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The State Children's Health Insurance Program: Eligibility, Enrollment, and Program Funding

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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. SCHIP represents the largest publicly funded effort to provide health insurance to children since the enactment of Medicaid in 1965. The program offers federal matching funds for states and territories to provide health insurance coverage to uninsured, low-income children from families whose annual incomes are higher than Medicaid eligibility thresholds. States may choose from three options when designing their SCHIP programs; they may (1) expand their current Medicaid program, (2) create a new, separate state insurance program, or (3) devise a combination of both approaches. A majority of states are expanding eligibility for SCHIP to levels between 150% and 200% of the federal poverty level (FPL). In one state, New Jersey, the upper income eligibility limit for Medicaid expansions and separate state programs under SCHIP has reached 350% of the federal poverty level.

Until recently, the 106th Congress and the Clinton Administration expressed disappointment with implementation progress under SCHIP, citing low enrollment rates early in the program. By FY2000, the pace of enrollment under SCHIP had improved. The Health Care Financing Administration (HCFA) reported that nearly1 million children (982,000) were enrolled in SCHIP in FY1998 under 43 operational state programs. In FY1999, enrollment increased to nearly 2 million children (1,979,450) under 53 operational programs. On January 5, 2001, the Clinton Administration announced that enrollment in the SCHIP program reached approximately 3.3 million children by the end of FY2000. Subsequent to the enactment of BBA 97, CBO estimated that SCHIP would cover an average of 2.3 million children per year after 1999. The Clinton Administration's goal was to enroll 5 million children in SCHIP by FY2002.

In the original enacting statute, Congress provided appropriations of nearly $40 billion for the FY1998 to FY2007 period. Federal funds are allotted among the states based on a formula that takes into account the combination of the number of low-income children and the number of low-income, uninsured children residing in a state, as well as a state cost factor. A total of $4.295 billion in federal funds was available to states and territories for FY1998 and $4.307 billion was available in FY1999. Each of FY2000 and FY2001, federal funding levels total $4.309 billion.

Like Medicaid, SCHIP is a federal-state matching program. In order to determine a state's matching payments, SCHIP uses Medicaid's concept of "federal medical assistance percentage," but modifies it to provide states an "enhanced federal medical assistance percentage" (enhanced FMAP). A state's share of total SCHIP spending is equal to 100% minus the enhanced FMAP. In FY2001, the states' regular Medicaid federal medical assistance percentages (FMAPs) range from 50% to 76.82%. Under the SCHIP program, the FY2001 enhanced FMAPs range from 65% to 83.77% in the states. While all age groups of children have benefitted from increases in eligibility for SCHIP coverage, many of the states have taken advantage of these enhanced matching funds to extend eligibility to older adolescents.

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Background

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. Several recent laws made technical and funding changes to Title XXI.[1] The final rules and regulations governing the SCHIP program were published on January 11, 2001 (*Federal Register*, v. 66, no. 8).[2,3,4]

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[1]For more details, see CRS Report RL30400, *Medicaid and the State Children's Health Insurance Program (SCHIP): Provisions in the Consolidated Appropriations Act of FY2000*,by Jean Hearne and Lisa Herz, and CRS Report RL30718, *Medicaid, SCHIP and Other Health Provisions in H.R. 5661: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000*, by Jean Hearne, Lisa Herz, and Evelyne Baumrucker.

[2]Proposed regulations for governance of the program were published on November 8, 1999 (*Federal Register*, v. 64, no. 215). An earlier proposed rule for the SCHIP program reported the allotments and grants to the states for FY1998 and FY1999 and appears in the Federal Register, v. 64, no. 42 [Thursday, March 4, 1999] Proposed Rule. The final rule for the State Children's Health Insurance Program's allotments and payments to states appeared in the *Federal Register*, v. 65, no. 101 [Wednesday, May 24, 2000] Rules and Regulations. This final rule provides final SCHIP program allotments for FY1998 through FY2000.

[3]On January 20, 2001 the Bush Administration issued a regulatory review memorandum addressed to the heads and acting heads of executive departments and agencies. This memorandum issues a 60-day delay on the effective dates of any of the Clinton Administration's regulatory actions published in the *Federal Register* in the last 60 days of his Administration. It is not clear what will happen when the hold expires. The Administration may turn to Congress to overturn some of the features of the regulations. Alternatively, the Bush Administration could seek to retract the final rules and issue new ones. Action of this type may be subject to legal challenge. The intent of Bush's regulatory plan review is to ensure that the President's appointees have the opportunity to review any new or pending regulations.

[4]In a January 8, 2001 *Dear State Health Official Letter*, distributed at the time the SCHIP final rule was released, HCFA identified the main areas where new flexibility or further clarification was provided. The issues highlighted include: (1) Premium Assistance Programs (Employer-Sponsored Insurance), (2) Substitution Prevention, (3) Employment with a Public Agency, (4) American Indians/Alaskan Natives, (5) Coordination with Medicaid, (6) Gender, Race, Ethnicity, and Primary Language Reporting, (7) Cost-Sharing, (8) Access to Services, and (9) Reviews of Eligibility, Enrollment and Health Services Decisions. For more details

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SCHIP is a federal-state partnership intended to provide health insurance coverage to low-income, uninsured children. SCHIP targets children in families whose annual incomes are higher than applicable Medicaid eligibility thresholds, and who do not have other health insurance coverage. In the original enacting statute Congress authorized and appropriated SCHIP federal matching grants in the amount of $39.7 billion for FY1998 through FY2007. Later, Congress provided additional appropriations for SCHIP in order to increase allocations to the territories, bringing the total of appropriations available for the period closer to $40 billion.

States may choose from three options when designing their SCHIP programs. They may expand their current Medicaid program, create a new, separate state insurance program, or devise a combination of both approaches. Under limited circumstances, states have the option to purchase a health benefits plan that is provided by a community-based health delivery system or to purchase family coverage under a group health plan as long as it is cost effective to do so.[5] As of late 1999, HCFA approved SCHIP plans for all 50 states, the District of Columbia and the five territories. As of December 11, 2000, 21 jurisdictions use Medicaid expansions (ME) and another 16 use separate state programs (SSP) for their SCHIP programs, with the remaining 19 providing health insurance coverage through a combination approach (COMBO).

Eligibility

The federal Medicaid statute mandates that states cover certain groups of children based on age and income criteria and gives states several options to expand coverage beyond these federal minimum standards. Children (and families) who meet the financial and categorical rules under the states' former Aid to Families with Dependent Children (AFDC) programs (in effect on July 16, 1996) are eligible for Medicaid even if they do not qualify for cash grants under the new Temporary Assistance for Needy Families (TANF) program. In addition, states *must* provide coverage to all pregnant women and children age 5 and under living in families with incomes at or below 133% of the federal poverty level. States also *must* phase in coverage to children living in families with incomes below 100% of the federal poverty level who were born after September 30, 1983, until all such children under

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[4](...continued)
of the program rules see forthcoming update of CRS Report 97-92, *The State Children's Health Insurance Program: Guidance on Frequently Asked Questions.*

[5]In the case of community-based health delivery systems, the cost of coverage cannot exceed, on an average per child basis, the cost of coverage that would otherwise be provided. In the case of family coverage, the alternative must be cost-effective relative to the amount paid to obtain comparable coverage only of the targeted low-income children, and it must not substitute for health insurance coverage that would otherwise be provided to the children.

age 19 are covered.[6] As a result of this requirement, in FY2001 states must cover all children ages 6 to 17 whose family income is below the federal poverty threshold.[7]

States that wish to cover more children at higher levels of income, have the *option* of (1) making pregnant women and infants under 1 year of age up to 185% of the federal poverty level eligible for Medicaid; (2) using more liberal income and asset standards to determine eligibility than those required under law (as allowed under §1902(r)(2) of Medicaid law); and (3) using research and demonstration waivers (authorized under §1115 of the Social Security Act) to cover children who would not otherwise be eligible for the program. Forty-one states have expanded Medicaid eligibility for at least some children beyond federal mandates.[8] **Table 1** shows income limits for Medicaid eligibility as a percentage of the federal poverty level by age group in each of the 50 states and the District of Columbia, in effect on June 1, 1997.[9]

Under SCHIP, states may cover uninsured children in families with incomes that are above the state's applicable Medicaid eligibility standard but less than 200% of the federal poverty level. However, states, in which the maximum Medicaid income level for children was at or above 200% federal poverty level as of June 1, 1997,[10] may increase this income level by an additional 50 percentage points under SCHIP, even if the resulting income limit exceeds 200% of the federal poverty level.

Not all targeted low-income uninsured children will necessarily receive medical assistance under SCHIP for two reasons. First, unlike Medicaid, federal law does not establish an *individual* entitlement to benefits under SCHIP. Instead, it entitles *states* with approved SCHIP plans to pre-determined federal allotments based on a distribution formula set in the law. Second, states are allowed under the law to define the group of targeted low-income children who may enroll in SCHIP. Title XXI

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[6]Medicaid eligibility for all low-income children born after September 30, 1983 was mandated in the Omnibus Budget Reconciliation Act of 1990 (OBRA-90).

[7]These children are commonly referred to as the "Waxman Kids" after Representative Henry Waxman of California who spearheaded eligibility expansions for children and pregnant women under Medicaid in the late 1980s.

[8]As of October 1997, 35 states used various options available to them to exceed the federal minimum mandate of 133% federal poverty level for pregnant women and infants. Thirteen states expanded eligibility for children ages 1 through 5 above this same mandatory minimum (133% FPL). Twenty-eight states moved beyond the federal mandate of 100% FPL and/or age requirements for children ages 6 and older. See Henneberry, Joan. *State Medicaid Coverage of Pregnant Women and Children.* NGA Center for Best Practices, Health Policy Studies Division, September 30, 1997.

[9]The final rule for the SCHIP program (published in the *Federal Register*, v. 66, no. 8, January 11, 2001) makes a change to the official start date of SCHIP. The date to which income eligibility is keyed has changed from March 31, 1997 to June 1, 1997; however, the final rule also states that children who became eligible for Medicaid as a result of an expansion of Medicaid that was effective between March 31, 1997 and June 1, 1997 will be considered targeted low-income children. The new start date will represent the lower bounds for income eligibility in the SCHIP program. The final rule is subject to the Bush Administration's regulatory review. (See footnote 3.)

[10]Ibid.

allows states to use the following characteristics in determining eligibility: geography, age, income and resources, residency, disability status, access to other health insurance, and duration of eligibility for SCHIP coverage.

In addition to the Medicaid eligibility thresholds in effect at the start of the SCHIP program, **Table 1** shows how the states, the District of Columbia, and the territories[11] will use SCHIP funds to expand eligibility thresholds beyond those applicable under Medicaid. The table shows the type of SCHIP program implemented as well as the targeted age groups affected. A majority of the states are expanding eligibility to levels between 150% and 200% FPL. In one state, New Jersey, the upper income eligibility limit for Medicaid expansions and separate state programs under SCHIP has reached 350% of the federal poverty level.

While expansions in coverage have been achieved for all age groups of children under SCHIP, the most significant increases in eligibility benefit older adolescents. States are taking advantage of the opportunity to use enhanced matching funds under SCHIP to cover a portion of the older teens ages 17-18 in families with incomes up to 100% of the federal poverty level sooner than required under current Medicaid law. In many cases, states are also expanding their programs to cover children of all ages in families with income well above the 100% FPL requirement.

On January 18, 2001 HCFA approved the first three SCHIP §1115 waivers. These waivers will allow the states of New Jersey, Rhode Island, and Wisconsin to offer health insurance coverage to the parents of children eligible under either SCHIP or Medicaid. Additionally, the demonstration projects in New Jersey and Rhode Island will expand coverage to pregnant women.

At the start of the SCHIP program many states submitted Medicaid expansions as place-holder plans to ensure their access to the enhanced matching funding available through SCHIP. These early Medicaid expansions were used to create more uniformity in income eligibility criteria (e.g., provide coverage to at least 100% FPL) for all children under the age of 18. As the program has evolved, states have submitted amendments to their original Medicaid expansions to define separate state programs that further expand eligibility thresholds. Of the 43 state plan amendments that expand eligibility in some way, 11 build on their original submission to create combination programs that cover new groups of children not previously covered. Twenty-three eligibility-related amendments increased thresholds beyond the limits defined in the state's original submission. Nine amendments have had the effect of expanding eligibility under SCHIP by modifying methods of counting income through the use of income disregards.[12,13]

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[11]The five territories are American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the Virgin Islands.

[12]For determining income eligibility for SCHIP and Medicaid, some states may apply "income disregards." These are specified dollar amounts subtracted from gross income to compute net income, which is then compared to the applicable income criterion. Such disregards increase the effective income level above the stated standard. SCHIP state plans do not consistently report the use of income disregards, nor whether the stated income standards include or

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Enrollment

Until recently, the 106th Congress and the Clinton Administration expressed disappointment with implementation progress under SCHIP, citing low enrollment rates early in the program. By FY2000, the pace of enrollment under SCHIP had improved. Early enrollment estimates from HCFA[14] indicated that nearly 1 million children (982,000) were enrolled in SCHIP under 43 operational state programs as of December 1998. More recently, HCFA reported that nearly 2 million children (1,979,459) were enrolled in SCHIP by the end of FY1999 under 53 operational state programs.[15] Over 1.2 million of these children were served by separate state programs and almost 700,000 were enrolled in Medicaid Expansions. On January 5, 2001, the Clinton Administration announced that enrollment in the SCHIP program reached approximately 3.3 million children in FY2000, with 2.3 million children enrolled in separate state programs, and a little more than 1 million enrolled in Medicaid expansion programs.[16] The Clinton Administration's goal was to enroll 5 million children in SCHIP by FY2002.[17] As of March 2000, an estimated 10.8 million children under the age 19 were without health insurance in 1999, 6.3 million of those children were from families with incomes less than 200% FPL.[18]

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[12](...continued)
exclude such disregards.

[13]CRS analysis of all amendments approved by HCFA as of January 30, 2001.

[14]Health Care Financing Administration. *A Preliminary Estimate of the Children's Health Insurance Program Aggregate Enrollment Numbers Through December 31, 1998* (background only). April 20, 1999.

[15]Health Care Financing Administration. *The State Children's Health Insurance Program. Annual Enrollment Report, October 1, 1998-September 30, 1999.* (no date)

[16]Bureau of National Affairs. HCFA Releases Final SCHIP Rule, As Clinton Notes 70% Participation Increase. *Health Care Daily Report,* v. 6, no. 5, January 8, 2001.

[17]At the time of enactment of BBA 97, CBO estimated that SCHIP would cover an average of 2.3 million children per year after 1999. For more detail on the state by state enrollment patterns in SCHIP, see CRS Report RL30556, *Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?* by Elicia Herz, and Evelyne Baumrucker, and CRS Report RL30473, *State Children's Health Insurance Program: A Brief Overview,* by Elicia Herz and Evelyne Baumrucker.

[18]For more information on uninsured children, see CRS Report 97-310, *Health Insurance: Uninsured Children by State, 1997-1999,* by Paulette Morgan and CRS Report 97-975, *Health Insurance Coverage of Children, 1999,* by Madeline Smith.

Program Funding

Appropriations for FY1998 through FY2001

The original enacting statute provided appropriations for SCHIP for FY1998 through FY2007. The statute authorizes and appropriates these funds in advance of any appropriations act so that the SCHIP program operates like a mandatory spending program. The appropriation committees do, however, have the authority to increase, defer, or rescind funding for the SCHIP program and on several occasions have considered proposals to do so. On three occasions, Congress has increased appropriations for SCHIP, and on two occasions considered proposals to reduce funding for the program.[19]

The law[20] sets forth methodologies and procedures to determine state-specific allotments of federal funds for each federal fiscal year; these are described below. DHHS issues final rules in the *Federal Register* that enumerate specific state allotments.

A total of $4.295 billion in federal matching funds was available to the states and territories for FY1998.[21] Of this total appropriation, the amount available for allotment to the 50 states and the District of Columbia was $4.224 billion. An additional $10.738 million was set-aside for allotment to the territories, as was another $60 million for Special Diabetes Grants.[22,23]

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[19]For more information see CRS Report RS20628, *State Children's Health Insurance Program (SCHIP): Funding Changes in the 106th Congress*, by Evelyne Baumrucker.

[20]*Federal Register*, v. 65, no. 101, May 24, 2000.

[21]P.L. 105-100, §162(8)(a), struck out "$4,275,000,000" and substituted "$4,295,000,000," effective as if included in the enactment of P.L. 105-33, August 5, 1997.

[22]The original authorizing legislation for SCHIP requires that .25% of the program's total authorization be set-aside for the territories. In addition, the law requires that the amount available to the 50 states and the District of Columbia be further reduced (after the set-aside to the territories) by $60,000,000; $30,000,000 each for a special diabetes research program for Type I diabetes and for special diabetes programs for Native Americans. The diabetes programs are funded out of the SCHIP appropriation for FY1998 through FY2002 only. P.L. 106-554 extends for 1 year, to FY2003, the authority for grants to be made for both the Special Diabetes Program for Type I Diabetes and for the Special Diabetes Program for Indians. P.L. 106-554 also expands funding available to these programs. For each grant program , total funding will be increased to $100 million for each of FY2001, FY2002, and FY2003. For FY2001 and FY2002, $30 million of the $100 million for each program will be transferred from SCHIP; the remaining $70 million would be drawn from the Treasury out of funds not otherwise appropriated. In FY2003, the entire $100 million will be drawn from the Treasury out of funds not otherwise appropriated. In addition, P.L. 106-554, extends the due date on final evaluation reports for these two grant programs from January 1, 2002 to January 1, 2003.

[23] P.L 106-554 requires the redistribution of unspent FY1998 and FY1999 allotments and a method to be used for redistribution. See discussion later in the text.

For FY1999, $4.307 billion in federal matching funds was appropriated for the states and territories. For this year, an additional $32 million was appropriated for allotment to the territories under the FY1999 Omnibus Appropriations Act, (P.L. 105-277). These new funds brought the FY1999 federal funds available to the territories for SCHIP to $42.690 million. The states and the District of Columbia will share $4.204 billion, and $60 million is available for diabetes grants for FY1999.[24]

For each of FY2000 and FY2001, SCHIP appropriations total $4.309 billion. The amount of federal funds available for distribution to the states and the District of Columbia is $4.204 billion. The territories will receive $44.890 million, consisting of their original FY2000 (or FY2001) allotment plus an additional sum of $34.200 million provided by P.L. 106-113, the Balanced Budget Refinement Act. Again, $60 million is set aside for diabetes grants.[25]

Allotments Among the States

For each fiscal year, the states and the District of Columbia are allotted a "proportion" of the total amount of title XXI dollars available for that year. A state's proportion refers to the amount of the allotment for a state for a given fiscal year divided by the total amount available nationally for all states for that fiscal year. The state proportions are determined by a two-step process described below.

Under the first step, each state's proportion is calculated as the product of two components: the Number of Children Factor and the State Cost Factor. In general, the Number of Children Factor is the combination of the number of low-income children regardless of insurance status, and the number of low-income, uninsured children residing in a state for a given fiscal year.[26] The State Cost Factor is the sum of .85 multiplied by the ratio of the annual average wages per employee in the health services industry for the year to the national average wages per such employee for the year, and .15. For each fiscal year and state, counts of children are 3-year averages taken from recent March Supplements of the Current Population Survey. Employee wages are 3-year averages as reported by the Bureau of Labor Statistics.

The definition of the Number of Children Factor in this formula varies across fiscal years. For FY1998 and FY1999 only, this factor is defined as the 3-year average of uninsured children in families with income below 200% FPL. For FY2000

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[24]Ibid.

[25]The Balanced Budget Refinement Act provided additional funding for SCHIP-related issues. For each of the FY2000 through FY2007, $10 million is provided to the Secretary of Commerce to make appropriate adjustments to the annual Current Population Survey (CPS) to improve the reliability of state-specific estimates of the number of low-income uninsured children. In addition, for FY2000, $10 million is provided for a new federal evaluation of the SCHIP program. For more details on changes made to the Medicaid and SCHIP programs by P.L. 106-113, see CRS Report RL30400, *Medicaid and the State Children's Health Insurance Program (SCHIP): Provisions in the Consolidated Appropriations Act for FY2000* by Jean Hearne and Elicia Herz. (Hereafter cited as CRS Report RL30400, *Medicaid and the State Children's Health Insurance Program*)

[26]Low-income is defined as a family with income below 200% of the federal poverty level.

only, for each state this factor is the sum of 75% of the number of low-income uninsured children, and 25% of the number of low-income children. For FY2001 through FY2007, for each state this factor is the sum of 50% of the number of low-income, uninsured children and 50% of the number of low-income children.

In the second step, floors, ceilings, and a reconciliation process are applied to the "preadjusted" proportions determined in step one. The SCHIP statute specifies three minimum proportions that must be applied when determining each state's allotment: (1) the program floor for every state is $2 million; (2) for each fiscal year, the floor will not be less than 90% of a state's allotment proportion for the preceding year; and (3) the floor is set at 70% of the proportion for FY1999. The state's proportion must not go below any of these three floors. Comparably, each state's proportion for a fiscal year is also limited by a maximum ceiling. The ceiling is equal to145% of a state's allotment proportion for FY1999. Finally, the sum of the "preadjusted" proportions for all states must be equal to one. If they are not, the allotment proportions will be subject to a reconciliation process. Under the reconciliation process, if the application of the floors and ceilings across states results in a surplus for a given year, HCFA must apply a pro-rata increase for all states below the ceiling. If the distribution creates a deficit in a given year, there will be a ceiling in the maximum increase permitted in that year to ensure budget neutrality.

A state's final annual allotment is then calculated by multiplying the state's "adjusted" proportion for that fiscal year by the national total appropriated in that year. Final allotments are published in the *Federal Register*.

Payments to the States

To receive federal funds, states must submit a plan describing their program to the Health Care Financing Administration (HCFA) for approval. In order to access FY1998 allotments, states must have received such approval prior to October 1, 1999. All states had approved plans by the deadline. Funds not drawn down from a state's federal allotment by the end of each fiscal year will continue to be available for 2 additional fiscal years, giving each state a total of 3 years to spend its allotment of federal matching funds from a given fiscal year. A state must draw down its entire allotment from a given fiscal year before it may access the next year's funding. For example, FY2001 money not spent by the of FY2003 (as of September 30, 2003) will be distributed, by a method to be determined by the Secretary of HHS, to states that have fully expended their existing FY2001 allotments, and are able to provide matching funds. These states will have 1 year to spend the redistributed funds. Redistributed funds not spent by the end of the fiscal year in which they are reallotted will officially expire.

Public Law 106-554 makes a change to the redistribution process by creating a special rule for the redistribution and availability of unused FY1998 and FY1999 SCHIP allotments. States that use all their SCHIP allotments (for each of FY1998 and FY1999) will receive an amount equal to spending estimates in excess of their original exhausted allotments submitted to HCFA as of a specified date. Each territory that spends its original allotment will receive an amount that bears the same ratio to 1.05% of the total amount available for redistribution as the ratio of its original allotment to the total allotment for all territories.

States that do *not* use all their SCHIP allotment will receive an amount equal to the total amount of unspent funds, less amounts distributed to states that fully exhausted their original allotments, multiplied by the ratio of a state's unspent original allotment to the total amount of unspent funds. States that did not use their full FY1998 allotments may use up to 10% of the retained FY1998 funds under the new redistribution formula specifically for outreach activities.

To calculate the amount available for redistribution in each formula described above, the Secretary will use amounts reported by states not later than December 15, 2000 for the FY1998 redistribution, and November 30, 2001 for the FY1999 redistribution on the HCFA Form 64 or HCFA Form 21, as approved by the Secretary.[27] Redistributed funds will be available through the end of FY2002.

Federal law limits the funds available to pay for the administrative costs of SCHIP to 10% of spending for benefits in any given year. Activities included in the 10% cap consist of (1) costs incurred through data collection, assessment of the state plan, quality assurance activities, eligibility determination, performance measurements, outreach and coordination initiatives, and public involvement, (2) health benefit coverage of specialty and sub-speciality care, and (3) special initiatives for improving the health of children.

Administrative costs tend to be higher during the initial start-up of a new program, compared with the costs of running an existing program. During the first 2 years after SCHIP was enacted, many states in the start-up phase of their program found the 10% cap to be particularly burdensome. Many states were concerned that the 10% administrative cap would limit their ability to fund outreach initiatives necessary to find and enroll eligible children. Because the 10% cap is applied to the total benefit payments made to a state in any year (10% of the money a state actually draws down, as opposed to its full allotment), states questioned whether there would be sufficient funds available to pay the substantial start-up costs of their SCHIP programs. In response to these concerns, HCFA published guidance that gives states some flexibility on the 10% cap. As described above, P.L. 106-554 also makes a special outreach accommodation for states that were not able to spend their entire FY1998 SCHIP allotments.

States that chose Medicaid expansions can claim federal matching funds for administrative and outreach expenditures either through the regular Medicaid program at the applicable Medicaid federal matching rate or under SCHIP at the enhanced matching rate. This allows states to spread out their administrative costs across two programs. States also have the option to delay the submission of claims for administrative expenditures to HCFA for up to 2 years from the date of the expenditure. This process allows states with low benefit expenditures in the early years of their program to maximize reimbursement for administrative expenditures at the enhanced federal matching rate.

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[27] **Table 3** provides amounts of unexpended FY1998 SCHIP allotments available for redistribution to states using all of their allotments and for continued availability to states failing to use all of their allotments. FY1999 redistribution and continued availability totals will not be available until after November 30, 2001.

Table 2 provides SCHIP program funding information for the states and territories for FY2001. The second column of the table shows total allotments of federal funds. Allotment amounts for FY2002 (and beyond) will be published in the *Federal Register*.

Like Medicaid, SCHIP is a federal-state matching program. For each dollar of state spending, the federal government will make a matching payment. The third and fourth columns of **Table 2,** provide Federal Medical Assistance Percentages (FMAP)[28] and Enhanced Federal Medical Assistance Percentages (Enhanced FMAP). Under Medicaid, a state's share of program spending is equal to 100% minus the FMAP for the state. Under SCHIP, the Enhanced FMAP is equal to the 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%. For example, if a state has a Medicaid FMAP of 50%, under Medicaid the state must spend 50 cents for every 50 cents that the federal government contributes. The Enhanced FMAP would be equal to the Medicaid federal matching percentage increased by 15 percentage points, (50% + (30% multiplied by 50%) = 65%). The state share under SCHIP would be equal to 100% - 65% = 35%.

Compared with Medicaid FMAPs, which ranged from 50% to 76.82% in FY2001, the Enhanced FMAP for the SCHIP programs ranged from 65% to 83.77%. The Enhanced FMAP applies to all SCHIP assistance for targeted low-income children, including child health coverage provided through a Medicaid expansion. The FMAP and Enhanced FMAP are subject to ceilings of 83% and 85%, respectively.

The totals in the fifth, sixth, and final columns of **Table 2** are estimates of the required state match necessary to claim the maximum federal SCHIP allotments; estimates of the ratio of federal dollars spent to each state dollar; and estimates of potential total program expenditures (state share + federal share), respectively. Because states have 3 years to draw down a given year's funding and the Enhanced FMAPs are variable from year to year, it is not possible to report a precise dollar amount in these columns. The Enhanced FMAP used to determine the required state match is based on the date the state makes a payment to cover a SCHIP claim.[29] The state then submits claims for these payments to HCFA on a quarterly expenditure report. Once state claims have been approved by HCFA, the federal portion is paid to the state using the oldest open allotment and the Enhanced FMAP applicable to the date the state made specific payments to providers. For example, assume a state makes a payment to a provider in April of FY2001. If the state then submits its corresponding claim to HCFA on its FY2001, third quarter expenditure report and the state's FY1999 allotted funds are still available, then the federal dollars paid to the state for that claim will be paid out of the FY1999 allotment and the amount will be based on the state's FY2001 Enhanced FMAP.

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[28]FMAP is a measure of the 3-year average per capita income in each state squared, compared to that of the nation as a whole.

[29]*Federal Register*, v. 65, no. 101, May 24, 2000 and Federal Register, 45 CFR Parts 92 and 95, May 24, 2000.

Spending

Spending projections in the first 2 years of the program are consistent with HCFA's enrollment figures and fall well below total federal appropriation levels. Federal spending in FY1998 totaled less than $500 million. Federal spending in FY1999 totaled approximately $1 billion. Program spending is expected to accelerate over time. CBO estimates that federal SCHIP spending will total approximately $1.8 billion for FY2000 and $2.6 billion for FY2001.[30] For each of these years, total annual federal appropriation levels are approximately $4.3 billion. Based on actual spending as reported and certified by the states and approved by HCFA as of December 15, 2000, $2.0 billion remained unspent from the FY1998 allotments by the end of FY2000 and thus was subject to the special redistribution rules of P.L. 106-554 in FY2001.[31] At that point in time, only 12 states and five territories had claimed their full FY1998 allotments. **Table 3** provides amounts of unexpended FY1998 SCHIP allotments that are available for redistribution to states using all of their allotments, and amounts that continue to be available for states failing to use all of their allotments. It is too early to determine whether states will ultimately claim their full FY1999, FY2000, or FY2001 federal SCHIP funding.[32]

For more information about SCHIP, see CRS Report 97-92, *The State Children's Health Insurance Program: Guidance on Frequently Asked Questions*, CRS Report RL30718, *Medicaid, SCHIP, and Other Health Provisions in H.R. 5661: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000*, CRS Report RL30473, *State Children's Health Insurance Program: A Brief Overview*, and CRS Report RL30556, *Reaching Low- Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?*

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[30]U.S. Congressional Budget Office. *CBO January 2001 Baseline*. January, 2001. Washington, GPO, 2001.

[31]HCFA's FY1998 SCHIP spending projections are based on state submitted actual expenditures through FY1999 and state submitted expenditure estimates for FY2000 through February of this year (HCFA, unpublished data, April 4, 2000) See footnote 26.

[32]For more information on SCHIP funding changes in the 106th Congress, see CRS Report RS20628, *State Children's Health Insurance Program (SCHIP): Funding Changes in the 106th Congress*, by Evelyne P. Baumrucker.

Table 1. Medicaid and SCHIP Income and Age Related Eligibility Criteria as a Percent of the Federal Poverty Level

States	Medicaid standards in effect March 31, 1997 (lower income boundary for SCHIP)[a/b]				SCHIP (in effect January 1, 2001)[c]									
					Medicaid expansion					Separate state plan				
	Age 0 to 1[d]	Ages 1 thru 5[e]	Ages 6 thru 14 [a]	Ages 15 thru 18[f]	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children age 6 and over (Through upper age limit)	Children 17-18	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children ages 6 and over (Through upper age limit)	Children 17-18
Alabama	133	133	100	15	–	–	–	–	100	200	–	–	–	–
Alaska	133	133	100	100	200	–	–	–	–	–	–	–	–	–
American Samoa[g]	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	140	133	100	30	–	–	–	–	–	200	–	–	–	–
Arkansas[h]	133	133	100	18	–	–	–	–	100 (born after 9/30/82 and before 10/1/83)	–	–	–	–	–
California	200	133	100	82	–	–	–	–	100	250	–	–	–	–
Colorado	133	133	100	37	–	–	–	–	–	185	–	–	–	–
Connecticut	185	185	185	100	–	–	–	–	185	300[i]	–	–	–	–
Delaware	133	133	100	100	–	–	–	–	–	200	–	–	–	–

States	Medicaid standards in effect March 31, 1997 (lower income boundary for SCHIP)[a/b]				SCHIP (in effect January 1, 2001)[c]									
					Medicaid expansion					Separate state plan				
	Age 0 to 1[d]	Ages 1 thru 5[e]	Ages 6 thru 14 [a]	Ages 15 thru 18[f]	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children age 6 and over (Through upper age limit)	Children 17-18	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children ages 6 and over (Through upper age limit)	Children 17-18
District of Columbia	185	133	100	50	200	–	–	–	–	–	–	–	–	–
Florida[j]	185	133	100	28	–	200 (infants only)	–	–	100	200 (1 -18)	–	–	–	–
Georgia	185	133	100	100	–	–	–	–	–	200	–	–	–	–
Guam[k]	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Hawaii[l]	185	133	100	100	200	–	–	–	–	–	–	–	–	–
Idaho	133	133	100	100	150	–	–	–	–	–	–	–	–	–
Illinois	133	133	100	46	–	–	–	133 (6-18)	–	185 (1-18)	–	–	–	–
Indiana	150	133	100	100	150 (1-18)	–	–	–	–	200	–	–	–	–
Iowa	185	133	100	37	–	200	–	–	133 (6-18)	200[m] (1-18)	–	–	–	–
Kansas	150	133	100	100	–	–	–	–	–	200	–	–	–	–
Kentucky	185	133	100	33	150 (1-18)	–	–	–	–	200	–	–	–	–
Louisiana	133	133	100	10	150	–	–	–	–	–	–	–	–	–

States	Medicaid standards in effect March 31, 1997 (lower income boundary for SCHIP)[a/b]				SCHIP (in effect January 1, 2001)[c]									
					Medicaid expansion					Separate state plan				
	Age 0 to 1[d]	Ages 1 thru 5[e]	Ages 6 thru 14 [a]	Ages 15 thru 18[f]	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children age 6 and over (Through upper age limit)	Children 17-18	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children ages 6 and over (Through upper age limit)	Children 17-18
Maine	185	133	125	125	150 (1-18)	–	–	–	–	185 (1-18)	–	–	–	–
Maryland	185	185	185	100	200 [n]	–	–	–	–	300 [n]	–	–	–	–
Massachusetts	185	133	114	86	150 (1-18)	200	–	–	–	200 (1 -18)	–	–	–	–
Michigan	185	133	100	100	–	–	–	–	150	200	–	–	–	–
Minnesota	275	275	275	275	–	280 (0-2)	–	–	–	–	–	–	–	–
Mississippi	185	133	100	34	–	–	–	–	100	200	–	–	–	–
Missouri[o]	185	133	100	100	300	–	–	–	–	–	–	–	–	–
Montana	133	133	100	40.5	–	–	–	–	–	150	–	–	–	–
Nebraska	150	133	100	33	185	–	–	–	–	–	–	–	–	–
Nevada	133	133	100	31	–	–	–	–	–	200	–	–	–	–
New Hampshire	185	185	185	185		300 (infants only)	–	–	–	300 (1-18)[p]	–	–	–	–

States	Medicaid standards in effect March 31, 1997 (lower income boundary for SCHIP)[a/b]				SCHIP (in effect January 1, 2001)[c]									
					Medicaid expansion					Separate state plan				
	Age 0 to 1[d]	Ages 1 thru 5[e]	Ages 6 thru 14 [a]	Ages 15 thru 18[f]	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children age 6 and over (Through upper age limit)	Children 17-18	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children ages 6 and over (Through upper age limit)	Children 17-18
New Jersey	185	133	100	41	–	–	–	133 (6-18)	–	350 200 (parents and pregnant women)[z]	–		–	
New Mexico	185	185	185	185	235	–	–	–	–	–	–	–	–	–
New York[j]	185	133	100	51	–	–	–	–	100	192	–	–	–	–
North Carolina	185	133	100	100	–	–	–	–	–	200	–	–	–	–
Northern Marianas[q]	–	–	–	–	–	–	–	–	–	–	–	–	–	–
North Dakota	133	133	100	100 (thru age 17)	–	–	–	–	100 (18 only)	140	–	–	–	–
Ohio	133	133	100	33	200	–	–	–	–	–	–	–	–	–
Oklahoma	150	133	100	48	185 (0-17 and preg. teens)	–	–	–	–	–	–	–	–	–
Oregon	133	133	100	100	–	–	–	–	–	170	–	–	–	–
Pennsylvania[j]	185	133	100	41	–	–	–	–	–	200[r]	–	–	–	–

States	Medicaid standards in effect March 31, 1997 (lower income boundary for SCHIP)[a/b]				SCHIP (in effect January 1, 2001)[c]									
					Medicaid expansion					Separate state plan				
	Age 0 to 1[d]	Ages 1 thru 5[e]	Ages 6 thru 14 [a]	Ages 15 thru 18[f]	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children age 6 and over (Through upper age limit)	Children 17-18	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children ages 6 and over (Through upper age limit)	Children 17-18
Puerto Rico[s]	–	–	–	–	200 (0-18)[s]	–	–	–	–	–	–	–	–	–
Rhode Island	250	250 (thru age 7)	100 (ages 8 thru 14)	100	–	–	–	185 (parents)[z] 250 (8-18 and pregnant women)[t]	–	–	–	–	–	–
South Carolina	185	[u]	[u]	[u]	150 (1-18)[u]	–	–	–	–	–	–	–	–	–
South Dakota	133	133	100	100	140	–	–	–	–	200	–	–	–	–
Tennessee[v]	–	–	–	16	–	–	–	–	100 (17-18)[v]	–	–	–	–	–
Texas	185	133	100	17	–	–	–	–	100	200	–	–	–	–
Utah	133	133	100	100 (thru age 17)	–	–	–	–	–	200	–	–	–	–
Vermont	225	225	225	225	–	–	–	–	–	300 (0-17)[w]	–	–	–	–
Virginia	133	133	100	100	–	–	–	–	–	200	–	–	–	–

States	Medicaid standards in effect March 31, 1997 (lower income boundary for SCHIP)[a/b]				SCHIP (in effect January 1, 2001)[c]									
					Medicaid expansion					Separate state plan				
	Age 0 to 1[d]	Ages 1 thru 5[e]	Ages 6 thru 14 [a]	Ages 15 thru 18[f]	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children age 6 and over (Through upper age limit)	Children 17-18	All ages 0-18	Preg. teens and infants[d]	Children below age 6[e]	Children ages 6 and over (Through upper age limit)	Children 17-18
Virgin Islands[x]	–	–	–	–	Family of four <$8,500 annually	–	–	–	–	–	–	–	–	–
Washington	200	200	200	200	–	–	–	–	–	250	–	–	–	–
West Virginia	150	133	100	100	–	–	–	–	–	200	–	–	–	–
Wisconsin	185	185	100	45	–	–	185 (6-18 and parents)[y,z]	–	–	–	–	–	–	–
Wyoming	133	133	100	55	–	–	–	–	–	–	–	–	133	–

Source: CRS analysis of submitted state plans and amendments.

[a] Title XXI contains a provision that a child's family income must exceed the applicable Medicaid income level that was in effect on March 31, 1997 in order for that child to be eligible for SCHIP-funded coverage. The SCHIP final rule (published in the *Federal Register*, v. 66, no. 8, Thursday January 11, 2001) changes the start date of SCHIP from March 31, 1997 to June 1, 1997 and further stipulates that children who became eligible for Medicaid as a result of an expansion of Medicaid that was effective between March 31 and June 1, 1997 are to be considered targeted low-income children. These percentages represent the lower income boundary for the SCHIP program. Information for the Medicaid eligibility portion of this table comes from the Health Care Financing Administration, *The State Children's Health Insurance Program; Annual Enrollment Report; October 1, 1998 through September 30, 1999;* January 2000. Medicaid expansion and separate state expansion program eligibility limits were updated to reflect amendments approved as of December 11, 2000.

[b] In 34 states, children may also qualify for Medicaid through medically needy programs (data not shown). In most cases, income criteria for medically needy programs are above AFDC-related standards but less than 133% of the federal poverty level.

[c] The 2000 federal poverty guideline for a family of three is $14,150 per year; for Alaska $17,690; and for Hawaii $16,270.

[d] To be eligible as an infant, a child is under age 1 and has not yet reached his or her first birthday.

[e] To be eligible in this category, the child is age 1 or older, but has not yet reached his or her 6th birthday.

[f] Federal law requires states to provide Medicaid to children in families with incomes that meet the state's former Aid to Families with Dependent Children (AFDC) income eligibility standards in effect on July 16, 1996. In addition, since July 1, 1991, states (under OBRA 1990) have been required to cover all children under age 19, who were born after September 30, 1983, and whose family income is below 100% of the federal poverty level. The 1983 start date means that the mandatory coverage is extended to children by one age cohort each year until reaching those under age 19 in FY2002.

If a state has expanded eligibility to older children beyond the OBRA 1990 mandate, the former AFDC standard as it applies to Medicaid eligibility is not applicable. The data in this column reflect the federal minimum requirements of states for children ages 15 and older on June 1, 1997 (see footnote "a"). The eligibility levels recorded in this column were in effect at the start of the SCHIP program and thus represent the lower income boundary for SCHIP.

[g] In American Samoa, Medicaid and SCHIP eligibility determinations are based on a system they call "presumptive eligibility." Presumptive eligibility under Medicaid and SCHIP normally means a period of time for which a person is "presumed eligible" for Medicaid or SCHIP benefits. During this time, services may be rendered and billed to the Medicaid or SCHIP program with the understanding that an official eligibility determination will be made and the beneficiary will be properly enrolled shortly after receiving services. American Samoa uses the term "presumptive eligibility" to refer to its process for setting its income eligibility limits for coverage under its Medicaid Program. American Samoa does not use a system of individual eligibility determinations.

[h] Arkansas increased Medicaid eligibility to 200% FPL effective September 1997 through a §1115 demonstration authority.

[i] State-sponsored health insurance will be available to all uninsured children in Connecticut. If the family's income is above 300% federal poverty level, the family will be expected to pay premiums and cost-sharing to access services. For children with family incomes greater than 300% federal poverty level, only state dollars will be used for funding.

[j] These states had state-funded programs that existed prior to SCHIP. Title XXI permitted children in these state-funded programs to be covered under SCHIP and required these states to maintain their previous levels of state spending.

[k] In Guam, Medicaid and SCHIP eligibility determinations are made by the Department of Public Health and Social Services. The Medicaid program claims federal financial participation (FFP) only for covered services to the categorically needy.

[l] Hawaii's coverage of pregnant women and children is through Hawaii QUEST, a §1115 waiver managed care program.

[m] On January 3, 2000, the state submitted an amendment to its approved Title XXI plan which allows for a 20% deduction to earned income in determining eligibility for the Hawk-I program and includes an additional managed health care plan, Unity Choice, from Wellmark Health Plan of Iowa.

[n] Maryland submitted an amendment January 3, 2000 that amends its §1115 demonstration waiver to implement state legislation enacted in the 1999 legislative session. It imposes a premium on children whose families have incomes above 185% FPL enrolled in the Maryland Children's Health Program by July 1, 2000. Maryland's expansion to 300% FPL was approved by HCFA but will not be implemented until July 1, 2001.

[o] Missouri will use Title XXI funds to expand its Medicaid program to children up to age 18 with family incomes up to 185% federal poverty level; Missouri will cover children with family incomes between 186-300% of the federal poverty level with their §1115 Medicaid Waiver. The §1115 waiver allows the state to charge cost sharing payments to eligible families between 186-300% of the federal poverty level for children between the ages 0-18. The §1115 Medicaid Waiver will be financed with Title XXI enhanced matching funds.

[p] New Hampshire will apply an income disregard to determine eligibility for SCHIP.

[q] The Northern Mariana Islands do not have an AFDC or TANF program. However, it is the only U.S. Territory that does have Supplemental Security Income (SSI), and its entire Medicaid program is based on SSI requirements. All individuals receiving SSI cash payments are eligible for Medicaid. All other individuals who meet the income and resource standards for SSI, with the standard exemptions and deductions, are also eligible. In addition, although the Northern Mariana Islands do not have a medically needy program, anyone can spend down to become eligible for any month in which medical costs reduce income to the appropriate level.

[r] Pennsylvania uses state funds to extend coverage up to 235% of the federal poverty level for all children up to their 19th birthday.

[s] Puerto Rico's Medicaid program extends covered services to both the categorically needy (TANF) and the medically needy. There is no SSI, rather the former mainland classifications of Old Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled, exist. Although mandated on the mainland, the Commonwealth has not opted to cover poverty level groups, and is exempt from requirements linking the "medically needy" income levels to "categorically needy" (formerly AFDC) income levels. The FY2000 medically needy income level for a family of four is 8,220 with a resource level of $900. The FY2000 categorically needy standard for a family of four is $1,536.

[t] Rhode Island expanded Medicaid eligibility up to 250% federal poverty level through a §1115 waiver. Benefits for children age 8 thru age 18 under this waiver will be financed by Title XXI funds and are considered the state's Medicaid Expansion under SCHIP. HCFA approved eligibility up to 300% FPL as submitted in the state's original plan submission, but the Rhode Island state legislature has not approved this expansion.

[u] In August of 1997, the South Carolina state legislature approved an expansion of the state's Medicaid program to cover all children in families with incomes less than 150% federal poverty level up to age 19. Because Title XXI was created just months later (October of 1997) HCFA approved the use of Title XXI funds for this expansion. Cells were left blank in the Medicaid columns to underscore that the expansion to Medicaid in the state is funded by Title XXI.

[v] TennCare offers health insurance for uninsured families at any income level. Premiums are charged on a sliding fee scale based on family size and income. Uninsured enrollees from families with incomes above 400% federal poverty level are charged a monthly premium based on a higher sliding fee scale than for those below 400% federal poverty level. Through SCHIP, the state will extend eligibility to uninsured children born before October 1, 1983, who are under age 19 in families with incomes at or below 100% of the federal poverty level and who could not have been enrolled under the operating rules for the state's Medicaid demonstration program before April 1, 1997. TennCare's eligibility for this population was officially closed on March 31, 1997 because they had exhausted state and federal dollars at the regular Medicaid FMAP. The state can cover this population with Title XXI enhanced matching funds since this group was not covered by Medicaid at the date specified in the SCHIP legislation, and therefore would be eligible for SCHIP.

[w] In Vermont Title XXI funds are used to cover children through their 17th birthday up to 300% FPL. Vermont also covers under-insured children through age 17 up to 300% FPL using a §1115 Medicaid waiver with §1902(r)(2) cost-sharing requirements.
[x] The Virgin Islands cover the medically needy, and persons in families with an annual income less than $8,500. There is an income disregard of $1,800 for specified resources. HCFA approved a state plan amendment on February 4, 2000 that permits the use of SCHIP monies to pay any medical expenses incurred after the Virgin Islands runs out of Medicaid federal dollars. Previously, SCHIP payments were restricted for payments to hospitals and clinics. The amendment allows the Virgin Islands to pay inpatient pediatric medical bills incurred by an approved medical provider for children less than age 19 in the territory's hospitals.
[y] Once a family is enrolled, eligibility is maintained until income exceeds 200% federal poverty level. Wisconsin may receive enhanced Title XXI FMAP to cover both parents and children if the cost-effectiveness of family coverage is demonstrated. Also, Wisconsin may cover families through employer-sponsored insurance when it is demonstrated to be cost-effective.
[z] On January 18, 2001 HCFA approved the first round of SCHIP §1115 waivers. These waivers will allow the states of New Jersey, Rhode Island, and Wisconsin to offer health insurance coverage to the parents of children eligible under either SCHIP or Medicaid. Additionally, the demonstration projects in New Jersey and Rhode Island will expand coverage to pregnant women.

Table 2. Financial Program Information for States and Territories FY2001[a]

State (or other territory)	Total federal allotments in dollars FY2001[b]	FMAP % FY2001[c]	Enhanced FMAP % FY2001[c]	Required state match for maximum federal allocation in dollars FY2001[d]	Federal dollars for each state dollar FY2001[d]	Potential total program expenditures in dollars (federal share +state share FY2001)[d]
Alabama	69,331,033	69.99	78.99	18,879,738	3.67	88,210,771
Alaska	8,987,100	56.04	69.23	3,652,997	2.46	12,640,097
American Samoa	538,650	50.00	65.00	290,042	1.86	828,692
Arizona	124,519,004	65.77	76.04	39,546,738	3.15	164,065,742
Arkansas	53,957,231	73.02	81.11	12,592,903	4.28	66,550,134
California	704,930,926	51.25	65.88	362,844,683	1.94	1,067,775,609
Colorado	44,648,559	50.00	65.00	23,753,033	1.88	68,401,592
Connecticut	39,398,021	50.00	65.00	21,214,319	1.86	60,612,340
Delaware	10,505,758	50.00	65.00	5,656,947	1.86	16,162,705
District of Columbia	11,751,544	70.00	79.00	3,123,828	3.76	14,875,372

State (or other territory)	Total federal allotments in dollars FY2001[b]	FMAP % FY2001[c]	Enhanced FMAP % FY2001[c]	Required state match for maximum federal allocation in dollars FY2001[d]	Federal dollars for each state dollar FY2001[d]	Potential total program expenditures in dollars (federal share +state share FY2001)[d]
Florida	220,217,905	56.62	69.63	97,821,913	2.25	318,039,818
Georgia	135,053,332	59.67	71.77	52,068,074	2.59	187,121,406
Guam	1,571,063	50.00	65.00	845,957	1.86	2,417,020
Hawaii	11,669,166	53.85	67.70	6,032,804	1.93	17,701,970
Idaho	20,715,109	70.76	79.53	5,498,503	3.77	26,213,612
Illinois	159,838,759	50.00	65.00	86,067,024	1.86	245,905,783
Indiana	63,023,791	62.04	73.43	23,422,569	2.69	86,446,360
Iowa	32,940,215	62.67	73.87	11,451,262	2.88	44,391,477
Kansas	29,337,719	59.85	71.90	11,412,740	2.57	40,750,459
Kentucky	55,939,972	70.39	79.27	14,558,365	3.84	70,498,337
Louisiana	82,017,657	70.53	79.37	21,431,853	3.83	103,449,510
Maine	13,444,691	66.12	76.28	4,145,505	3.24	17,590,196
Maryland	51,422,315	50.00	65.00	27,688,939	1.86	79,111,254
Massachusetts	55,879,946	50.00	65.00	30,089,202	1.86	85,969,148
Michigan	119,473,472	56.18	69.33	57,022,605	2.10	176,496,077
Minnesota	37,042,610	51.11	65.78	19,118,221	1.94	56,160,831
Mississippi	55,987,988	76.82	83.77	10,860,747	5.16	66,848,735
Missouri	65,460,375	61.03	72.72	25,051,736	2.61	90,512,111
Montana	15,169,315	73.04	81.13	3,700,243	4.10	18,869,558

State (or other territory)	Total federal allotments in dollars FY2001[b]	FMAP % FY2001[c]	Enhanced FMAP % FY2001[c]	Required state match for maximum federal allocation in dollars FY2001[d]	Federal dollars for each state dollar FY2001[d]	Potential total program expenditures in dollars (federal share +state share FY2001)[d]
Nebraska	19,084,374	60.38	72.27	7,124,622	2.68	26,208,996
Nevada	31,344,200	50.36	65.25	16,812,981	1.86	48,157,181
New Hampshire	11,932,994	50.00	65.00	6,425,458	1.86	18,358,452
New Jersey	98,823,044	50.00	65.00	53,212,408	1.86	152,035,452
New Mexico	50,766,995	73.80	81.66	11,756,109	4.32	62,523,104
New York	322,025,819	50.00	65.00	173,398,518	1.86	495,424,337
North Carolina	103,718,942	62.47	73.73	36,364,230	2.85	140,083,172
North Dakota	6,575,656	69.99	78.99	1,751,510	3.75	8,327,166
Northern Marianas	493,763	50.00	65.00	265,872	1.86	759,635
Ohio	142,214,540	59.03	71.32	58,265,688	2.44	200,480,228
Oklahoma	69,088,406	71.24	79.87	17,654,869	3.91	86,743,275
Oregon	50,134,100	60.00	72.00	19,231,998	2.61	69,366,098
Pennsylvania	138,968,854	53.62	67.53	66,593,101	2.09	205,561,955
Puerto Rico	41,116,950	50.00	65.00	22,139,896	1.86	63,256,846
Rhode Island	9,300,803	53.79	67.65	4,422,865	2.10	13,723,668
South Carolina	64,591,234	70.44	79.31	17,192,295	3.76	81,783,529
South Dakota	8,177,039	68.31	77.82	2,342,151	3.49	10,519,190
Tennessee	86,296,823	63.79	74.65	29,871,533	2.89	116,168,356
Texas	452,531,213	60.57	72.40	164,261,330	2.75	616,792,543

State (or other territory)	Total federal allotments in dollars FY2001[b]	FMAP % FY2001[c]	Enhanced FMAP % FY2001[c]	Required state match for maximum federal allocation in dollars FY2001[d]	Federal dollars for each state dollar FY2001[d]	Potential total program expenditures in dollars (federal share +state share FY2001)[d]
Utah	30,184,401	71.44	80.01	7,450,843	4.05	37,635,244
Vermont	4,611,995	62.40	73.68	1,666,277	2.77	6,278,272
Virginia	75,491,290	51.85	66.30	38,576,846	1.96	114,068,136
Virgin Islands	1,167,075	50.00	65.00	628,425	1.86	1,795,500
Washington	60,869,643	50.70	65.49	30,904,193	1.97	91,773,836
West Virginia	21,144,989	75.34	82.74	4,566,847	4.63	25,711,836
Wisconsin	49,597,970	59.29	71.50	19,977,924	2.48	69,575,894
Wyoming	7,193,664	64.60	75.22	2,404,264	2.99	9,597,928

Source: CRS analysis of submitted state plans, and *Federal Register*, v. 66, no. 14, January 22, 2001 and *Federal Register*, v. 65, no. 36, February 23, 2000.

[a] Financial information for FY2001 is published in the *Federal Register*, v. 66, no. 14, January 22, 2001. FMAP and Enhanced FMAP figures for FY2001 can be found in the *Federal Register*, v. 65, no. 36, February 23, 2000.

[b] The amount of federal funding available for allotment to the states and the District of Columbia for FY2001 is $4,204,312,500, determined by reducing the FY2001 appropriation ($4,275,000,000) by the total amount available for allotment to the Commonwealths and Territories ($10,687,500) and amounts for the Special Diabetes Grants ($60,000,000) under sections 4921 and 4922 of BBA 97. The diabetes programs are funded from FY1998 through FY2002 only. P.L. 106-113 increased amounts available to the territories by $34,200,000 for FY2001. The total amount of federal funds available to the Commonwealths and territories in FY2001 is therefore $44,887,500. Total appropriations available to states and territories is $4.309 billion. Allotments for FY2001 come from *Federal Register*, v. 66, no. 14, January 22, 2001.

[c] These numbers represent the Federal Medical Assistance Percentage (FMAP) and the Enhanced FMAP. They are effective from October 1, 2000 to September 30, 2001 and are presented in the *Federal Register*, v. 65, no. 36, February 23, 2000.

[d] The totals in these columns are: (1) estimates of the required state match necessary to claim maximum federal SCHIP allotments; (2) estimates of the ratio of federal dollars spent to each state dollar; and (3) estimates of potential total program expenditures (state share + federal share). Because state have 3 years to draw down a given year's funding and the Enhanced FMAP rates are variable from year to year – it is not possible to report a precise dollar amount in these columns.

Table 3. Redistribution and Continued Availability of Unexpended FY1998 SCHIP Allotments

State (or other territory)	FY1998-FY2000 expenditures as reported and certified by states, and approved by HCFA, through December 15, 2000	FY1998 allotment	Unexpended FY1998 allotment amounts	Redistributed amounts	Continued allotment availability[a]
Alabama	$57,311,038	$85,975,213	$28,664,175	NA	$18,512,188
Alaska	$21,894,847	$6,889,296	NA	$15,005,551	NA
Arizona	$38,242,389	$116,797,799	$78,555,410	NA	$50,733,452
Arkansas	$2,202,763	$47,907,958	$45,705,195	NA	$29,517,793
California	$257,011,950	$854,644,807	$597,632,857	NA	$385,969,313
Colorado	$23,942,735	$41,790,546	$17,847,811	NA	$11,526,654
Connecticut	$25,062,575	$34,959,075	$9,896,500	NA	$6,391,458
Delaware	$2,289,855	$8,053,463	$5,763,608	NA	$3,722,312
District of Columbia	$6,262,215	$12,076,002	$5,813,787	NA	$3,754,719
Florida	$183,046,365	$270,214,724	$87,168,359	NA	$56,295,954
Georgia	$56,178,012	$124,660,136	$68,482,124	NA	$44,227,820
Hawaii	$420,296	$8,945,304	$8,525,008	NA	$5,505,707
Idaho	$12,775,632	$15,879,707	$3,104,075	NA	$2,004,705
Illinois	$53,472,202	$122,528,573	$69,056,371	NA	$44,598,686
Indiana	$115,420,868	$70,512,432	NA	$44,908,436	NA
Iowa	$26,332,129	$32,460,463	$6,128,334	NA	$3,957,863

State (or other territory)	FY1998-FY2000 expenditures as reported and certified by states, and approved by HCFA, through December 15, 2000	FY1998 allotment	Unexpended FY1998 allotment amounts	Redistributed amounts	Continued allotment availability[a]
Kansas	$21,561,892	$30,656,520	$9,094,628	NA	$5,873,585
Kentucky	$77,851,894	$49,932,527	NA	$27,919,367	NA
Louisiana	$35,655,148	$101,736,840	$66,081,692	NA	$42,677,548
Maine	$17,018,705	$12,486,977	NA	$4,531,728	NA
Maryland	$106,284,158	$61,627,358	NA	$44,656,800	NA
Massachusetts	$79,551,043	$42,836,231	NA	$36,714,812	NA
Michigan	$51,726,748	$91,585,508	$39,858,760	NA	$25,741,989
Minnesota	$15,221	$28,395,980	$28,380,759	NA	$18,329,150
Mississippi	$29,178,423	$56,017,103	$26,838,680	NA	$17,333,228
Missouri	$60,909,264	$51,673,123	NA	$9,236,141	NA
Montana	$4,887,358	$11,740,395	$6,853,037	NA	$4,425,898
Nebraska	$9,881,246	$14,862,926	$4,981,680	NA	$3,217,319
Nevada	$13,063,864	$30,407,067	$17,343,203	NA	$11,200,763
New Hampshire	$2,539,250	$11,458,404	$8,919,154	NA	$5,760,258
New Jersey	$70,008,328	$88,417,899	$18,409,571	NA	$11,889,456
New Mexico	$4,210,228	$62,972,705	$58,762,477	NA	$37,950,579
New York	$690,516,665	$255,626,409	NA	$434,890,256	NA
North Carolina	$100,410,653	$79,508,462	NA	$20,902,191	NA

State (or other territory)	FY1998-FY2000 expenditures as reported and certified by states, and approved by HCFA, through December 15, 2000	FY1998 allotment	Unexpended FY1998 allotment amounts	Redistributed amounts	Continued allotment availability[a]
North Dakota	$1,859,325	$5,040,741	$3,181,416	NA	$2,054,654
Ohio	$97,579,565	$115,734,364	$18,154,799	NA	$11,724,916
Oklahoma	$51,257,243	$85,699,060	$34,441,817	NA	$22,243,563
Oregon	$20,147,896	$39,121,663	$18,973,767	NA	$12,253,831
Pennsylvania	$123,046,184	$117,456,520	NA	$5,589,664	NA
Rhode Island	$12,671,272	$10,684,422	NA	$1,986,850	NA
South Carolina	$116,071,531	$63,557,819	NA	$52,513,712	NA
South Dakota	$4,655,275	$8,541,224	$3,885,949	NA	$2,509,663
Tennessee	$41,705,133	$66,153,082	$24,447,949	NA	$15,789,222
Texas	$81,261,672	$561,331,521	$480,069,849	NA	$310,043,579
Utah	$20,835,906	$24,241,159	$3,405,253	NA	$2,199,215
Vermont	$1,955,112	$3,535,445	$1,580,333	NA	$1,020,627
Virginia	$23,549,911	$68,314,914	$44,765,003	NA	$28,910,588
Washington	$604,279	$46,661,213	$46,056,934	NA	$29,744,956
West Virginia	$10,771,106	$23,606,744	$12,835,638	NA	$8,289,642
Wisconsin	$23,461,361	$40,633,039	$17,171,678	NA	$11,089,987
Wyoming	$1,040,982	$7,711,638	$6,670,656	NA	$4,308,111
Total states only	**$2,889,609,712**	**$4,224,262,500**	**$2,033,508,296**	**$698,855,508**	**$1,313,300,951**

State (or other territory)	FY1998-FY2000 expenditures as reported and certified by states, and approved by HCFA, through December 15, 2000	FY1998 allotment	Unexpended FY1998 allotment amounts	Redistributed amounts	Continued allotment availability[a]
Commonwealths and territories					
Puerto Rico	$75,076,505	$9,835,550	NA	$19,558,283	NA
Guam	$1,536,662	$375,812	NA	$747,314	NA
Virgin Islands	$898,004	$279,175	NA	$555,148	NA
Northern Marianas	$2,795,386	$118,113	NA	$234,870	NA
Total	$82,807,173	$10,737,500	$0	$21,351,837	$0
National Total	$2,972,416,885	$4,235,000,000	$2,033,508,296	$720,207,345	$1,313,300,951
			Total FY1998 redistribution and retained amounts	Total FY1998 redistributed amounts	Total FY1998 retained amounts

Source: Health Care Financing Administration.

[a] The following example illustrates how amounts of redistributed funds are calculated for individual states failing to spend their full FY1998 allotments. According to P.L.106-554, states that do *not* use all their SCHIP allotment will receive an amount equal to the total amount of unspent funds, less amounts distributed to states that fully exhausted their original allotments, multiplied by the ratio of a state's unspent original allotment to the total amount of unspent funds. For Alabama, this amount equals: ($2,033,508,296 - $698,855,508) multiplied by ($28,664,175 / $2,033,508,296). This amount is a preadjusted amount. The sum of the "preadjusted" proportions for all states must be equal to one. If they are not, the allotment proportions are subject to a reconciliation process to ensure budget neutrality.