIP waiver expiration date: 11/30/11.

j. New Jersey adult SCHIP waiver expiration date: 1/17/09.

k. New Mexico adult SCHIP waiver expiration date: 6/30/10.

l. Oregon adult SCHIP waiver expired 10/31/07.

m. Rhode Island adult SCHIP waiver expiration date: 7/31/08.

n. Virginia adult SCHIP waiver expiration date: 6/30/10.

o. Wisconsin adult SCHIP waiver expiration date: 3/31/10. As of 10/1/07, parents are eligible for SCHIP between 130% and 185% FPL. Although family income cannot exceed 185% FPL for initial eligibility, parents may continue enrollment as long as family income does not exceed 200% FPL.

## Table 2. FY2007 Federal SCHIP Financing, by State and Territory

(millions of dollars)

| State and territory | Available unspent FY2005 and FY2006 balances, beginning of FY2007 | Redistribution of other states' unspent FY2004 and certain FY2005 allotments | FY2007 federal SCHIP allotments | Additional allotments in FY2007 to eliminate state shortfalls[a] | Total available federal SCHIP funds | FY2007 federal SCHIP spending |
|---|---|---|---|---|---|---|
| A | B | C | D | E | F = B + C + D + E | G |
| Alabama | $66.7 | | $74.3 | | $141.0 | $95.2 |
| Alaska | $5.3 | | $11.5 | | $16.8 | $16.2 |
| Arizona | $22.9 | | $127.9 | | $150.8 | $117.7 |
| Arkansas | $76.0 | | $49.3 | | $125.3 | $68.8 |
| California | $486.0 | | $790.8 | | $1,276.8 | $980.7 |
| Colorado | $99.8 | | $71.5 | | $171.3 | $65.9 |
| Connecticut | $71.1 | | $39.9 | | $111.0 | $30.1 |
| Delaware | $18.1 | | $11.1 | | $29.1 | $8.6 |
| DC | $18.3 | | $11.7 | | $30.0 | $7.2 |
| Florida | $438.7 | | $296.1 | | $734.8 | $261.7 |
| Georgia | $17.8 | $35.7 | $165.9 | $108.7 | $328.1 | $328.1 |
| Hawaii | $17.4 | | $15.3 | | $32.7 | $18.7 |
| Idaho | $39.8 | | $24.3 | | $64.1 | $27.4 |
| Illinois | $3.3 | $55.2 | $209.8 | $180.3 | $448.5 | $448.5 |
| Indiana | $113.9 | | $93.5 | | $207.3 | $92.1 |
| Iowa | $5.5 | | $36.2 | $9.6 | $51.3 | $51.3 |
| Kansas | $28.0 | | $36.5 | | $64.6 | $45.1 |
| Kentucky | $74.0 | | $70.1 | | $144.1 | $81.2 |
| Louisiana | $67.2 | | $89.6 | | $156.8 | $119.9 |
| Maine | $9.3 | | $15.2 | $6.7 | $31.2 | $31.2 |

| State and territory | Available unspent FY2005 and FY2006 balances, beginning of FY2007 | Redistribution of other states' unspent FY2004 and certain FY2005 allotments | FY2007 federal SCHIP allotments | Additional allotments in FY2007 to eliminate state shortfalls[a] | Total available federal SCHIP funds | FY2007 federal SCHIP spending |
|---|---|---|---|---|---|---|
| A | B | C | D | E | F = B + C + D + E | G |
| Maryland | $4.7 | $26.4 | $67.0 | $40.4 | $138.4 | $138.4 |
| Massachusetts | $0.0 | $62.3 | $73.3 | $75.9 | $211.5 | $211.5 |
| Michigan | $65.9 | | $149.4 | | $215.3 | $171.6 |
| Minnesota | $14.3 | | $48.6 | $1.5 | $64.4 | $64.4 |
| Mississippi | $36.4 | | $60.5 | $10.5 | $107.5 | $107.5 |
| Missouri | $23.2 | | $72.1 | | $95.4 | $79.4 |
| Montana | $16.5 | | $15.7 | | $32.2 | $18.2 |
| Nebraska | $11.7 | | $21.9 | | $33.6 | $33.2 |
| Nevada | $82.3 | | $52.1 | | $134.3 | $30.3 |
| New Hampshire | $16.6 | | $10.8 | | $27.4 | $11.1 |
| New Jersey | $2.7 | $78.2 | $105.2 | $93.9 | $280.0 | $280.0 |
| New Mexico | $84.3 | | $52.0 | | $136.4 | $49.9 |
| New York | $430.5 | | $340.8 | | $771.3 | $324.4 |
| North Carolina | $46.3 | | $136.1 | | $182.4 | $166.6 |
| North Dakota | $4.7 | | $7.7 | | $12.4 | $10.5 |
| Ohio | $91.3 | | $158.0 | | $249.3 | $186.9 |
| Oklahoma | $59.3 | | $70.8 | | $130.2 | $96.4 |
| Oregon | $73.8 | | $56.7 | | $130.5 | $66.6 |
| Pennsylvania | $165.6 | | $173.6 | | $339.1 | $190.0 |
| Rhode Island | $6.2 | $27.0 | $14.0 | $0.6 | $47.7 | $47.7 |
| South Carolina | $90.1 | | $70.7 | | $160.8 | $31.4 |

| State and territory | Available unspent FY2005 and FY2006 balances, beginning of FY2007 | Redistribution of other states' unspent FY2004 and certain FY2005 allotments | FY2007 federal SCHIP allotments | Additional allotments in FY2007 to eliminate state shortfalls[a] | Total available federal SCHIP funds | FY2007 federal SCHIP spending |
|---|---|---|---|---|---|---|
| A | B | C | D | E | F = B + C + D + E | G |
| South Dakota | $5.3 | | $10.4 | | $15.6 | $9.8 |
| Tennessee | $159.3 | | $97.5 | | $256.8 | $4.1 |
| Texas | $904.7 | | $558.0 | | $1,462.7 | $385.7 |
| Utah | $38.8 | | $40.5 | | $79.2 | $38.9 |
| Vermont | $8.7 | | $5.8 | | $14.5 | $5.9 |
| Virginia | $82.0 | | $94.1 | | $176.1 | $110.7 |
| Washington | $129.4 | | $79.9 | | $209.3 | $36.8 |
| West Virginia | $31.2 | | $27.5 | | $58.7 | $35.4 |
| Wisconsin | $26.7 | | $69.6 | | $96.2 | $84.5 |
| Wyoming | $10.6 | | $6.9 | | $17.5 | $7.8 |
| Puerto Rico | $58.2 | | $48.1 | | $106.3 | $104.5 |
| Guam | $0.0 | | $1.8 | | $1.8 | $1.8 |
| Virgin Islands | $0.6 | | $1.4 | | $2.0 | $1.3 |
| American Samoa | $0.0 | | $0.6 | | $0.6 | $0.9 |
| N. Mariana Islands | $0.1 | | $0.6 | | $0.6 | $0.7 |
| **Total** | **$4,461.2** | **$284.7** | **$5,040.0** | **$528.2** | **$10,314.1** | **$6,040.8** |

**Source:** Congressional Research Service (CRS) analysis of data from the Centers for Medicare and Medicaid Services.

a. This column shows the amount of funds provided to states to eliminate their FY2007 federal SCHIP shortfalls (up to $650 million), as appropriated in the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28, enacted May 25, 2007).

## Table 3. Cumulative FY1998-FY2007 Federal SCHIP Financing, by State and Territory

(millions of dollars)

| State and territory | FY1998-FY2007 original SCHIP allotments | Net funds gained (forfeited) through redistributions | FY2006 and FY2007 shortfall allotments[a] | FY1998-FY2007 Federal SCHIP expenditures | Amount of expired FY1998-FY2002 reallocated SCHIP funds |
|---|---|---|---|---|---|
| A | B | C | D | E | F |
| Alabama | $680 | ($73) | | $561 | |
| Alaska | $82 | $98 | | $170 | $9 |
| Arizona | $1,091 | $25 | | $1,083 | |
| Arkansas | $451 | ($134) | | $249 | $11 |
| California | $6,892 | ($1,455) | | $5,141 | |
| Colorado | $479 | ($55) | | $319 | |
| Connecticut | $338 | ($89) | | $160 | |
| Delaware | $90 | ($29) | | $39 | |
| DC | $100 | ($24) | | $53 | |
| Florida | $2,326 | $50 | | $1,902 | |
| Georgia | $1,248 | ($37) | $109 | $1,356 | |
| Hawaii | $108 | ($24) | | $71 | |
| Idaho | $186 | ($20) | | $129 | |
| Illinois | $1,466 | ($167) | $237 | $1,591 | |
| Indiana | $659 | $67 | | $610 | |
| Iowa | $285 | ($11) | $16 | $290 | |
| Kansas | $283 | $32 | | $295 | |
| Kentucky | $509 | $240 | | $588 | $99 |
| Louisiana | $804 | ($127) | | $640 | |
| Maine | $121 | $50 | $7 | $172 | $6 |
| Maryland | $499 | $390 | $54 | $961 | $8 |
| Massachusetts | $519 | $217 | $98 | $865 | $31 |
| Michigan | $1,065 | ($153) | | $868 | |

| State and territory | FY1998-FY2007 original SCHIP allotments | Net funds gained (forfeited) through redistributions | FY2006 and FY2007 shortfall allotments[a] | FY1998-FY2007 Federal SCHIP expenditures | Amount of expired FY1998-FY2002 reallocated SCHIP funds |
|---|---|---|---|---|---|
| A | B | C | D | E | F |
| Minnesota | $343 | $52 | $9 | $404 | |
| Mississippi | $497 | $81 | $84 | $662 | |
| Missouri | $540 | $41 | $8 | $573 | |
| Montana | $125 | ($5) | | $106 | |
| Nebraska | $165 | $0 | $16 | $180 | |
| Nevada | $346 | ($63) | | $175 | |
| New Hampshire | $100 | ($34) | | $50 | |
| New Jersey | $855 | $586 | $144 | $1,663 | |
| New Mexico | $468 | ($177) | | $170 | $33 |
| New York | $2,680 | $1,788 | | $3,070 | $951 |
| North Carolina | $957 | $165 | $3 | $1,109 | |
| North Dakota | $59 | ($8) | | $50 | |
| Ohio | $1,238 | ($14) | | $1,161 | |
| Oklahoma | $637 | ($171) | | $433 | |
| Oregon | $439 | ($116) | | $260 | |
| Pennsylvania | $1,242 | ($33) | | $1,060 | |
| Rhode Island | $95 | $157 | $24 | $303 | |
| South Carolina | $577 | $144 | | $440 | $152 |
| South Dakota | $77 | ($1) | $1 | $71 | |
| Tennessee | $728 | ($247) | | $72 | $97 |
| Texas | $4,482 | ($832) | | $2,512 | |
| Utah | $282 | ($11) | | $230 | |
| Vermont | $42 | ($6) | | $28 | |
| Virginia | $692 | ($134) | | $493 | |

| State and territory | FY1998-FY2007 original SCHIP allotments | Net funds gained (forfeited) through redistributions | FY2006 and FY2007 shortfall allotments[a] | FY1998-FY2007 Federal SCHIP expenditures | Amount of expired FY1998-FY2002 reallocated SCHIP funds |
|---|---|---|---|---|---|
| A | B | C | D | E | F |
| Washington | $559 | ($178) | | $183 | $12 |
| West Virginia | $219 | $25 | | $220 | |
| Wisconsin | $480 | $142 | | $610 | |
| Wyoming | $65 | ($19) | | $36 | |
| Puerto Rico | $348 | $93 | $3 | $442 | |
| Guam | $13 | $4 | $0 | $19 | |
| Virgin Islands | $10 | $3 | $0 | $12 | |
| American Samoa | $5 | $1 | $0 | $8 | |
| N. Mariana Islands | $4 | $1 | $0 | $9 | |
| **Total** | **$39,651** | **$0** | **$811** | **$34,925** | **$1,409** |

**Source:** Congressional Research Service (CRS) analysis of data from the Centers for Medicare and Medicaid Services.

a. This column shows the amount of funds provided to states to eliminate their FY2006 and FY2007 federal SCHIP shortfalls as appropriated, respectively, in the Deficit Reduction Act of 2005 (P.L. 109-171, enacted February 8, 2006) and the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28, enacted May 25, 2007).

## Author Contact Information

Elicia J. Herz
Specialist in Health Care Financing
eherz@crs.loc.gov, 7-1377

Chris L. Peterson
Specialist in Health Care Financing
cpeterson@crs.loc.gov, 7-4681

Evelyne P. Baumrucker
Analyst in Health Care Financing
ebaumrucker@crs.loc.gov, 7-8913