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SCHIP Original Allotments: Funding Formula Issues and Options

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Summary

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) authorized the State Children's Health Insurance Program (SCHIP) for FY1998-FY2007. In BBA 97, Congress appropriated annual funding levels totaling nearly $40 billion for the 10-year period of SCHIP's authorization, with each state receiving access to a portion of the annual amount. Each state's portion — the original allotment — is calculated based on a formula that has been altered one time since the program's inception.

SCHIP's authorization expires at the end of FY2007. When Congress takes up reauthorization, the focus regarding SCHIP original allotments will be on (1) setting the *national* annual appropriations for SCHIP, and (2) deciding how those funds will be allotted to individual *states*. Some of the issues are technical — for example, whether there is a better data source for estimating the number of low-income children. Other issues raise more fundamental questions about the program.

For example, beginning in FY2002, states' total spending of federal SCHIP funds has exceeded their annual original allotments, a trend projected to continue through the current authorization. Shortfalls of federal SCHIP funds have largely been avoided by leftover prior-year balances and because administrative actions targeted unspent funds from other states to those states facing shortfalls. However, the funds available for redistribution have been shrinking over the past several years. In fact, because such amounts will be inadequate to prevent shortfalls in FY2006, Congress appropriated an additional $283 million for projected shortfall states in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). As a result, how much is provided to states in their original allotments is becoming increasingly important.

Increasing current SCHIP appropriations across the board to match total national demand for funds would not necessarily prevent shortfalls because there is wide state-level variation between how much states are allotted and how much they spend. In reauthorization, Congress will have to decide the extent to which other factors, such as states' historical spending and the populations they cover under SCHIP, should be added to the original allotment formula.

If current allotment formulas continue to be used — for example, if states' SCHIP spending has *no* bearing on their original allotments, as is currently the case — then several states will face chronic shortfalls of federal SCHIP funds. However, such shortfalls are an inherent possibility in a capped-grant program such as SCHIP. Congress will be grappling with a number of issues in determining the level and distribution of original allotments in reauthorization. These include whether SCHIP is effectively operating as an open-ended entitlement to states and whether the current original allotment structure is inadequate.

This report describes how SCHIP original allotments have operated from FY1998 to FY2007, and discusses issues and options Congress might consider for reauthorization. This report will be updated as major developments occur.

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SCHIP Original Allotments: Funding Formula Issues and Options

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) authorized the State Children's Health Insurance Program (SCHIP) for FY1998-FY2007. In general, this program allows states[1] to cover targeted low-income children with no health insurance in families with incomes above Medicaid eligibility levels. In BBA 97, Congress appropriated annual funding levels totaling nearly $40 billion for the 10-year period of SCHIP's authorization, with each state receiving access to a portion of the annual amount. Each state's portion — the original allotment[2] — is calculated based on a formula that has been altered one time since the program's inception.

Each year's original allotment is available to states for three years. At the end of the three-year period of availability, unspent balances are to be redistributed to states that have exhausted that allotment, with some exceptions. This report does *not* analyze the impact or amounts of redistributed funds. Nor does this report quantify projected state shortfalls of federal SCHIP funds. Other CRS reports delve into these issues[3] and describe the characteristics of each state's SCHIP program.[4] This report is narrowly focused on the amounts and formulas for the original allotments. Other SCHIP issues are presented only to the extent that they inform the discussion of original allotments.

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[1] For this report, "states" includes the District of Columbia, since it is treated as other states for SCHIP purposes. Generally, the word "states" does not include the five territories, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands. These five "commonwealths and territories" are identified in §2104(c)(3) of the Social Security Act and are treated differently from states for purposes of calculating their original allotments. Unless noted otherwise, section references in law used in this report are to the Social Security Act.

[2] §2104 is the section entitled "Allotments." The term "original allotments" does not occur in the law. However, CRS uses this term to distinguish each year's original, or initial, allotment (paragraphs (a) through (e) of §2104) from the reallocation of the unspent balances of these funds available for redistribution to other states (paragraphs (f) and (g)).

[3] CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz, et al. CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson.

[4] CRS Report RL32389, *A State-by-State Compilation of Key State Children's Health Insurance Program (SCHIP) Characteristics*, by Elicia J. Herz, et al.

SCHIP Appropriation: Total Amount of Original Allotments

BBA 97 established SCHIP under a new Title XXI of the Social Security Act. Section 2104(a) specified the total appropriation available in every fiscal year from FY1998-FY2007. The only change to these numbers since BBA 97 was to add $20 million to the total FY1998 appropriation.[5] The current-law numbers in Section 2104(a) are shown in column A of **Table 1**. For SCHIP's first four years, BBA 97 held the total appropriation constant. However, for FY2002-FY2004, the annual appropriation was $1.125 billion less than in FY1998-FY2001. This drop in funding, sometimes referred to as the "SCHIP dip," was written into BBA 97 due to budgetary constraints applicable at the time the legislation was drafted.

Sections 4921 and 4922 of BBA 97 called for $60 million to be used from the total SCHIP appropriation each year from FY1998-FY2002 for special diabetes grants.[6] These subtractions to the total original allotments available to states and territories are shown in column B of **Table 1**. Beginning in FY2003, these two diabetes programs have been funded by direct appropriations, not from the SCHIP appropriation.

Besides the $20 million adjustment to the total FY1998 SCHIP appropriation, all legislative changes to the total SCHIP appropriation since BBA 97 have affected only the original allotments to the five territories.[7] BBA 97 called for the territories to receive 0.25% of the amounts shown in column A of **Table 1**. The FY1999 Omnibus Appropriations Act (P.L. 105-277) appropriated $32 million for the territories' SCHIP original allotment for FY1999, in addition to the 0.25% of the total appropriation. The $32 million was approximately 0.75% of the $4.275 billion in column A of **Table 1**. The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (P.L. 106-113) specified additional amounts to be appropriated to the territories for FY2000-FY2007. The amounts specified for these years were exactly 0.8% of the total appropriations shown in column A of **Table 1**. Thus, for FY2000-FY2007, territories were slated to receive a total of 1.05% of the amounts specified in §2104(a), although only the 0.25% portion would reduce the amount of original allotments available to the states specifically.[8] Column C of **Table 1** shows the additional appropriations for the territories from these provisions.

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[5] §162 of P.L. 105-100 made changes "[e]ffective as if included in the enactment of ... the Balanced Budget Act of 1997." Paragraph (8)(A) increased the FY1998 appropriation of $4,275,000,000 by $20 million to $4,295,000,000.

[6] Public Health Service Act §330B and §330C.

[7] The appropriation of $283 million to SCHIP for FY2006 through the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) is not considered a legislative change to original allotments. The DRA appropriation for SCHIP is a special appropriation targeted to shortfall states. It did not go through the original allotment formula, nor is it available for three years.

[8] As discussed in other previously referenced CRS reports, the 1.05% amount is used in the annual reallocation of unspent original allotment funds after their three-year period of availability has passed. Of the total unspent funds, 1.05% is designated for the territories.

Column D of **Table 1** displays the total amount of federal SCHIP original allotments provided to the states and territories under current law. For comparative purposes, column E shows the total spending or demand for federal SCHIP funds in each of those years, projecting for FY2006 and FY2007. If the amounts represented only federal SCHIP "spending," the maximum that a state could spend is its available balance. For states that exhausted or are projected to exhaust all available balances, "demand" is used to reflect not only total spending but also the shortfall of federal SCHIP funds (that is, the additional amount of federal SCHIP funds the state would have used had the funds been available). The spending/demand is applied against *all* available federal SCHIP funds, not just the original allotments. Thus, even though the spending/demand for federal SCHIP funds has exceeded some years' total original allotments, state shortfalls of federal SCHIP funds have largely been avoided because of the redistribution of unspent funds.[9]

Table 1. Federal SCHIP Appropriations, Original Allotments, and Spending, FY1998-FY2007

	A	B	C	D = A-B+C	E
		Subtract	Add		
FY	Allotments specified in §2104(a)	Special diabetes grants	For territories per §2104(c)(4)	Original allotments to states and territories	Total spending/ demand
1998	$4,295,000,000	$60,000,000		$4,235,000,000	$121,800,000
1999	$4,275,000,000	$60,000,000	$32,000,000	$4,247,000,000	$921,800,000
2000	$4,275,000,000	$60,000,000	$34,200,000	$4,249,200,000	$1,928,800,000
2001	$4,275,000,000	$60,000,000	$34,200,000	$4,249,200,000	$2,671,600,000
2002	$3,150,000,000	$60,000,000	$25,200,000	$3,115,200,000	$3,776,200,000
2003	$3,150,000,000		$25,200,000	$3,175,200,000	$4,276,400,000
2004	$3,150,000,000		$25,200,000	$3,175,200,000	$4,644,700,000
2005	$4,050,000,000		$32,400,000	$4,082,400,000	$5,089,500,000
2006	$4,050,000,000		$32,400,000	$4,082,400,000	$5,983,700,000
2007	$5,000,000,000		$40,000,000	$5,040,000,000	$6,343,500,000
Total	$39,670,000,000	$300,000,000	$280,800,000	$39,650,800,000	$35,758,100,000

Source: Congressional Research Service (CRS) analysis and CRS SCHIP Projection Model.

Notes: Section numbers refer to Title XXI of the Social Security Act. The special diabetes grants are described in Public Health Service Act §330B and §330C. Numbers rounded to the nearest $100,000. "Spending/demand" is included for comparative purposes and is from all federal SCHIP funds — reallocated funds (that is, amounts from the redistribution and retention of unspent funds after original allotments' three-year period of availability) as well as from original allotments. Spending/demand for FY2006 and FY2007 are projections. If the projections were only of federal SCHIP spending, the maximum that a state could spend is its available balance. For states that exhausted (or are projected to exhaust) all available balances, demand reflects not only total spending but also the shortfall of federal SCHIP funds (the additional amount of federal SCHIP funds the state would have spent had the funds been available). For more details, see CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson.

[9] For additional details, see CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson.

Allotment Formulas for Territories and States

Territories

Of the total amount of original allotments available to territories (described above), a certain percentage is provided to each of the territories as its original allotment: Puerto Rico receives 91.6%, Guam 3.5%, the Virgin Islands 2.6%, American Samoa 1.2%, and the Northern Mariana Islands 1.1%. These percentages are specified in law and have been unaltered since BBA 97.[10]

States

Each state's original allotment is based primarily on two factors described in law as the "number of children" and a "state cost factor."[11] Once calculated, these two factors are multiplied by each other for each state, with the results added for a national total. Each state's percentage of the total, subject to floors and ceilings, is then multiplied by the total allotment funds available to states in that year (after the reductions for the territories and, for FY1998-FY2002, the special diabetes grants). The result is the amount allotted to each state for that fiscal year.

Number of Children. The "number of children" is composed of two estimates for each state:

- the number of low-income children without health insurance; and
- the number of all low-income children.

A low-income child is an individual under the age of 19 whose family income is at or below 200% of the poverty line.[12] The weight attached to each of the two factors varies by fiscal year. For FY1998 and FY1999, the "number of children" in each state relied solely on the number of *uninsured* low-income children, as shown in **Table 2**. As SCHIP began to cover more low-income children, the formula was designed to rely less on the number of *uninsured* low-income children and more on the number of *all* low-income children. FY2000 was the transition year, in which the "number of children" used 75% of the number of *uninsured* low-income children and 25% of the number of *all* low-income children, as illustrated in **Table 2**.[13] For FY2001 onward, the "number of children" is weighted evenly between the number of *uninsured* low-income children and the number of *all* low-income children in each state.

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[10] §2104(c)(2).

[11] §2104(b).

[12] For 2005, this measure of poverty for a family of three with two children was $15,735 [http://www.census.gov/hhes/www/poverty/threshld/thresh05.html]. At 200% of this level, the amount would be $31,470. The measures of poverty are discussed in greater detail in the technical appendix of this report.

[13] In BBA 97, FY2001 was slated to be the transition year rather than FY2000. The transition year was moved up by BBRA.

Table 2. Factors, with Associated Weights, for Calculating States' SCHIP Original Allotments, by Fiscal Year

FY	*State's original allotment = "number of children" x "state cost factor" (subject to floors and ceilings shown in Table 3)*			
	"Number of children" in §2104(b)(2) is the sum of the two factors below multiplied by the associated percentage		**"State cost factor" in §2104(b)(3) is the sum of the two factors below multiplied by the associated percentage**	
	Number of low-income children without health insurance	**Number of all low-income children**	**Constant (at the national average)**	**Ratio of state's average annual wages (health services industry) to national average**
1998	100%	0%	15%	85%
1999	100%	0%	15%	85%
2000	75%	25%	15%	85%
2001	50%	50%	15%	85%
2002	50%	50%	15%	85%
2003	50%	50%	15%	85%
2004	50%	50%	15%	85%
2005	50%	50%	15%	85%
2006	50%	50%	15%	85%
2007	50%	50%	15%	85%

Source: Congressional Research Service (CRS) analysis.

Table 3. Applicable Floors and Ceilings for Calculating States' SCHIP Original Allotments, by Fiscal Year

FY	**Floor: state's minimum original allotment (greatest applicable factor applies)**			**Ceiling: state's maximum original allotment**
	$2,000,000	**90% of last year's original allotment**	**70% of 1999 original allotment**	**145% of 1999 original allotment**
1998	X			
1999	X			
2000	X	X	X	X
2001	X	X	X	X
2002	X	X	X	X
2003	X	X	X	X
2004	X	X	X	X
2005	X	X	X	X
2006	X	X	X	X
2007	X	X	X	X

Source: Congressional Research Service (CRS) analysis.

Note: The "X" represents factors applicable for that fiscal year. Once a state's original allotment based on **Table 2** is calculated, it is tested against the applicable floors and ceilings in this table. The tests are evaluated in terms of the state's *percentage of the total original allotments to states* for each year, *not* on the dollar amounts. This is described in the text of the report.

The source of data for these state-level estimates is the March supplement of the Current Population Survey (CPS), which is administered by the U.S. Census Bureau. The CPS is a monthly survey of households that provides estimates of employment and unemployment in the U.S. Some time between February and April, respondents

are asked additional questions about their work experience, income, noncash benefits, migration and health insurance status in the previous year. Because the supplement is no longer given only in March, it has been renamed the Annual Social and Economic (ASEC) Supplement, though many analysts continue to call it the March supplement.

Since survey estimates come from only a sample of the population, the estimates could differ from the results from a complete census using the same survey questions. It is possible to estimate this "sampling error" based on the sample size (that is, the number of respondents). Because sample sizes can be relatively small in less populous states, results from multiple years are often averaged together to reduce the sampling error. Current law specifies that for estimating the SCHIP original allotment's "number of children," an average of the most recent *three* years is used.[14]

The original allotments for FY2006 were announced June 24, 2005.[15] The "number of children" for these allotments was based on ASEC data from 2001, 2002, and 2003. Data for 2004, collected in the 2005 ASEC, were not released until August 30, 2005. Regardless, that later data could not be used for calculating the FY2006 original allotments. The law specifies that the original allotment for a fiscal year must be based on "the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the calendar year in which such fiscal year begins."[16] FY2006 began (October 1, 2005) in calendar year 2005. Thus, the Centers for Medicare and Medicaid Services (CMS) interpreted the law to mean that, for the FY2006 original allotments, the CPS data can be no more recent than those available on December 31, 2004. On that date, the 2004 ASEC, providing data from 2003, was the most recent officially available. Thus, the FY2006 original allotments were based on data averaged over the three-year period 2001-2003.

State Cost Factor. The other major factor used in calculating states' portion of the total annual SCHIP appropriation is a state cost factor, based on wages of employees in the health services industry. The factor is intended to adjust for geographic variations in health costs. The national average is scaled to equal 1.00. States with above-average wages in the health services industry will have an amount greater than 1.00, which will increase the amount of their allotment — and vice versa. As shown in **Table 2**, 15% of state cost factor does not vary. In essence, that portion is held at 1.00, the national average. The remaining 85% reflects how different a state's average wages are compared to the national average.

The law specifies that the wage data are to be obtained from the Bureau of Labor Statistics (BLS) of the Department of Labor, using three-year averages for the same years used to calculate the number of children. The law also defines the "health

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[14] §2104(b)(2)(B).

[15] U.S. Department of Health and Human Services, "State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2006," 70 *Federal Register* 36615, June 24, 2005.

[16] §2104(b)(2)(B).

services industry" as employers with a Standard Industrial Classification (SIC) code of 8000.[17] However, in 2002, BLS replaced SIC with the North American Industry Classification System (NAICS). Although the mapping between the two systems for the health services industry was not identical, the NAICS wage data codes "represent approximately 98 percent of the wage data that would have been provided under the related SIC code 8000."[18] The NAICS codes now used are 621 (ambulatory health care services), 622 (hospitals), and 623 (nursing and residential care facilities). These three codes are under the broader category (62) for health care and social assistance. The only NAICS code from this category not used for the state cost factor is 624 (social assistance).[19]

The source of data BLS uses for calculating the average wages is from mandatory reports filed quarterly by every employer on their unemployment insurance contributions. BLS provides the data directly to CMS. Because the data cover all employers subject to unemployment insurance coverage under federal law (nearly 99% of employers), it is not technically a survey, but rather a census.[20] As a result, using a three-year average does not reduce sampling error, since censuses do not have sampling error.

Floors and Ceilings. For FY1998 and FY1999, the only adjustment to the calculated state shares of annual SCHIP appropriations was a floor, guaranteeing that every state would receive an allotment of at least $2 million, as shown in **Table 3**. No state's preadjusted allotment for FY1998 or FY1999 was below $2 million, so this floor never applied.

BBRA added two other tests to ensure states' original allotments did not drop below certain levels. The legislation also added a ceiling to cap the amount of the allotments to individual states based on certain prior-year allotments. These BBRA provisions were effective beginning with the FY2000 allotment. As previously mentioned, in calculating the allotment for each state, the number of children and the state cost factor are multiplied together, with the results added for a national total. Each state's percentage of the total — its "preadjusted proportion" — became the values against which BBRA's floors and ceilings are assessed. For the floor, two new tests were applied: (1) a state's original allotment could not be less than 90% of last year's, and (2) its original allotment could not be less than 70% of the FY1999 allotment, as shown in **Table 3**. For the ceiling, no state's original allotment could exceed 145% of the FY1999 allotment, also shown in **Table 3**. Once the floors and ceilings were applied to affected states to produce their *adjusted proportion*, the other states' proportions were adjusted equally to use exactly 100% of the original funding

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[17] §2104(b)(3)(B).

[18] U.S. Department of Health and Human Services, "State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2006," 70 *Federal Register* 36617, June 24, 2005.

[19] U.S. Census Bureau, "2002 NAICS Codes and Titles," Title 62, at [http://www.census.gov/epcd/naics02/naicod02.htm#N62].

[20] U.S. Department of Labor Bureau of Labor Statistics, "Quarterly Census of Employment and Wages: Overview," at [http://www.bls.gov/cew/cewover.htm].

for the year available to the states. **Table 4** shows how all of these factors were applied to calculate states' and territories' FY2006 original allotments.

Table 4. Derivation of FY2006 Federal SCHIP Original Allotments

State or territory	A Number of children (000s)	B State cost factor	C=A*B Product	Pre-adjusted proportion	Adjusted proportion	Allotment
Alabama	289	0.9793	283.0266	1.5802%	1.5887%	$64,182,128
Alaska	38	1.0701	40.1300	0.2241%	0.2253%	$9,100,310
Arizona	434	1.0909	473.4557	2.6435%	2.6577%	$107,365,854
Arkansas	210	0.9178	192.7374	1.0761%	1.0841%	$43,795,428
California	2,531	1.1267	2,851.7012	15.9220%	16.0075%	$646,682,123
Colorado	248	1.0678	264.2903	1.4756%	1.4345%	$57,951,287
Connecticut	134	1.1365	152.2908	0.8503%	0.8549%	$34,535,088
Delaware	35	1.1396	39.8866	0.2227%	0.2239%	$9,045,121
D.C.	34	1.2395	42.1444	0.2353%	0.2366%	$9,557,107
Florida	1,062	1.0353	1,099.4804	6.1388%	6.1717%	$249,329,871
Georgia	555	1.0295	570.8758	3.1874%	3.2045%	$129,457,875
Hawaii	64	1.1167	71.4686	0.3990%	0.3071%	$12,404,524
Idaho	102	0.8911	90.8880	0.5075%	0.5102%	$20,610,739
Illinois	719	1.0384	746.1197	4.1658%	4.1882%	$169,198,045
Indiana	333	0.9667	321.9135	1.7973%	1.8070%	$73,000,528
Iowa	133	0.8948	119.0055	0.6644%	0.6680%	$26,986,944
Kansas	134	0.9080	121.2234	0.6768%	0.6805%	$27,489,909
Kentucky	267	0.9540	254.7259	1.4222%	1.4299%	$57,764,350
Louisiana	366	0.9306	340.1369	1.8991%	1.9093%	$77,133,066
Maine	59	0.8915	52.6004	0.2937%	0.2953%	$11,928,229
Maryland	201	1.0713	214.7894	1.1992%	1.2057%	$48,707,931
Massachusetts	246	1.1072	272.3684	1.5207%	1.4704%	$59,401,346
Michigan	506	1.0211	516.6683	2.8847%	2.9002%	$117,165,211
Minnesota	177	1.0242	181.2763	1.0121%	0.9747%	$39,376,933
Mississippi	243	0.9058	220.1172	1.2290%	1.2356%	$49,916,118
Missouri	264	0.9420	248.2235	1.3859%	1.3934%	$56,289,799
Montana	63	0.8860	55.3778	0.3092%	0.3109%	$12,558,064
Nebraska	82	0.9116	74.2934	0.4148%	0.4170%	$16,847,571
Nevada	155	1.1919	184.7509	1.0315%	1.0371%	$41,896,088
New Hampshire	39	1.0529	40.5358	0.2263%	0.2275%	$9,192,336
New Jersey	346	1.1420	394.5673	2.2030%	2.2148%	$89,476,287
New Mexico	166	0.9561	158.2400	0.8835%	1.0435%	$42,156,779
New York	1,111	1.0814	1,201.4443	6.7081%	6.7441%	$272,452,310
North Carolina	559	0.9900	553.4211	3.0899%	2.7292%	$110,255,024
North Dakota	32	0.8745	27.9849	0.1562%	0.1571%	$6,346,156
Ohio	568	0.9676	549.5955	3.0686%	3.0850%	$124,632,131
Oklahoma	258	0.8818	227.0515	1.2677%	1.4201%	$57,370,830
Oregon	205	1.0110	206.7594	1.1544%	1.1606%	$46,886,967
Pennsylvania	594	0.9955	591.3332	3.3016%	3.3193%	$134,097,011
Rhode Island	44	0.9803	43.1345	0.2408%	0.2421%	$9,781,641
South Carolina	247	0.9917	244.9403	1.3676%	1.3749%	$55,545,268
South Dakota	38	0.9205	34.5204	0.1927%	0.1938%	$7,828,211
Tennessee	348	1.0189	354.5737	1.9797%	1.9903%	$80,406,910
Texas	2,055	0.9758	2,005.2932	11.1962%	11.2563%	$454,741,626
Utah	160	0.8905	142.0277	0.7930%	0.7972%	$32,207,704
Vermont	23	0.9236	21.2435	0.1186%	0.1192%	$4,817,413

State or territory	A Number of children (000s)	B State cost factor	C=A*B Product	Pre-adjusted proportion	Adjusted proportion	Allotment
Virginia	315	1.0122	318.8368	1.7802%	1.7897%	$72,302,825
Washington	327	0.9914	324.1917	1.8101%	1.6017%	$64,705,479
West Virginia	114	0.9072	102.9648	0.5749%	0.5780%	$23,349,395
Wisconsin	245	1.0057	245.9053	1.3730%	1.3803%	$55,764,106
Wyoming	28	0.9430	25.9337	0.1448%	0.1456%	$5,881,004
State subtotals			17,910.4652	100.0000%	100.0000%	
Total amount available to states = $4,050,000,000 less 0.25% for territories =						$4,039,875,000
Puerto Rico					91.6%	$38,952,900
Guam					3.5%	$1,488,375
Virgin Islands					2.6%	$1,105,650
American Samoa					1.2%	$510,300
N. Mariana Islands					1.1%	$467,775
Total amount available to territories = 0.25% of $4,050,000,000 + $32,400,000 =						$42,525,000
Total original allotments to states and territories						**$4,082,400,000**

Source: U.S. Department of Health and Human Services, "State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2006," 70 *Federal Register* 36619, June 24, 2005.

The decision to use the preadjusted proportion rather than the dollar amounts of the allotments for applying floors and ceilings was a practical one, particularly because of the impact of the SCHIP dip that occurred in FY2002. Using a hypothetical example to illustrate, assume that the preadjusted proportions for all the states were the same in FY2002 as in FY2001. Because of the SCHIP dip, every state in FY2002 would have been slated to receive 73.3% of the dollar amount of its FY2001 allotment, even if its preadjusted proportion was unchanged.[21] One of the BBRA's new floors specified that no state would have its allotment be less than 90% of the previous year's. In this hypothetical example, if that floor were applied to the *dollar* amounts calculated from the formula, then every state would have hit it. The BBRA's floors were not intended to prevent a state's allotment from falling below a particular dollar amount; rather, their purpose was to ensure that, regardless of whether the total amount available for allotments rose or fell, individual states' *share* of the overall appropriation would not vary substantially over time.

Issues and Options Affecting States

Total Appropriation

The last row of **Table 5** (below) shows that the FY2005 appropriation to states was $4.0 billion. However, federal SCHIP spending in FY2005 (the most recent full fiscal year) was $5.0 billion — 25% more than the total original allotments to states for that year, also shown in the table. Funds available in FY2005 in addition to the

[21] From column D of **Table 1**: 3,115,200,000/4,249,200,000 = 73.3%. Reducing both the numerator and the denominator by the 0.25% going to the territories would still yield 73.3%.

FY2005 original allotments were the FY2003 and FY2004 original allotments (if balances remained) and redistributed funds from other states' unspent FY2002 original allotments. With all of these funds, no state experienced a shortfall of federal SCHIP funds in FY2005.

In FY2006, the total appropriation to states is the same as in FY2005 ($4.0 billion), but states' demand for federal SCHIP funds is projected to be approximately $5.9 billion, 47% greater than the year's original allotments. In FY2007, the appropriation to states will rise to $4.9 billion, but states' demand for federal SCHIP funds is projected to be approximately $6.3 billion, 26% greater than the year's original allotments.[22]

For SCHIP's first four years (FY1998-FY2001), the total annual amount provided to states in original allotments exceeded federal SCHIP spending for the year. Beginning in FY2003, however, states' total annual spending exceeded the total annual original allotment amounts, resulting in a greater reliance by many states on unspent funds redistributed from other states. However, as more states spend more of their own allotments, less money is available for redistribution. Simultaneously, more states face the prospect of shortfalls as the gap grows between what they plan to spend in federal SCHIP funds and the amounts projected to be available. CRS projects that 18 states may likely face shortfalls of federal SCHIP funds in FY2007 under current law.[23] (As of the end of FY2005, no more than one state has ever experienced a shortfall in a given year.) If the total annual appropriated amount in reauthorization continues to be the same as the FY2007 amount, the number of states experiencing shortfalls will likely increase annually for several years, according to preliminary CRS projections.[24]

Original Allotment Formula

Once the total amount appropriated to states has been set, the original allotment formula determines how much each state will receive. This is as important to individual states as the total amount allotted nationally. For example, in FY2000, there were billions more dollars in federal SCHIP funds available to states through their allotments than were being spent. However, in that year, Alaska experienced a shortfall of federal SCHIP funds of about $419,000. Even though ample funds appeared available from a national perspective, the way in which those funds were allotted to individual states meant that Alaska exhausted all available federal SCHIP funds, with no capability to tap into other states' unspent funds that year.

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[22] For additional information on these projections, see CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson. States' demand for federal SCHIP funds in FY2006 and FY2007 is based on states' own projections provided to CMS.

[23] CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson.

[24] Projections based on states' adjusted proportions for the FY2006 original allotments. Beginning in FY2008, demand for federal SCHIP funds is held at the FY2007 level increased by the projected growth rate of average per-capita health care expenditures, according to CMS Office of the Actuary.

(Redistribution of states' unspent original allotments to other states did not begin until FY2001.)

For many states, there is a disconnect between their original allotment level and their demand for federal SCHIP funds. **Table 5** shows every state's FY2005 original allotment compared to its FY2005 federal SCHIP spending (from all available federal SCHIP funds, not just the FY2005 original allotment). Only 16 states had total federal SCHIP spending in FY2005 that was less than their FY2005 original allotment. Tennessee is the lowest spender and Rhode Island is the highest spender relative to their original allotment amounts. Tennessee's federal SCHIP spending in FY2005 was only 4% of its FY2005 original allotment amount.[25] At the other extreme, Rhode Island spent six times what was allotted to it in FY2005.[26]

Table 6 shows similar information, but for all full fiscal years since SCHIP's inception. The same two states are at the extremes. From FY1998-FY2005, Tennessee's federal SCHIP spending was only 12% of its total original allotments, while Rhode Island had demand (i.e., actual spending plus shortfalls) for federal SCHIP funds amounting to 259% of its total original allotment funds.

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[25] Targeted low-income children are defined as those who, among other factors, must have family income that is above the Medicaid income eligibility level as of Mar. 31, 1997, per §2210(b)(4). On that date, Tennessee's Medicaid program covered children up to 400% of the federal poverty level (FPL). Tennessee had used SCHIP funds to expand its existing comprehensive Medicaid Section 1115 waiver program. Under the state's SCHIP Medicaid expansion, Tennessee began enrolling children in Oct. 1997. In FY2002, enrollment reached 10,216. Eligibility for this Medicaid expansion program was limited to older children in families with income up to 100% FPL. As of Oct. 1, 2002, all such children had to be covered under regular Medicaid — that is, they were no longer eligible for SCHIP coverage. Thus, Tennessee has had no SCHIP enrollment since FY2002. Since then, Tennessee's federal SCHIP expenditures have been limited to "20% spending." This type of spending, per §2105(g), permits 11 qualifying states to use federal SCHIP funds to cover the difference between the enhanced (SCHIP) and regular (Medicaid) federal medical assistance percentages (FMAPs) for Medicaid enrollees, who are under age 19 and whose family income exceeds 150% of poverty.

[26] Rhode Island covers targeted low-income children from conception (covering pregnant women) to age 19 with income up to 250% FPL. SCHIP coverage is available to Medicaid/SCHIP-enrolled children's parents and adult caretakers up to 185% FPL. For more information, see State of Rhode Island "RIte Care/RIte Share Fact Sheet," at [http://www.dhs.state.ri.us/dhs/reports/rc_rs_fact_sheet_eng.pdf].

Table 5. FY2005 Original Allotments and Federal SCHIP Spending, by State

(Millions of dollars; sorted by spending as a percentage of original allotment)

State	Original allotment	Spending	Spending as a percent of original allotment
Tennessee	$78.9	$3.4	4%
New Mexico	$42.2	$23.2	55%
Connecticut	$36.6	$20.5	56%
Washington	$64.7	$40.3	62%
Texas	$450.0	$287.7	64%
Nevada	$40.4	$26.6	66%
Colorado	$58.0	$38.7	67%
Delaware	$9.0	$6.4	71%
Vermont	$4.9	$3.7	75%
D.C.	$9.6	$7.4	77%
Idaho	$20.7	$16.6	80%
New Hampshire	$9.3	$7.6	82%
Oregon	$47.3	$38.6	82%
Wyoming	$6.4	$5.7	90%
Utah	$31.7	$28.7	91%
Florida	$249.2	$244.0	98%
Indiana	$73.4	$76.1	104%
Montana	$12.3	$12.8	104%
Virginia	$76.3	$79.8	105%
Hawaii	$12.4	$13.0	105%
South Carolina	$54.3	$57.3	106%
Pennsylvania	$131.0	$140.9	108%
Oklahoma	$57.4	$63.6	111%
California	$667.4	$760.0	114%
Alabama	$68.0	$80.2	118%
North Dakota	$6.4	$8.3	129%
Arkansas	$48.7	$63.0	130%
Kentucky	$54.1	$70.8	131%
New York	$270.1	$362.5	134%
West Virginia	$24.4	$33.3	136%
Ohio	$125.8	$172.3	137%
Louisiana	$77.5	$109.9	142%
Iowa	$28.3	$40.8	144%
South Dakota	$7.9	$11.9	151%
Kansas	$28.5	$43.1	151%
Georgia	$130.9	$201.6	154%
Michigan	$111.3	$172.2	155%
Missouri	$54.0	$88.7	164%
Maine	$12.5	$20.6	165%
Wisconsin	$51.9	$86.3	166%
Minnesota	$38.6	$71.5	185%
Arizona	$106.5	$198.0	186%
North Carolina	$110.3	$211.0	191%
Illinois	$164.9	$320.2	194%
Nebraska	$17.1	$34.0	199%
Massachusetts	$59.4	$121.5	204%
Mississippi	$48.2	$112.5	233%
New Jersey	$84.7	$204.9	242%
Maryland	$48.3	$122.4	253%
Alaska	$9.0	$24.4	271%
Rhode Island	$9.4	$56.4	603%

State	Original allotment	Spending	Spending as a percent of original allotment
State total	$4,040	$5,045	125%

Source: Congressional Research Service (CRS).

Table 6. Sum of FY1999-FY2005 Original Allotments and Demand for Federal SCHIP Funds, by State

(Millions of dollars; sorted by spending as a percentage of original allotment)

State	Sum of annual original allotments	Sum of annual spending/demand (i.e., expenditures and shortfalls)	Spending/demand as a percent of original allotments
Tennessee	$549.7	$68.0	12%
New Mexico	$374.1	$88.9	24%
Washington	$414.1	$109.8	27%
Delaware	$69.7	$23.5	34%
New Hampshire	$80.3	$28.6	36%
Arkansas	$357.5	$130.5	36%
Oregon	$335.7	$134.9	40%
Connecticut	$263.3	$109.5	42%
Wyoming	$51.7	$22.0	42%
Nevada	$252.1	$117.5	47%
Hawaii	$80.7	$38.1	47%
D.C.	$78.5	$37.7	48%
Oklahoma	$509.0	$255.3	50%
Vermont	$31.9	$16.8	53%
Texas	$3,469.5	$1,856.8	54%
Virginia	$525.4	$286.2	54%
Colorado	$349.9	$193.0	55%
California	$5,454.4	$3,009.3	55%
Idaho	$141.5	$83.3	59%
North Dakota	$44.9	$28.4	63%
Michigan	$798.0	$521.3	65%
Louisiana	$637.1	$423.2	66%
Utah	$209.3	$146.1	70%
Alabama	$541.1	$378.3	70%
Montana	$96.5	$70.0	73%
Illinois	$1,087.1	$818.2	75%
Pennsylvania	$934.4	$705.5	76%
South Carolina	$451.1	$359.1	80%
Florida	$1,780.4	$1,426.5	80%
Ohio	$955.4	$804.7	84%
South Dakota	$58.9	$50.4	86%
Iowa	$221.8	$190.8	86%
Georgia	$952.9	$835.4	88%
Indiana	$492.1	$439.0	89%
West Virginia	$167.8	$150.9	90%
Kansas	$219.3	$201.7	92%
Nebraska	$125.9	$125.4	100%
Arizona	$856.1	$856.6	100%
Missouri	$411.8	$415.9	101%
Minnesota	$255.5	$273.9	107%
North Carolina	$710.5	$765.2	108%
Kentucky	$381.4	$429.4	113%
Mississippi	$386.4	$450.9	117%

State	Sum of annual original allotments	Sum of annual spending/demand (i.e., expenditures and shortfalls)	Spending/demand as a percent of original allotments
New York	$2,067.0	$2,417.5	117%
Wisconsin	$354.8	$437.2	123%
Maine	$94.0	$115.8	123%
Massachusetts	$386.5	$501.9	130%
New Jersey	$660.0	$1,140.9	173%
Maryland	$383.3	$684.9	179%
Alaska	$61.0	$134.3	220%
Rhode Island	$71.7	$186.1	259%
State total	$30,243	$23,095	76%

Source: Congressional Research Service (CRS).

Separate from the issue of the allotments being sufficient to cover states' expenditures is states' concern that the formula causes substantial variation and unpredictability.[27] This unpredictability is partly driven by the relatively large standard errors associated with the two formula factors derived from the ASEC: the number of low-income children and the number of those children without health insurance. According to one source, "The funding fluctuations present significant problems for states as they develop budget priorities under difficult fiscal conditions."[28] **Table 7** shows this variation in states' original allotments, based on each state's percentage of the total appropriation available to states between FY1998 and FY2006. Over the nine-year period, the average difference between the lowest and highest amounts was 31%. This calculation takes into account that the amounts were limited in 19 states that hit the statutory floor and in 14 states that hit the statutory ceiling, also shown in the table.

[27] For example, see David Bergman, "Perspectives on Reauthorization: SCHIP Directors Weigh In," National Academy for State Health Policy, June 2005.

[28] Michael Davern et al., "State Variation in SCHIP Allocations: How Much Is There, What Are Its Sources, and Can It Be Reduced?" *Inquiry*, vol. 40, no. 2, summer 2003, p. 184.

Table 7. Variation in States' SCHIP Original Allotments (Adjusted Proportion of Total Appropriation Available to States) and Number of Years State Hit Floor or Ceiling, FY1998-FY2006, by Percentage Difference between Lowest and Highest

State	Lowest	Highest	Difference	Floor	Ceiling
Alaska	0.16%	0.24%	45%	0	1
Colorado	0.99%	1.43%	45%	0	2
Delaware	0.19%	0.28%	45%	2	2
Hawaii	0.21%	0.31%	45%	0	5
Idaho	0.38%	0.55%	45%	0	1
Illinois	2.90%	4.21%	45%	0	1
Massachusetts	1.01%	1.47%	45%	0	5
Michigan	2.17%	3.14%	45%	0	1
Minnesota	0.67%	0.97%	45%	0	4
North Carolina	1.88%	2.73%	45%	0	3
North Dakota	0.12%	0.17%	45%	0	3
Vermont	0.08%	0.12%	45%	0	4
Washington	1.10%	1.60%	45%	0	4
Wisconsin	0.96%	1.39%	45%	0	1
Nevada	0.72%	1.04%	44%	0	0
Oklahoma	1.42%	2.03%	43%	7	0
New Mexico	1.04%	1.49%	43%	7	0
Oregon	0.93%	1.30%	40%	0	0
Nebraska	0.35%	0.49%	39%	1	0
Utah	0.57%	0.80%	39%	0	0
Maryland	1.07%	1.46%	36%	1	0
Texas	9.79%	13.29%	36%	2	0
Ohio	2.74%	3.65%	33%	0	0
Tennessee	1.57%	2.05%	31%	0	0
Montana	0.28%	0.36%	30%	1	0
New Hampshire	0.23%	0.29%	30%	3	0
Alabama	1.58%	2.04%	29%	2	0
Louisiana	1.87%	2.41%	29%	2	0
Indiana	1.43%	1.82%	27%	1	0
Missouri	1.22%	1.56%	27%	0	0
New York	6.05%	7.66%	27%	0	0
California	16.01%	20.23%	26%	1	0
South Carolina	1.34%	1.70%	26%	1	0
Wyoming	0.15%	0.18%	25%	0	0
Iowa	0.63%	0.78%	25%	0	0
D.C.	0.23%	0.29%	25%	2	0
Florida	5.24%	6.40%	22%	1	0
Kentucky	1.18%	1.43%	21%	0	0
Connecticut	0.78%	0.94%	21%	1	0
West Virginia	0.50%	0.60%	20%	1	0
Pennsylvania	2.78%	3.32%	19%	0	0
Arkansas	1.08%	1.28%	18%	1	0
Mississippi	1.17%	1.38%	18%	0	0
Arizona	2.64%	3.10%	18%	0	0
Virginia	1.62%	1.89%	17%	0	0
Georgia	2.95%	3.41%	15%	0	0
New Jersey	2.05%	2.35%	15%	0	0
Rhode Island	0.22%	0.25%	14%	1	0
Kansas	0.68%	0.78%	14%	0	0
Maine	0.30%	0.33%	13%	0	0

State	Lowest	Highest	Difference	Floor	Ceiling
South Dakota	0.18%	0.20%	10%	0	0
All States			31% average	19 states	14 states

Source: Congressional Research Service (CRS) analysis using CRS SCHIP Projection Model.

Notes: Numbers displayed are rounded; calculations are based on unrounded numbers. The "adjusted proportion" is each state's percentage of the total appropriation available to states, taking into account the statutory floors and ceilings described earlier in the report.

Discussion

SCHIP has been lauded for the health insurance it provides to children and the flexibility states have in designing their SCHIP programs. With the expiration of SCHIP's current authorization looming, Congress is expected to examine some of the issues surrounding the SCHIP original allotment levels and formula. This section of the report discusses generally how these issues have played out in SCHIP's current authorization and how they could be handled in reauthorization.

Although SCHIP is a capped grant program to states, shortfalls of federal SCHIP funds have largely been avoided through congressional and administrative actions. These past actions highlight the tensions in a program that is popular because it provides health insurance to children, yet was not originally structured as an open-ended entitlement to states (or individuals). Comparing the experience of SCHIP in Rhode Island and Texas illustrates these tensions.

In FY2005, Rhode Island spent $56 million in federal SCHIP funds but had only $9 million available from its own available original allotments.[29] Redistributed unspent funds from other states covered the $47 million difference. As previously mentioned, Rhode Island's SCHIP program covers children in families with income up to 250% FPL and parents or adult caretakers of Medicaid/SCHIP-enrolled children with income up to 185% FPL. In fact, the state's SCHIP program had nearly as many adult enrollees as child enrollees.[30] Families with incomes between 150% and 250% of the FPL pay a monthly premium of $61, $77, or $92 per month, depending on their income.[31] Enrollees face no cost-sharing (e.g., copayments) for services.[32] Rhode Island has one of the lowest rates of uninsured children in the country, at 6.1%.[33]

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[29] In fact, the $9 million was entirely from its FY2005 original allotment, since the state had already depleted the balances in its FY2003 and FY2004 original allotments.

[30] **Table 1** of CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz, et al.

[31] State of Rhode Island "RIte Care/RIte Share Fact Sheet," at [http://www.dhs.state.ri.us/dhs/reports/rc_rs_fact_sheet_eng.pdf].

[32] CRS Report RL32389, *A State-by-State Compilation of Key State Children's Health Insurance Program (SCHIP) Characteristics*, by Elicia J. Herz, et al.

[33] CRS Report 97-310, *Health Insurance: Uninsured Children by State*, by Chris L. Peterson. (Hereafter cited as CRS Report 97-310.)

On the other hand, Texas has the highest rate of uninsured children in the country, at 21.7%.[34] After three years' access to its FY2002 original allotment of $302 million, $105 million was unspent and redistributed to states like Rhode Island. Texas does not cover adults in its SCHIP program. Texas's SCHIP covers children in families with income up to 200% FPL. All of these enrollees face cost-sharing (i.e., copayments charged when receiving services). Families with incomes between 101% and 200% of the FPL pay a monthly premium of $15, $20, or $25 per month, depending on their income.[35]

Although the SCHIP programs in these two states vary along several dimensions, the biggest difference is Rhode Island's adult enrollment, which comprises a substantial portion of its SCHIP enrollees, while Texas reports no adult enrollees. If the goal is to reach as many children as possible, research has shown that extending coverage to parents is effective.[36] But in a program with capped federal funding, covering adults raises questions about the appropriate level of funds to be provided to each state. This is one example of the state-level differences in SCHIP that affect states' spending and could be used as factors for calculating future allotments.

One option for reauthorization is for Congress to continue with current appropriation levels and original allotment formula. Despite the variation in what states have been allotted, the same criteria have been in place for nearly a decade. Many states have expanded beyond the original populations targeted by the authorizing SCHIP language. To the extent that they have done so and this has led to potential shortfalls of federal SCHIP funds, Congress is not obliged to devise ways to prevent such shortfalls, even if some congressional action has been taken in the past. There has never been a guarantee that states would not face shortfalls. In fact, Rhode Island in particular is a state that has experienced shortfalls in years past. One may argue that the original allotment levels and formula are adequate, and states are ultimately responsible to deal with the consequences of their decisions to expand eligibility, covered benefits, and the like.

An opposing argument is that the appropriation levels and formula have been an inefficient way for Congress to allocate money among states, particularly when its attempts historically have demonstrated a desire to prevent any shortfalls of

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[34] Ibid.

[35] Centers for Medicare and Medicaid Services (CMS), "Texas Title XXI Fact Sheet," available at [http://www.cms.hhs.gov/LowCostHealthInsFamChild/SCHIPASPI/list.asp].

[36] See, for example, Lisa Dubay and Genevieve Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid," *Health Services Research*, vol. 38, no. 5, Oct. 2003, p. 1283. The article states, "Children who reside in states that expanded public health insurance programs to parents participate in Medicaid at a rate that is 20 percentage points higher than of those who live in states with no expansions. The Massachusetts expansion in coverage to parents led to a 14 percentage point increase in Medicaid coverage among children due principally to reductions in uninsurance among already eligible children."

federal SCHIP funds, with some exceptions.[37] If the goal is to expand coverage to as many children as possible, then some may argue that turning SCHIP into an open-ended entitlement, like Medicaid, would be most beneficial, as states would not fear the prospect of exhausting their federal funds for the program. If this were the case, one could argue, the only limitation to states expanding coverage to children would be each state's ability to pony up the state share of the costs of coverage. However, with a marked expansion of covered individuals on an open-ended basis, one might also expect a marked expansion in federal outlays.

Because the current levels of state spending reflect state-level decisions about their willingness to cover individuals in what are now relatively mature SCHIP programs, some may contend that original allotment levels in reauthorization should be set according to states' spending. This approach could be used rather than using the levels and formula that were originally created without the benefit of any SCHIP experience. Under such an approach, there would likely be a 25% or more increase in the national SCHIP appropriation compared to the last one slated to occur under the current authorization, in FY2007.[38]

Of course, this does not mean that every state would receive a 25% increase in its original allotment. An approach linking original allotments to actual spending would mean that some states would get markedly smaller original allotments compared to previous years, and other states would receive much larger ones. For example, CRS projects that under current law, Texas will receive an FY2007 original allotment of approximately $560 million but is projected to spend only $409 million that year. If its FY2008 original allotment were linked to its FY2007 expenditures, that allotment would be approximately $150 million less than the FY2007 one.

States that have annual spending less than their original allotments may argue that such an approach for original allotments would penalize them and make it more difficult for them to expand coverage or benefits in the future. Alternatively, there could be some blend between current allotment levels and states' recent expenditures, with some adjustments built in depending on Congress's willingness to cover populations not defined as SCHIP's targeted low-income children. In addition, flexibility could be built in to accommodate new expansions in some states, particularly those that had historically spent relatively smaller portions of their available funds, as well as other factors.

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[37] One exception is the possible impact of a provision in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). The administration projected an FY2006 shortfall of federal SCHIP funds amounting to $283 million, based on states' own projections of their FY2006 spending. DRA included a $283 million appropriation for shortfall states (and 1.05% of the appropriation for the territories). However, DRA specified that the funds could not be used for coverage of non-pregnant adults. Previously cited CRS projections find that two states, Minnesota and Rhode Island, will likely experience a shortfall because of this provision, totaling approximately $20 million. This is still a much smaller shortfall than these states would otherwise have experienced.

[38] As previously mentioned, in FY2007 the appropriation to states will rise to $4.9 billion, but states' demand for federal SCHIP funds is projected to be approximately $6.3 billion, 26% greater than the year's original allotments.

Another issue is the period of availability of the original allotment. Under current law, original allotments are available to states for three years.[39] The first Senate-passed version of DRA would have reduced the period of availability to two years for the FY2004 and FY2005 original allotments. The shortened period of availability of the FY2004 original allotment would have helped close projected shortfalls in FY2006; the redistribution of FY2005 original allotment funds would have occurred in FY2007. The enacted version of DRA dropped those provisions, instead appropriating an additional $283 million for FY2006. DRA did not address the projected shortfalls of federal SCHIP funds in FY2007. The President's FY2007 budget calls for shortening the period of availability of the FY2005 original allotment to two years to address the projected FY2007 shortfall.

Part of the rationale for shortening the period of availability of original allotments hearkens back to BBA 97. When SCHIP was first created, original allotments far outpaced states' spending, since they were still trying to get their programs started. After a decade, however, the states' SCHIP programs are arguably mature, and three years of availability is no longer necessary. Congress has yet to enact any legislation shortening the period of availability of original allotments. If, however, the period is shortened for the FY2005 original allotment for the benefit of shortfall states in FY2007, as proposed by the President, then a reversion back to the three-year period beginning with the FY2006 original allotment means that no redistribution of unspent funds would occur in FY2008.

Finally, SCHIP has been responsible for decreases in the percentage of children who are uninsured. This occurred in the face of significant drops in employer-sponsored coverage for both children and adults (and significant *increases* in uninsurance among adults). In FY1998 and FY1999, the original allotment formula's number of children relied totally on the number of *uninsured* low-income children, to provide funding for states' new SCHIP programs consistent with the number of children potentially eligible for SCHIP. Beginning in FY2001, the formula's number of children has relied equally on the number of *uninsured* low-income children and the number of *all* low-income children. Retaining the *uninsured* children as a factor gives states a somewhat perverse incentive — that as they increase coverage of children through SCHIP, their original allotments *drop*, all else being equal. The declining reliance on the uninsured factor between FY1999 and FY2001 was intended to ameliorate this perverse incentive. Whether Congress decides to continue that decline as part of reauthorization or leave it as it has been for several years is one of many questions to be answered.

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[39] §2104(e).

Technical Appendix: Sources of Data for Current Original Allotment Formula

If the components of the current original allotment formula are retained in reauthorization, the sources of data may merit some additional consideration. As previously mentioned, the SIC industry code used for the health services industry is no longer in use, and has been replaced by codes using NAICS. CMS has simply adopted the NAICS standard, but this could be updated in reauthorization. Additionally, because this data source for the state cost factor does not include the self-employed, some have argued that high rates of self-employment among physicians in some states artificially depresses their state-level factor in the allotment formula.

The other source of data in the formula is the Census Bureau's Current Population Survey (CPS), used for estimating the number of low-income children (below 200% FPL) and the number of those children who are uninsured. A three-year average is used in the formula to reduce the sampling error, as previously discussed. Even with that, however, there can be marked variation, raising questions about the reliability of the CPS estimates for purposes of calculating the original allotments. To address some of these concerns, BBRA appropriated an additional $10 million annually, beginning in FY2000, for the CPS to boost its sample size of children.

Even with the sample-size increase, the variation from year to year that may be attributable simply to small sample sizes is sometimes quite large. For example, Rhode Island has one of the lowest rates of uninsurance among children (6.1%), using a three-year average of the most recently available data. Taking into account the small sample size, there is in fact no significant difference, statistically speaking, between that rate and the lowest rate in the country, 5.5% in Vermont.[40]

Table 8. Estimated Percentage of Uninsured Children in Rhode Island and Vermont, 2002-2004

Year	Rhode Island	Vermont
2002	5.3%	5.8%
2003	5.8%	5.2%
2004	7.3%	5.5%
2002-2004 average	6.1%	5.5%

Source: Congressional Research Service (CRS) analysis of the Annual Social and Economic (ASEC) Supplement of the Current Population Survey (CPS). See also CRS Report 97-310, *Health Insurance: Uninsured Children by State*, by Chris L. Peterson.

[40] CRS Report 97-310, which includes confidence intervals around each state's three-year average uninsurance rate.

As shown in **Table 8**, Vermont's 5.5% average is based on the estimate of 5.8% for 2002, 5.2% for 2003, and 5.5% for 2004. For Rhode Island, its 6.1% average was based on 5.3% in 2002 (less than the Vermont estimate for that year), 5.8% for 2003, and 7.3% for 2004. In the 2005 CPS (providing data on 2004), the number of children represented in the sample for Vermont was 848; for Rhode Island the number was 1,198. Looking at children specifically under 200% FPL, the sample size falls to 607 in Vermont and 750 in Rhode Island.

The Census Bureau's American Community Survey (ACS) is a new alternative data source not available when SCHIP was initially authorized. The ACS is an annual survey that replaces the decennial census's long form. Like the census, response to the ACS is mandatory. The CPS is a voluntary survey. The ACS has several times more households in the sample than the CPS.

The Census Bureau has also acknowledged that the CPS produces estimates of the uninsured that differ substantially from other nationally representative surveys.[41] Those other surveys have smaller sample sizes than the CPS, and are therefore not able to produce estimates for all the states. The ACS is also not presently an alternative for estimates of the uninsured because it does not include a question on health insurance coverage. A health insurance question is being tested in the ACS. However, if it were decided to add such a question to the survey, it would not be added until at least 2008.

FY2001 was the first year in which the original allotment formula is the same as the current one (i.e., the number of children is weighted evenly between the number of low-income children and the number of those children without health insurance). For reference purposes, **Table 9** shows the number of children based on the factors previously discussed for FY2001 and FY2006 (columns A and B), with the percentage difference between them (column C). The decrease in the total number reflects, among other factors, the decreasing rates of uninsurance partly due to SCHIP. For assessing the impact of these changes in the "number of children" on states' original allotments, the change in the number is not as important as the change in each state's share of the total, shown in column D. The state cost factors for FY2001 and FY2006, along with the percentage difference between them, are also shown in **Table 9** (columns E through F, respectively). The impact of these changes in the factors is mitigated by the applicable floors and ceilings.

As described in §2104(b)(2)(B), the number of low-income children and the number of uninsured low-income children are reported as defined in the CPS. The poverty line used by the Census Bureau, the *poverty thresholds*, is not the same typically used by the federal government for determining income-related program eligibility, the *poverty guidelines*. Except for the CPS estimates, SCHIP's targeted low-income children are those below 200% of the *poverty guidelines* (§2110(c)(5)). **Table 10** shows the 2005 poverty thresholds, and **Table 11** shows the poverty guidelines. If the poverty guidelines were used for the CPS estimates, the resulting changes in the number of children could affect states' original allotments.

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[41] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," p. 16, at [http://www.census.gov/prod/2005pubs/p60-229.pdf].

Table 9. Number of Children and State Cost Factor for SCHIP Original Allotment Formula, FY2001 and FY2006

	Number of children (in thousands)				State cost factor		
	A	B	C	D	E	F	G
State	2001	2006	Change	Change in proportion of total	2001	2006	Change
Alabama	302	289	-4.3%	4.1%	0.9659	0.9793	1.4%
Alaska	41	38	-8.5%	-0.5%	1.0392	1.0701	3.0%
Arizona	542	434	-19.9%	-12.9%	1.0514	1.0909	3.8%
Arkansas	277	210	-24.2%	-17.5%	0.8931	0.9178	2.8%
California	2,905	2,531	-12.9%	-5.2%	1.1108	1.1267	1.4%
Colorado	204	248	21.3%	32.0%	1.0017	1.0678	6.6%
Connecticut	162	134	-17.3%	-10.0%	1.1165	1.1365	1.8%
Delaware	51	35	-31.4%	-25.4%	1.0889	1.1396	4.7%
D.C.	42	34	-19.0%	-11.9%	1.296	1.2395	-4.4%
Florida	978	1,062	8.6%	18.1%	1.0305	1.0353	0.5%
Georgia	621	555	-10.7%	-2.9%	0.9953	1.0295	3.4%
Hawaii	74	64	-13.5%	-5.9%	1.169	1.1167	-4.5%
Idaho	110	102	-7.3%	0.9%	0.8893	0.8911	0.2%
Illinois	787	719	-8.7%	-0.7%	0.9966	1.0384	4.2%
Indiana	298	333	11.7%	21.5%	0.9234	0.9667	4.7%
Iowa	178	133	-25.3%	-18.7%	0.8469	0.8948	5.7%
Kansas	154	134	-13.3%	-5.7%	0.8719	0.9080	4.1%
Kentucky	276	267	-3.3%	5.2%	0.9276	0.9540	2.8%
Louisiana	396	366	-7.7%	0.4%	0.8876	0.9306	4.8%
Maine	68	59	-13.2%	-5.6%	0.9049	0.8915	-1.5%
Maryland	225	201	-10.9%	-3.1%	1.046	1.0713	2.4%
Massachusetts	292	246	-15.8%	-8.4%	1.0495	1.1072	5.5%
Michigan	573	506	-11.7%	-3.9%	1.0074	1.0211	1.4%
Minnesota	255	177	-30.6%	-24.5%	0.9824	1.0242	4.3%
Mississippi	289	243	-15.9%	-8.5%	0.8882	0.9058	2.0%
Missouri	326	264	-19.2%	-12.1%	0.9204	0.9420	2.3%
Montana	83	63	-24.7%	-18.1%	0.8415	0.8860	5.3%
Nebraska	102	82	-20.1%	-13.1%	0.8563	0.9116	6.5%
Nevada	120	155	29.2%	40.5%	1.1954	1.1919	-0.3%
New Hampshire	58	39	-33.6%	-27.8%	0.9826	1.0529	7.2%
New Jersey	403	346	-14.3%	-6.8%	1.1237	1.1420	1.6%
New Mexico	219	166	-24.4%	-17.8%	0.9225	0.9561	3.6%
New York	1,360	1,111	-18.3%	-11.1%	1.0841	1.0814	-0.2%
North Carolina	501	559	11.6%	21.4%	0.9899	0.9900	0.0%
North Dakota	48	32	-33.3%	-27.5%	0.8697	0.8745	0.6%
Ohio	675	568	-15.9%	-8.5%	0.965	0.9676	0.3%
Oklahoma	262	258	-1.7%	6.9%	0.8523	0.8818	3.5%
Oregon	228	205	-10.3%	-2.4%	1.0063	1.0110	0.5%
Pennsylvania	638	594	-6.9%	1.3%	0.9969	0.9955	-0.1%
Rhode Island	44	44	0.0%	8.8%	0.9785	0.9803	0.2%
South Carolina	294	247	-16.0%	-8.6%	1.0055	0.9917	-1.4%
South Dakota	43	38	-12.8%	-5.1%	0.8703	0.9205	5.8%
Tennessee	446	348	-22.0%	-15.1%	0.9991	1.0189	2.0%
Texas	2,028	2,055	1.3%	10.2%	0.9277	0.9758	5.2%
Utah	153	160	4.2%	13.4%	0.9059	0.8905	-1.7%
Vermont	29	23	-20.7%	-13.7%	0.8696	0.9236	6.2%
Virginia	350	315	-10.0%	-2.1%	0.9885	1.0122	2.4%
Washington	314	327	4.1%	13.3%	0.9467	0.9914	4.7%
West Virginia	108	114	5.1%	14.3%	0.8961	0.9072	1.2%

State	Number of children (in thousands)				State cost factor		
	A	B	C	D	E	F	G
	2001	2006	Change	Change in proportion of total	2001	2006	Change
Wisconsin	241	245	1.5%	10.3%	0.9438	1.0057	6.6%
Wyoming	38	28	-27.6%	-21.3%	0.8779	0.9430	7.4%
All states	**21,212 total**	**19,502 total**	**-11.0% average**	**-3.1% average**	**Not applicable**	**Not applicable**	**2.6% average**

Source: Congressional Research Service (CRS) analysis of "Corrected SCHIP Allotments for Federal Fiscal Year 2001," 66 *Federal Register* 6631, Jan. 22, 2001, and "State Children's Health Insurance Program Allotments for Federal Fiscal Year 2006," 70 *Federal Register* 36619, June 24, 2005.

Table 10. U.S. Census Bureau Poverty Thresholds, 2005

Size of family unit	Number of related children (under 18)								
	0	1	2	3	4	5	6	7	8+
One person									
Under 65 years	$10,160								
65+ years	9,367								
Two persons									
Householder under 65 years	13,078	13,461							
Householder 65 years and over	11,805	13,410							
Three persons	15,277	15,720	15,735						
Four persons	20,144	20,474	19,806	19,874					
Five persons	24,293	24,646	23,891	23,307	22,951				
Six persons	27,941	28,052	27,474	26,920	26,096	25,608			
Seven persons	32,150	32,350	31,658	31,176	30,277	29,229	28,079		
Eight persons	35,957	36,274	35,621	35,049	34,237	33,207	32,135	31,862	
Nine+	43,254	43,463	42,885	42,400	41,603	40,507	39,515	39,270	37,757

Source: U.S. Census Bureau.

Table 11. U.S. Health and Human Services Poverty Guidelines, 2005

Persons in family unit	48 contiguous states and D.C.	Alaska	Hawaii
1	$9,570	$11,950	$11,010
2	12,830	16,030	14,760
3	16,090	20,110	18,510
4	19,350	24,190	22,260
5	22,610	28,270	26,010
6	25,870	32,350	29,760
7	29,130	36,430	33,510
8	32,390	40,510	37,260
For each additional person, add	3,260	4,080	3,750

Source: U.S. Health and Human Services