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

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

Summary

The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels. As of 2004, the upper income eligibility limit under SCHIP had reached as high as 350% of the federal poverty level, or FPL (in one state).

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

Nearly $40 billion has been appropriated for SCHIP for FY1998 through FY2007. Annual allotments among the states are determined by a formula that is based on a combination of the number of low-income children and low-income uninsured children in the state, and includes a cost factor that represents the average health service industry wages in the state compared to the national average. Like Medicaid, SCHIP is a federal-state matching program. While the Medicaid federal medical assistance percentage (FMAP) ranged from 50% to 76% in FY2006, the enhanced SCHIP FMAP ranged from 65% to 83.2% across states.

All 50 states, the District of Columbia, and five territories have SCHIP programs in operation. As of June 2006, 17 use Medicaid expansions, 18 use separate state programs, and 21 use a combination approach. Since initial enrollment in FY1998, many states have amended their original SCHIP plans. For example, approved amendments and waivers expand eligibility, define new copayment standards, and/or modify benefit packages.

Approximately 6.2 million children were enrolled in SCHIP during FY2004. In addition, eight states reported enrolling about 646,000 adults in SCHIP through program waivers. Spending was slow in the early years of SCHIP due at least in part to lower than expected enrollment. But that trend changed in more recent years and has led some states to exhaust their federal SCHIP funds. The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) provided a new appropriation of $283 million to address anticipated FY2006 shortfalls in federal SCHIP funding. The Congressional Research Service (CRS) SCHIP Projection Model projects that four states will still experience shortfalls in FY2006, totaling $2.75 million. This model projects that 18 states will experience shortfalls in FY2007. SCHIP reauthorization and financing issues are likely to be addressed by Congress in this fiscal year or in FY2007.

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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. The program offers federal matching funds to states and territories to provide health insurance to certain low-income children.

Eligibility

In general, Title XXI defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. States can set the upper income level for targeted low-income children up to 200% of the federal poverty level (FPL),[1] or if the applicable Medicaid income level for children is at or above 200% FPL prior to SCHIP, the upper income limit may be raised an additional 50 percentage points above that level.

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

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

States may cover targeted low-income children by expanding their Medicaid programs in the following ways: (1) by establishing a new optional eligibility group

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[1] In 2006, the poverty guideline in the 48 contiguous states and the District of Columbia is $20,000 for a family of four. ("Annual Update of the HHS Poverty Guidelines," 71 *Federal Register* 3848, Jan. 24, 2006.)

for such children as authorized in Title XXI, and/or (2) by liberalizing the financial rules[2] for any of several existing Medicaid eligibility categories.

Many states have chosen to cover targeted low-income children under existing Medicaid eligibility pathways, especially Medicaid's poverty-related child groups, rather than by establishing the Title XXI optional coverage group.[3] Such a strategy reduces the administrative burden of creating and implementing a new coverage group.[4]

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

As of FY2004, the upper income eligibility limit under SCHIP had reached 350% of the FPL (see **Table 1**).[5] Twenty-five states and the District of Columbia had established upper income limits at 200% FPL. Another 13 states exceeded 200% FPL. The remaining 12 states set maximum income levels below 200% FPL.[6]

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[2] Under Medicaid law, Section 1902(r)(2) authority may be used to liberalize income and resource methodologies for a number of groups, including, for example, poverty-related children (i.e., those under age 6 in families with income up to 133% FPL and those between ages 6 and 18 in families with income up to 100% FPL). That same authority can be used to liberalize financial rules for SCHIP purposes. Family coverage is provided under Section 1931. This section has its own provisions for liberalizing income and resource standards.

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

[4] Because individuals can have other health insurance and still be covered by Medicaid, this approach also allows states to bring into Medicaid otherwise ineligible higher-income children *regardless* of their other health insurance status. Under this strategy, for example, states can provide Medicaid benefits to additional children whose existing health insurance is limited (sometimes referred to as under-insured). When states liberalize the financial rules for existing Medicaid eligibility groups, the federal share of the costs for services provided to the subset *without* other health insurance — the targeted low-income children — is paid for out of SCHIP funds (described in further detail below). The federal share of the costs for services delivered to the remaining children *with* other health insurance is paid for by Medicaid.

[5] For determining income eligibility for SCHIP and Medicaid, some states 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 may *increase* the *effective* income level above the stated standard.

[6] States may apply resource, or asset, tests in determining financial eligibility, but are not required to do so. In states with a resource test, individuals must have resources for which the dollar value is less than a specified standard amount in order to qualify for coverage.

(continued...)

Benefits

As noted above, when designing their SCHIP programs, states may cover targeted low-income children under their Medicaid program, create a new separate SCHIP program, or devise a combination of both approaches. Under limited circumstances, states have the option to purchase a health benefits plan that is provided by a community-based health delivery system (e.g., federally funded community health centers or hospitals that receive supplemental payments for serving a disproportionate share of Medicaid or other low-income populations) or to purchase family coverage under a group health plan.

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

States that choose to create separate SCHIP programs may elect any of three benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other health benefits plan that the Secretary of Health and Human Services determines will provide appropriate coverage to the targeted population of uninsured children.[7]

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

Benchmark-equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A state choosing to

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[6] (...continued)
States determine what items constitute countable resources and the dollar value assigned to those countable resources. Assets may include, for example, cars, savings accounts, real estate, trust funds, tax credits, etc.

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

provide benchmark-equivalent coverage must cover each of the benefits in the "basic benefits category." The benefits in the basic benefits category are inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray services, and well-baby and well-child care, including age-appropriate immunizations. Benchmark-equivalent coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category." These additional services include prescription drugs, mental health services, vision services, and hearing services. States are encouraged to cover other categories of service not listed above. Abortions may not be covered, except in the case of a pregnancy resulting from rape or incest, or when an abortion is necessary to save the mother's life.

Cost-Sharing

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

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

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

If a state implements SCHIP through a separate state program, premiums or enrollment fees for program participation may be imposed, but the maximum allowable amount is dependent on family income. For all families with incomes under 150% FPL and enrolled in separate state programs, premiums may not exceed the amounts set forth in federal Medicaid regulations. Additionally, these families may be charged service-related cost-sharing, but such cost-sharing is limited to (1) nominal amounts defined in federal Medicaid regulations for the subgroup with income below 100% FPL, and (2) slightly higher amounts defined in SCHIP

regulations for families with income between 100%-150% FPL. For a family with income above 150% FPL, cost-sharing may be imposed in any amount, provided that cost-sharing for higher-income children is not less than cost-sharing for lower-income children.

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

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

Financing

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

Federal Appropriations and Distribution Among the States and Territories. BBA 97 appropriated a total of $39.7 billion for SCHIP for FY1998-FY2007.[8] The funding level by fiscal year varies across time. The total annual appropriation for each of FY1998-FY2001 was a little more than $4.2 billion. This annual total dropped to a little under $3.2 billion in FY2002-FY2004. Then the appropriation rose to about $4.1 billion for FY2005 and FY2006, with a further increase to roughly $5.0 billion in FY2007. The drop in funding for FY2002-FY2004, sometimes referred to as the "SCHIP dip," was written into SCHIP's authorizing legislation due to budgetary constraints applicable at the time the legislation was drafted.

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

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

Annual allotments are basically separate, sequential funding accounts. For each state and territory, the account for a given fiscal year is made available at the beginning of that year, and remains available for up to three years. For example, FY2004 allotments are available until the end of FY2006. Typically, SCHIP payments are taken out of the earliest active account. Once that fiscal year allotment is fully expended, and the next year's allotment becomes available (active), states can begin to access the next fiscal year's allotment, and so forth.

Reallocation of Unspent Federal Funds. At the end of the applicable three-year period of availability, unspent allotments are subject to reallocation among the states. The rules regarding reallocation vary by fiscal year. Generally, the year-specific rules divide states into two groups for the purpose of reallocation:

- those states that fully exhaust the applicable original allotment by the three-year deadline, called *redistribution states* (shown in **Table 2** by fiscal year), and
- those states that did *not* exhaust the applicable original allotment by the three-year deadline, called *retention states*.

(Territories are treated differently; see the "Legislative History" section at the end of this report for more details.)

In the first reallocation legislation for FY1998 and FY1999 (P.L. 106-554), redistribution states (12 in FY1998 and 13 in FY1999) were given access to unspent funds from other states equal to their excess spending above their original allotments during the applicable three-year period. After a set-aside of 1.05% of the total unspent funds for territories that fully exhausted their original allotments (all five), the remaining unused funds were divided among the retention states in proportion to their contribution to the total pool of unspent funds. In contrast, under the second reallocation legislation for FY2000 and FY2001 (P.L. 108-74), a different rule was used. A set-aside of 1.05% of the total unspent funds was made for territories that fully exhausted their original allotments (again, all five). Then, retention states kept one-half of their unused funds. The remaining unspent funds were then distributed among redistribution states (14 for FY2000 and 19 for FY2001) in proportion to their contribution to the total pool of excess spending.[9]

Because no law was enacted specifying otherwise, the reallocation process followed BBA 97 requirements for unspent FY2002 funds. Under this law, unspent allotments are subject to redistribution among only those states that fully expend their allotments by the applicable three-year deadline, by a method to be determined by the Secretary of Health and Human Services. States that were projected to exhaust *all* of their available federal SCHIP accounts in FY2005, based on their estimated

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[9] Finally, P.L. 108-74 also permits certain states to spend their available balances from FY1998-FY2001 (up to a maximum of 20% of those original allotments) for services delivered to Medicaid beneficiaries under age 19 who are not otherwise eligible for SCHIP and have family income that exceeds 150% of the FPL. Subsequently, P.L. 108-127 modified the definition of a state that qualifies to make such expenditures. In addition, the Deficit Reduction Act of 2005 (P.L. 109-171) continued this authority with respect to FY2004 and FY2005 funds. See the "Legislative History" section below for details.

FY2005 expenditures, received access to FY2002 redistribution money equal to that estimated shortfall. The six "shortfall states" were Arizona, Minnesota, Mississippi, Nebraska, New Jersey, and Rhode Island. The remaining balance of unspent FY2002 funds was then divided among a total of 28 redistribution states, including the six shortfall states, based on each such state's percentage of the total excess spending above the FY2002 allotments during the three-year period of availability of these funds.[10] Also according to BBA 97, reallocation pots expire at the end of one year. In the case of reallocated FY2002 funds, the expiration date was the end of FY2005.

For FY2006, the Secretary was required to distribute both unspent FY2003 original allotments and the new appropriation of $283 million to cover shortfalls provided by the Deficit Reduction Act of 2005 (DRA; P.L. 109-171).[11] First, the Secretary of HHS distributed the DRA funds to the eight states that covered only children and were expected to experience shortfalls in FY2006. (DRA prohibits the use of these funds for non-pregnant adults; coverage for pregnant women is considered to be coverage of children). These eight states are Iowa, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, North Carolina, and South Dakota. These DRA funds entirely eliminated the expected FY2006 shortfall among these eight states. The remaining DRA funds were then distributed to the four additional shortfall states that also cover adults in their SCHIP programs — Illinois, Minnesota, New Jersey, and Rhode Island — ensuring that the amount of DRA funds to these states did not exceed projected spending on children. These four shortfall states also received *all* of the unspent FY2003 funds, which were not limited to covering the costs of SCHIP benefits for children only. After these reallocations, the four shortfall states that cover adults are still projected to have a shortfall of about $2.75 million in FY2006. This deficit is due to the 1.05% set-aside from the $283 million in DRA funds earmarked for the territories that was not accounted for in determining the total appropriation necessary to fully cover all anticipated shortfalls in FY2006. Both the reallocated unspent FY2003 funds and the DRA funds are available only during FY2006.

Access to reallocated funds (i.e., redistributed and retained funds from prior years) has added another layer of complexity to SCHIP financing. During FY2006, all states have access to original allotments from FY2004, FY2005, and FY2006. Selected states also have access to reallocated FY2003 funds and newly appropriated DRA funds (described above). Generally, when multiple accounts are available simultaneously, expenditures are applied against reallocated and original allotments in chronological order from earliest to most recent. However, in regulations, CMS has allowed redistribution states only (i.e., states with excess spending that qualified them for redistribution of unspent funds from other states) the option of defining the

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[10] All five territories also exceeded their FY2002 original allotments by the three-year deadline. As with prior redistributions (see the "Legislative History" section below for more details), 1.05% of all unspent FY2002 funds was set aside for the territories. Each received an amount equal to its original allotment for FY2002 divided by the sum of FY2002 allotments among the territories.

[11] For a more detailed description of the distribution of unspent FY2003 original allotments and the DRA funds, see by CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by C. Peterson.

order for applying expenditures against available redistribution accounts. That is, to optimize the use of funds, such states were given the flexibility to decide whether to use redistributed funds before or after other available funds/accounts. Once a specific order is chosen for a given set of open accounts, such states are not allowed to change that order (until a new redistribution account is added to the set).

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

Compared with the Medicaid FMAP, which ranges from 50% to 76% in FY2006, the enhanced FMAP for SCHIP ranges from 65% to 83.2%. All SCHIP assistance for targeted low-income children, including coverage provided under Medicaid, is eligible for the enhanced FMAP. The Medicaid FMAP and the enhanced SCHIP FMAP are subject to a ceiling of 83% and 85%, respectively.

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

General Program Characteristics

All 50 states, the District of Columbia, and five territories have SCHIP programs in operation. As of June 2006, 17 use Medicaid expansions, 18 use separate state programs, and 21 use a combination approach. Three states received authority under the Balanced Budget Act of 1997 to operate previously existing comprehensive state-based plans as their separate SCHIP program. Among other types of separate SCHIP programs, data from June 2003 indicate that most of the benchmark and benchmark-equivalent plans are based on the state employees' health plan, and most secretary-approved plans are modeled after Medicaid.

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

SCHIP programs across states are evolving rapidly, as evidenced by the numerous changes states have made to their original state plans over time. As of June 2006, 263 amendments to original state plans had been approved and 13 more were in review.[13] Most states have multiple amendments. The content of the plan amendments varies among states. For example, some states use amendments to extend coverage beyond income levels defined in their original state plans. Others define new copayment standards for program participants. Still others modify benefit packages.

In addition to the amendment process, states that want to make changes to their SCHIP programs that go beyond what the law will allow may do so through what is called a Section 1115 waiver (named for the section of the Social Security Act that defines the circumstances under which such waivers may be granted). The Secretary of Health and Human Services may waive certain statutory requirements for conducting research and demonstration projects under SCHIP that allow states to adapt their programs to specific needs. On August 4, 2001, the Bush Administration announced the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. Using Section 1115 waiver authority, this initiative is designed to encourage states to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches that maximize private health insurance coverage options and target populations with income below 200% FPL.

As of March 2006, 15 states had approved SCHIP Section 1115 waivers.[14] Four additional Section 1115 waiver proposals (three for new waivers and one for an amendment to an existing waiver) were under review at that time. Eleven states (Arizona, Arkansas, California, Colorado, Idaho, Illinois, Michigan, New Jersey, New Mexico, Oregon, and Virginia) have approved HIFA demonstrations. In 12 states with approved waivers (Arizona, California,[15] Colorado, Idaho, Illinois, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, Virginia, and Wisconsin), SCHIP coverage is expanded to include one or more categories of adults[16] with children, typically parents of Medicaid/SCHIP children, caretaker relatives, legal guardians, and/or pregnant women. Four states (Arizona, Michigan, New Mexico, and Oregon) also cover childless adults under their waivers. The

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

[14] The 15 states are Alaska, Arizona, Arkansas, California, Colorado, Idaho, Illinois, Michigan, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, Virginia, and Wisconsin. This information is taken from the following source: [http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/Section1115ReportApprovedUnderReview.pdf]. There may be other combined Medicaid/SCHIP waivers that also implement policies similar to those described in this section. Such waivers are not represented in this discussion.

[15] California has not yet implemented its parental expansion.

[16] States have the option to purchase family coverage under a group health plan or health insurance coverage that may cover adults as long as it is cost-effective to do so (relative to the amount paid for comparable coverage for the children only), and it must not substitute for health insurance that would otherwise be provided to the children. For states seeking greater flexibility both in selecting which adults to cover and in the benefit package offered to those adults, a waiver is required.

Deficit Reduction Act of 2005 (DRA) prohibits new waivers that would use SCHIP funds to provide coverage to non-pregnant, childless adults (see the "Legislative History" section below for more details).

In addition to expanding coverage to new populations under waivers, some states have used this authority for other purposes. For example, two states (Alaska and New Mexico) require periods of no insurance prior to enrollment under their waivers.[17] New Mexico also modified its cost-sharing rules for targeted low-income children under its Medicaid program. Seven states (Arkansas, Colorado, Idaho, Illinois, New Mexico, Oregon, and Virginia) offer premium assistance programs for employer-sponsored insurance under waiver authority. New York's demonstration provided temporary disaster relief in New York City due to the events of September 11, 2001. Finally, Ohio received approval to implement an annual enrollment fee and to give 12 months of continuous eligibility for certain targeted low-income children in its Medicaid program.[18]

Trends in Enrollment and Expenditures

Early enrollment estimates indicated that nearly 1 million children (982,000) were enrolled in SCHIP under 43 operational state programs as of December 1998.[19] Nearly two million children (1,979,450) were enrolled in SCHIP during FY1999 under 53 operational state programs.[20] The latest official numbers show that SCHIP enrollment reached a total of nearly 6.2 million children in FY2004 (see **Table 1**). Of this total, almost 4.4 million were covered in separate state programs, and 1.8 million were targeted low-income children under Medicaid.

Although total SCHIP enrollment has steadily increased over time at the national level, some states have occasionally experienced year-to-year declines in the number of children covered. For example, between FY2003 and FY2004,[21] annual SCHIP enrollment in 12 states fell. Seven of these states[22] had single-digit

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[17] SCHIP separate state programs have the authority of impose waiting periods without seeking special approval, and many do so. In general, for Medicaid expansions under SCHIP, all Medicaid rules apply. Thus, when states with SCHIP Medicaid expansions such as Alaska and New Mexico want to implement other rules (e.g., establish waiting periods before enrollment, implement enrollment fees, etc.), a waiver is required.

[18] Due to a variety of budget and resource constraints, in May 2002, Ohio decided not to implement its waiver.

[19] U.S. Health Care Financing Administration, *A Preliminary Estimate of the Children's Health Insurance Program Aggregate Enrollment Numbers Through Dec. 31, 1998* (background only), Apr. 20, 1999.

[20] U.S. Health Care Financing Administration, *The State Children's Health Insurance Program, Annual Enrollment Report, Oct. 1, 1998-Sept. 30, 1999* (no date).

[21] For detailed state-by-state FY2003 and FY2004 SCHIP enrollment data for children and adults, see [http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/list.asp].

[22] Maine -1.0%; Wisconsin -1.1%, Kansas -2.9%; Arizona -3.1%; Alaska -4.2%; Florida -5.3%; and New York -7.8%.

percentage declines, while five states[23] had double-digit percentage reductions in enrollment.

Eight states also reported enrollment of about 646,000 adults in SCHIP in FY2004 (see **Table 1**), up from nearly 484,000 in FY2003. Six of these states had increases in adult enrollment between these two fiscal years, while two (Minnesota and New Jersey) had a decline.[24] Finally, in FY2004, adult enrollment exceeded child enrollment in four states (Arizona, Michigan, Minnesota, and Wisconsin).

Expenditures under SCHIP have been the subject of much debate and controversy almost since the program's inception. Despite the fact that most states began enrolling children in SCHIP in late 1997 or 1998 (see **Table 1**), new programs always take time to get off the ground and participation rates in the early years of SCHIP rose more slowly than expected. As a consequence, spending was slow to ramp up too, as evidenced by the fact that a minority of states (12 to 19, depending on the year) fully expended their original FY1998-FY2001 allotments by the applicable three-year deadlines (see **Table 2**). It was not until FY2005, when the redistribution of unspent FY2002 funds took place, that more than half of the states (28) succeeded in qualifying for a portion of these unused funds because they spent all their own FY2002 allotments within the three-year period of availability. Even more states, a total of 40, exhausted their FY2003 allotments by the end of FY2006. But only selected shortfall states actually received the unspent FY2003 funds, as described above.

Table 3 provides a historical snapshot of SCHIP funding and expenditures for FY1998-FY2005. A total of $30.5 billion of the total federal SCHIP appropriation of nearly $40 billion was made available to states and territories during this period. By the end of FY2005, nearly 77% ($23.4 billion) of these funds was spent. However, an additional $1.4 billion available to 11 states actually expired by the close of FY2005; these expired funds were comprised of unspent FY1998 to FY2002 reallocated monies. The column displaying net funds gained or lost through the reallocation process indicates that 31 states forfeited more funds to redistribution than they received. California (-$1.5 billion) and Texas (-$808 million) had the largest absolute net losses, while New York ($1.8 billion)[25] and New Jersey ($531 million) had the largest absolute net gains.

Table 4 displays available SCHIP funds and estimated expenditures for the current fiscal year, FY2006. During FY2006, several SCHIP accounts are active, including the following:

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[23] Texas -10.4%; Maryland -14.3%; South Carolina -16.7%; Nevada -18.4%; and Nebraska -26.8%.

[24] In one additional state, Colorado covered 1,423 adults under SCHIP in FY2003, but did not report adult enrollment data to CMS for FY2004.

[25] Even though New York gained access to a lot of additional federal dollars through reallocations during this period, $951 million in SCHIP funds for this state still expired by the end of FY2005.

- reallocated FY2003 funds and the new DRA appropriation of $283 million to cover shortfalls, available only in FY2006, and
- original allotments for FY2004, FY2005, and FY2006, each available for a three-year period.

Only 11 states forfeited unspent FY2003 funds. As noted previously, only 12 of the 40 redistribution states (plus the five territories) received additional funds through the reallocation of unspent FY2003 funds and/or the DRA appropriation. After these distributions, four shortfall states (specifically those covering adults under SCHIP) are still projected to have a continuing shortfall of about $2.75 million in FY2006. This deficit is due to the 1.05% set-aside for the territories that was not accounted for in determining the total appropriation necessary to fully cover all anticipated shortfalls in FY2006. Of the $10.1 billion available this fiscal year, states estimate they will spend nearly $6 billion during FY2006.

Forthcoming SCHIP Issues

As with previous Congresses, the main SCHIP policy issue facing the 109th Congress is federal financing — specifically, dealing with insufficient unspent funds to prevent state shortfalls as well as identifying the best method for allocating original allotments among states. In the early years of SCHIP, the majority of states had not used available SCHIP allotments within applicable time frames, and these unspent funds were on the verge of expiring (to be returned to the Treasury). These states wanted continued access to their unspent funds, perhaps to support program expansions, but the law established in the Balanced Budget Act of 1997 (BBA 97) required that such funds be redistributed among only those states that fully exhausted their own allotments (12 to 19 states, depending on the fiscal year). In response, Congress passed reallocation legislation that tried to strike a balance between rewarding fast-spending states with additional funds, while giving slow-spending states continued access to a portion of their unused funds.

The BBA 97 rule applies to the redistribution of unspent SCHIP funds for FY2002 allotments forward. The Administration reallocated roughly $643 million in unspent FY2002 funds among 28 states that had exhausted their own FY2002 allotments, six of which had projected shortfalls in FY2005. For FY2006, unspent FY2003 allotments and a new appropriation under DRA were distributed among 12 shortfall states only. While this distribution was intended to cover the shortfalls among these states, a shortfall of $2.75 million remained due to a set-aside in the DRA appropriation for the territories.

The 109th Congress continues to face a *shrinking* pool of unspent funds to be reallocated among the states. With each passing year, more states have been able to spend their full allotments, leaving less and less funds to meet growing state financing needs. States' projected need for federal SCHIP funds for FY2007 points to a likely shortfall in 18 states.[26] In response, states may choose to cut back their

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[26] CRS has developed a model for projecting states' need for federal SCHIP funds based on current law assumptions. Results from this analysis are discussed in CRS Report RL32807, (continued...)

programs through reducing the number of beneficiaries, limiting benefits, lowering provider reimbursement rates, etc. However, it is important to note that when SCHIP was created under BBA 97, Congress intended for this program to be a capped federal grant to states, not an individual, open-ended entitlement; and SCHIP remains so today.

In addition, Congress will also be faced with reauthorizing SCHIP either this fiscal year or in FY2007, when the current period of authorization ends. Such reauthorization may further define the core populations to be served under SCHIP (i.e., children versus parents/caretaker relatives versus other adults), which may be incorporated in new criteria for distributing federal funds — both reallocation of unspent funds and new original allotments — among states into the future.

SCHIP Legislative History

Below is a summary of major SCHIP changes enacted in public laws beginning with the legislation authorizing the program in 1997:

Balanced Budget Act of 1997 (BBA 97), P.L. 105-33:

1. *Creation of SCHIP*. — Under BBA 97, the State Children's Health Insurance Program was established, effective August 5, 1997. A number of provisions specified eligibility criteria; coverage requirements for health insurance; federal allotments and the state allocation formula; payments to states and the enhanced FMAP formula; the process for submission, approval and amendment of state SCHIP plans; strategic objectives and performance goals, and plan administration; annual reports and evaluations; options for expanding coverage of children under Medicaid; and diabetes grant programs.

District of Columbia Appropriations Act of 1998, P.L. 105-100:

1. *Increased Appropriation.* This law increased the FY1998 SCHIP appropriation from $4.275 billion to $4.295 billion.

Omnibus Consolidated and Emergency Supplemental Appropriation Act, FY1999, P.L. 105-277:

1. *Increased Appropriation for Territories.* For FY1999, an additional appropriation of $32 million for the territories was provided, bringing the FY1999 total appropriation to $4.307 billion.

2. *Change in Allotment Formula Affecting Some Native American Children.* For FY1998 and FY1999, the law changed the annual state allotment formula by stipulating that children with access to health care funded by the Indian Health

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[26] (...continued)
SCHIP Financing: Funding Projections and State Redistribution Issues, by Chris L. Peterson.

Service and no other health insurance would be counted as uninsured (rather than as insured as required under the previously existing law).

The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 99), incorporated by reference in the Consolidated Appropriations Act for Fiscal Year 2000, P.L. 106-113:

1. *Stabilizing the SCHIP Allotment Formula.* Annual federal allotments to each state are determined in part by states' success in covering previously uninsured low-income children under SCHIP. Under prior law, the more successful a state was in enrolling children in SCHIP, especially early in the program, the greater the potential reduction in subsequent annual allotments. To limit the amount a state's allocation can fluctuate from one year to the next, BBRA 99 modified the allotment distribution formula and established new floors and ceilings.

2. *Targeted, Increased Allotments.* Additional allotments for the commonwealths and territories were provided for FY2000-FY2007.

3. *Improved Data Collection.* The law provided new funding for the collection of data to produce reliable, annual state-level estimates of the number of uninsured children. These data changes will improve research and evaluation efforts. They will also affect state-specific counts of the number of low-income children and the number of such children who are uninsured that feed into the formula that determines annual state-specific allotments from federal SCHIP appropriations.

4. *Federal Evaluation.* New funding was also provided for a federal evaluation[27] to identify effective outreach and enrollment practices for both SCHIP and Medicaid, barriers to enrollment, and factors influencing beneficiary drop-out.

5. *Additional Reports and a Clearinghouse.* The law also required (a) an inspector general audit[28] and GAO report on enrollment of Medicaid-eligible children in SCHIP,[29] (b) states to report annually the number of deliveries to pregnant women and the number of infants who receive services under the Maternal and Child Health Services Block Grant or who are entitled to SCHIP benefits, and (c) the Secretary of Health and Human Services to establish a clearinghouse for the consolidation and coordination of all federal databases and reports regarding children's health.

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[27] *Implementation of the State Children's Health Insurance Program: Momentum is Increasing After a Modest Start*, First Annual Report, Cambridge, MA: Mathematica Policy Research, Inc., Jan. 2001. For additional reports describing results from other components of the national evaluation of SCHIP, go to [http://aspe.os.dhhs.gov/health/schip/background.htm].

[28] The OIG has issued two audit reports: Department of Health and Human Services, Office of Inspector General, *State Children's Health Insurance Program: Assessment of State Evaluations Reports*, OEI-05-00-00240, Feb. 2001, and Department of Health and Human Services, Office of Inspector General, *State Children's Health Insurance Program: Ensuring Medicaid Eligibles are not Enrolled in SCHIP*, OEI-05-00-00241, Feb. 2001.

[29] U.S. General Accounting Office, *Children's Health Insurance: Inspector General Reviews Should Be Expanded to Further Inform the Congress*, GAO-02-512, Mar. 2002.

Agriculture Risk Protection Act of 2000, P.L. 106-224:

1. *Information Sharing*. This law allows schools operating federally subsidized school meal programs to take a more active role in identifying children eligible for, and enrolling such children in, the Medicaid and SCHIP programs. It permits schools to share income and other relevant information collected when determining eligibility for free and reduced-price school meals with state Medicaid and SCHIP agencies, as long as there is a written agreement that limits use of the information and parents are notified and given a chance to "opt out."

2. *Demonstration Project.* The law also establishes a demonstration project in one state in which administrative funds under the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to help identify children eligible for, and enroll such children in, the Medicaid and SCHIP programs.

Children's Health Act of 2000, P.L. 106-310:

1. *Rights of Institutionalized Children.* The law requires that general hospitals, nursing facilities, intermediate care facility and other health care facilities receiving federal funds, including SCHIP, protect the rights of each resident, including the right to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for the purposes of discipline or convenience. Restraints and seclusion may be imposed in such facilities only to ensure the physical safety of the resident, a staff member or others. Additional requirements govern reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement.

2. *Children's Rights in Community-Based Settings.* The law also includes requirements for protecting the rights of residents of certain non-medical, community-based facilities for children and adolescents, when that facility receives funding under this act or under Medicaid. (Existing regulations do not clarify if and how these rights apply to such facilities funded by SCHIP.) For such individuals and facilities, restraints and seclusion may only be imposed in emergency circumstances and only to ensure the physical safety of the resident, a staff member or others, and less restrictive interventions have been determined to be ineffective. Additional requirements govern reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement.

Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), incorporated by reference into the Consolidated Appropriations Act 2001, P.L. 106-554:

1. *Special Redistribution Rules for Unspent FY1998 and FY1999 Allotments.* For each of these years separately, a pool of unspent funds is created from the unused allotment amounts of those states that did not fully expend their original allotments within the applicable three-year time frame. From this pool, 1.05% is set aside for the territories that fully exhaust their original allotments. Each such territory receives a percentage of the available 1.05% pool equal to that territory's original allotment divided by the sum of original allotments for such territories. Then the states that *did* fully expend their original allotments within the three-year deadline receive access

to redistributed funds from the remaining pool equal to the amount by which their three-year spending exceeds their original allotments.[30] The remaining states that did *not* use all their original allotments for the year retain access to a portion of the remaining funds in the pool, equal to the ratio of such a state's unspent original allotment to the total amount of unspent funds for that fiscal year. These latter states are permitted to use up to 10% of their retained FY1998 funds for outreach activities. This allowance is over and above spending for such activities under the general administrative cap described above. The deadline for spending all redistributed and retained funds from FY1998 and FY1999 is September 30, 2002, although this date was extended by P.L. 108-74 as described below. (See the text for additional information on redistribution of unspent SCHIP funds.)

2. *Presumptive Eligibility.* Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards, until a final formal determination of eligibility is made. BIPA clarified states' authority to conduct presumptive eligibility determinations, as defined in Medicaid law, under separate (non-Medicaid) SCHIP programs.

3. *Authority to Pay SCHIP Medicaid Expansion Costs from Title XXI Appropriation.* Under prior law, states' allotments under SCHIP paid only the federal share of costs associated with separate (non-Medicaid) SCHIP programs. The federal share of costs associated with covering targeted low-income children under Medicaid was paid for by Medicaid. State SCHIP allotments were reduced by the amounts paid by Medicaid for such costs. BIPA authorized the payment of the costs of targeted low-income children under Medicaid, and the costs of benefits provided during periods of presumptive eligibility, from the SCHIP appropriation rather than the Medicaid appropriation, and as a conforming amendment, eliminated the requirement that state SCHIP allotments be reduced by these (former) Medicaid payments. Also, for FY1998-FY2000 only, BIPA authorized the transfer of unexpended SCHIP appropriations to the Medicaid appropriation account for the purpose of reimbursing payments made on behalf of targeted low-income children under Medicaid.

Public Health Security and Bioterrorism Preparedness and Response Act of 2002, P.L. 107-188:

1. *Waiver of Provider Requirements and Medicare+Choice Payment Limits.* The law authorizes the Secretary to temporarily waive conditions of participation and other certification requirements for any entity that furnishes health care items or services to Medicare, Medicaid, or SCHIP beneficiaries in an emergency area during a declared disaster or public health emergency. During such an emergency, the Secretary may waive: (a) participation, state licensing (as long as an equivalent license from another state is held and there is no exclusion from practicing in that state or any state in the emergency area), and pre-approval requirements for physicians and other practitioners; (b) sanctions for failing to meet requirements for emergency transfers between hospitals; (c) sanctions for physician self-referral; and (d) limitations on payments for health care and services furnished to individuals

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[30] For example, if a state's FY1998 allotment was $10 million, and the state's FY1998, FY1999 and FY2000 spending totaled $12 million, the state would receive access to a redistribution of $2 million.

enrolled in Medicare+Choice (M+C) plans when services are provided outside the plan. To the extent possible, the Secretary must ensure that M+C enrollees do not pay more than would have been required had they received care within their plan network.

2. *Notification to Congress*. The law also requires the Secretary to provide Congress with certification and written notice at least two days prior to exercising this waiver authority. It also provides for this waiver authority to continue for 60 days, and permits the Secretary to extend the waiver period.

3. *Evaluation.* The Secretary is further required, within one year after the end of the emergency, to provide Congress with an evaluation of this approach and recommendations for improvements under this waiver authority.

Health Care Safety Net Amendments of 2002, P.L. 107-251:

1. *Study of Migrant Farm Workers.* This law requires the Secretary to conduct a study of the problems experienced by farm workers and their families under Medicaid and SCHIP, specifically, barriers to enrollment, and lack of portability of Medicaid and SCHIP coverage for farm workers eligible in one state who move to other states on a periodic basis. The Secretary must also identify possible strategies to increase enrollment and access to benefits for these families. Strategies to be examined must include (a) use of interstate compacts to establish portability and reciprocity, (b) multi-state demonstration projects, (c) use of current law flexibility for coverage of residents and out-of-state coverage, (d) development of programs of national migrant family coverage, (e) use of incentives to private coverage alternatives, and (f) other solutions as deemed appropriate. In conducting the study, the Secretary must consult with several groups. The Secretary must submit a report on this study to the President and Congress in October 2003. This report shall address findings and conclusions and provide recommendations for appropriate legislative and administrative action.

State Children's Health Insurance Program Allotments Extension Act, P.L. 108-74:

1. *Extension of Available SCHIP Reallocated Funds from FY1998 and FY1999.* This law extends the availability of FY1998 and FY1999 reallocated funds through the end of FY2004 (rather than the end of FY2002).

2. *Revision of Methods for Reallocation of Unspent FY2000 and FY2001, and Extension of the Availability of Such Funds.* The law also establishes a new method for reallocating unspent funds from FY2000 and FY2001 allotments. For each of these years separately, a pool of unspent funds is created from the unused allotment amounts of those states that did not fully expend their original allotments within the applicable three-year time frame. From this pool, 1.05% is set aside for the territories that fully exhaust their original allotments. Each such territory receives a percentage of the available 1.05% pool equal to that territory's original allotment divided by the sum of original allotments for such territories. For each year separately, each state that does *not* spend its full original allotment by the three-year deadline retains 50% of its unspent funds. Then the remaining pool is allocated to each state that fully expends (exceeds) its original allotment by the three-year deadline. The redistribution amount for each such state is based on the proportion of its excess

spending relative to the total amount of excess spending for all such states. Reallocated funds for FY2000 and FY2001 are available until the end of FY2004 and FY2005, respectively.

3. *Authority for Qualifying States to Use Certain Funds for Medicaid Expenditures.* For specific expenditures occurring after August 15, 2003, the law permits certain states to apply federal SCHIP funds toward the coverage of certain children enrolled in regular Medicaid (not a SCHIP Medicaid expansion). Specifically, qualifying states may spend their available balances from FY1998-FY2001 (up to a maximum of 20% of those original allotments) for services delivered to Medicaid beneficiaries under age 19 who are not otherwise eligible for SCHIP and have family income that exceeds 150% of the FPL. For such services, these federal SCHIP funds can be used to pay the difference between the SCHIP enhanced federal matching rate and the regular Medicaid federal matching rate the state receives for these children. Qualifying states include those that on or after April 15, 1997 had an income eligibility standard of at least 185% of the FPL for at least one category of children, other than infants. (Other qualifications apply to states with statewide waivers under Section 1115 of the Social Security Act.) Under this law, the qualifying states included Connecticut, Minnesota, New Hampshire, Tennessee, Vermont, Washington, and Wisconsin. (See below for changes to this section of this law.)

Technical Corrections with Respect to the Definition of Qualifying State, P.L. 108-127:

1. *Change in the Income Standard and Applicable Dates.* This law modified P.L. 108-74 by changing the income eligibility standard affecting some qualifying states from 185% to 184% of the FPL. It also modified applicable dates with respect to certain states with Section 1115 waivers that covered children in families with income of at least 185% of the FPL. The effect of these changes was to add four states (i.e., Hawaii, Maryland, New Mexico, and Rhode Island) to the set of qualifying states, thus allowing them to also use certain funds for Medicaid expenditures (see above description for P.L. 108-74).

Deficit Reduction Act of 2005, P.L. 109-171:

1. *Additional allotments to eliminate FY2006 funding shortfalls.* This law appropriated $283 million for shortfall states and territories in FY2006. A shortfall state was defined as a state that the Secretary estimated would have expenditures in FY2006 that exceed the sum of all available SCHIP funds in that year (i.e., reallocated unspent FY2003 funds, balances remaining from FY2004 and FY2005 original allotments, and FY2006 original allotments), based on the most recent SCHIP data as of December 31, 2005. From the new FY2006 appropriation, after a 1.05% set-aside for the territories, each FY2006 shortfall state received an allotment intended to cover its projected shortfall. On October 1, 2006, any remaining unspent additional allotments revert to the Treasury. The additional FY2006 appropriation is restricted to payments for benefits provided to targeted low-income children only.

2. *Prohibition against covering non-pregnant, childless adults with SCHIP funds.* The Secretary of HHS is prohibited from approving new 1115 waivers, on or after October 1, 2005, that would use SCHIP funds to provide coverage to non-pregnant, childless adults. The Secretary may continue to approve projects that expand SCHIP

to caretaker relatives of Medicaid- or SCHIP-eligible children, and to pregnant adults. Existing waivers that use SCHIP funds to cover non-pregnant, childless adults (including extensions, amendments, and renewals of such waivers) that were approved before enactment of DRA are allowed to continue.

3. *Continued authority for qualifying states to use SCHIP funds for certain Medicaid expenditures.* The law allows qualifying states to use any available FY2001, FY2004, and FY2005 SCHIP funds (i.e., original allotments and/or reallocated funds, as applicable) for coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion) for such Medicaid payments made on or after October 1, 2005, up to the 20% allowance. See the discussion of P.L. 108-74 and P.L. 108-127 for more details.

Table 1. SCHIP Enrollment Data for the 50 States and the District of Columbia for FY2004

State	Date enrollment began	SCHIP upper income eligibility standard (% FPL)	FY2004 enrollment (number of children ever enrolled during year)			Adults ever enrolled in SCHIP demonstrations during FY2004
			Medicaid expansion	Separate child health program	Total	
Alabama (S)	2/1/98	200%		79,407	79,407	
Alaska (M)	3/1/99	175%	21,966		21,966	
Arizona (S)	11/1/98	200%		87,681	87,681	113,490
Arkansas [a] (M)	10/1/98	200%		799	799	
California (C)	3/1/98	250%	152,041	883,711	1,035,752	
Colorado[b] (S)	4/22/98	185%		57,244	57,244	NR
Connecticut (S)	7/1/98	300%		21,438	21,438	
Delaware (C)	2/1/99	200%	181	10,069	10,250	
District of Columbia (M)	10/1/98	200%	6,093		6,093	
Florida (C)	4/1/98	200%	2,031	417,676	419,707	
Georgia (S)	11/1/98	235%		280,083	280,083	
Hawaii (M)	7/1/00	200%	19,237		19,237	
Idaho (M)	10/1/97	185%	17,879	1,175	19,054	
Illinois (C)	1/5/98	200%	95,522	138,505	234,027	120,152
Indiana (C)	10/1/97	200%	55,187	25,511	80,698	
Iowa (C)	7/1/98	200%	14,996	26,640	41,636	
Kansas (S)	1/1/99	200%		44,350	44,350	
Kentucky (C)	7/1/98	200%	60,496	34,004	94,500	
Louisiana (M)	11/1/98	200%	105,580		105,580	
Maine (C)	7/1/98	200%	20,204	8,967	29,171	
Maryland (C)	7/1/98	300%	101,664	9,824	111,488	
Massachusetts (C)	10/1/97	200%	119,377	47,131	166,508	
Michigan (C)	5/1/98	200%	31,427	56,136	87,563	132,590
Minnesota (C)	10/1/98	280%	110	4674	4784	39,571
Mississippi (S)	7/1/98	200%		82,900	82,900	
Missouri (M)	9/1/98	300%	176,014		176,014	
Montana (S)	1/1/99	150%		15,281	15,281	
Nebraska (M)	5/1/98	185%	33,314		33,314	
Nevada (S)	10/1/98	200%		38,519	38,519	
New Hampshire (C)	5/1/98	300%	598	10,371	10,969	
New Jersey (C)	3/1/98	350%	39,870	87,374	127,244	88,826
New Mexico (M)	3/31/99	235%	20,804		20,804	
New York (C)	4/15/98	250%	136476	690,135	826,611	
North Carolina (S)	10/1/98	200%		174,434	174,434	
North Dakota (C)	10/1/98	140%	1,845	3,292	5,137	
Ohio (M)	1/1/98	200%	220,190		220,190	
Oklahoma (M)	12/1/97	185%	100,761		100,761	
Oregon (S)	7/1/98	185%		46,720	46,720	4,294
Pennsylvania (S)	5/28/98	200%		177,415	177,415	

State	Date enrollment began	SCHIP upper income eligibility standard (% FPL)	FY2004 enrollment (number of children ever enrolled during year)			Adults ever enrolled in SCHIP demonstrations during FY2004
			Medicaid expansion	Separate child health program	Total	
Rhode Island (C)	10/1/97	250%	24,089	1,484	25,573	23,327
South Carolina (M)	10/1/97	185%	75,597		75,597	
South Dakota (C)	7/1/98	200%	10,338	3,059	13,397	
Tennessee [c] (M)	10/1/97					
Texas (S)	7/1/98	200%		650,856	650,856	
Utah (S)	8/3/98	200%		38,693	38,693	
Vermont (S)	10/1/98	300%		6,693	6,693	
Virginia (C)	10/22/98	200%	41,651	57,918	99,569	
Washington (S)	2/1/00	250%		17,002	17,002	
West Virginia (S)	7/1/98	200%		36,906	36,906	
Wisconsin (M)	4/1/99	185%	67,893		67,893	123,999
Wyoming (S)	12/1/99	185%		5,525	5,525	
Total	—	—	1,773,431	4,379,602	6,153,033	646,159

Source: Data on date enrollment began is from the Centers for Medicare and Medicaid Services, *The State Children's Health Insurance Program, Annual Enrollment Report Federal Fiscal Year 2001: October 1, 2000-September 30, 2001,* Feb. 6, 2002. The SCHIP upper income eligibility standards are taken from **Table 1** in *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Families and Children*, by Donna Ross and Laura Cox, The Kaiser Commission on Medicaid and the Uninsured, Oct. 2004. The state-reported SCHIP enrollment figures are taken from Centers for Medicare and Medicaid Services, *Revised FY2004 Number of Children Ever Enrolled in SCHIP by Program Type,* May 23, 2005. For states with combination programs, the "total" column shows the sum of the unduplicated number of children ever enrolled in the SCHIP Medicaid expansion program during the year and the unduplicated number of children ever enrolled in the separate SCHIP program during the year. Because a child may be enrolled in both programs during the year, there may be some double counting of children enrolled in these states. SCHIP enrollment figures for the territories are not available.

Notes: S — Separate child health programs; M — Medicaid expansion programs; C — Combination programs. NR — Indicates that state has not reported data via the SCHIP Statistical Enrollment Data System (SEDS). FPL = poverty level.

a. Arkansas did not report enrollment data for its SCHIP Medicaid expansion in the SEDS database for FY2004. Under its comprehensive Medicaid Section 1115 waiver, this state uses a combination of Medicaid and SCHIP funds to cover uninsured children through age 18 in families with income up to 200% FPL. Waiver documents indicate that 77,246 children were enrolled in this demonstration as of January 2004.

b. Colorado reported in a letter that due to a new system they were only able to provide accurate data for 10.5 months for FY2004.

c. Tennessee 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 October 1997 through FY2002. In that year, 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 October 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 no SCHIP enrollment subsequent to FY2002.

Table 2. States Qualifying for Redistribution of Unspent FY1998-FY2003 Original Allotments

State	Exhausted FY1998 allotment by FY2001	Exhausted FY1999 allotment by FY2002	Exhausted FY2000 allotment by FY2003	Exhausted FY2001 allotment by FY2004	Exhausted FY2002 allotment by FY2005	Exhausted FY2003 allotment by FY2006
Alabama					Yes	Yes
Alaska	Yes	Yes	Yes	Yes	Yes	Yes
Arizona				Yes	Yes	Yes
Arkansas						Yes
California						Yes
Colorado						Yes
DC						Yes
Florida				Yes	Yes	Yes
Georgia				Yes	Yes	Yes
Hawaii						Yes
Illinois					Yes	Yes
Indiana	Yes	Yes				Yes
Iowa					Yes	Yes
Kansas			Yes	Yes	Yes	Yes
Kentucky	Yes	Yes	Yes	Yes	Yes	Yes
Louisiana					Yes	Yes
Maine	Yes	Yes	Yes	Yes	Yes	Yes
Maryland	Yes	Yes	Yes	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes	Yes	Yes
Michigan					Yes	Yes
Minnesota			Yes	Yes	Yes	Yes
Mississippi			Yes	Yes	Yes	Yes
Missouri	Yes	Yes			Yes	Yes
Montana					Yes	Yes
Nebraska				Yes	Yes	Yes
New Jersey		Yes	Yes	Yes	Yes	Yes
New York	Yes	Yes	Yes	Yes	Yes	Yes
North Carolina	Yes	Yes		Yes	Yes	Yes
North Dakota						Yes
Ohio					Yes	Yes
Oklahoma						Yes
Pennsylvania	Yes				Yes	Yes
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes
South Carolina	Yes	Yes	Yes			Yes
South Dakota				Yes	Yes	Yes
Utah						Yes
Virginia						Yes
West Virginia			Yes	Yes	Yes	Yes
Wisconsin		Yes	Yes	Yes	Yes	Yes
Wyoming						Yes
US	12	13	14	19	28	40

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

Note: All reallocated (redistributed and retained) funds for FY1998-FY2000 were available through FY2004. All reallocated funds for FY2001 and FY2002 were available through FY2005. Although 40 states qualified for the redistribution of other states' unspent FY2003 original allotments, only four states (those that are facing shortfalls of federal SCHIP funds in FY2006 and that cover adults in their SCHIP programs — Illinois, Minnesota, New Jersey and Rhode Island) received these funds.

Table 3. Status of FY1998-FY2005 Federal SCHIP Funds, by State and Territory

(millions of dollars)

States and territories	FY1998-FY2005 original SCHIP allotments	Net funds gained (forfeited) through reallocation of FY1998-FY2002 original allotments[a]	Federal SCHIP expenditures through the end of FY2005	Amount of expired FY1998-FY2002 reallocated SCHIP funds through the end of FY2005
Alabama	$541.1	($72.9)	$378.3	
Alaska	$61.0	$97.5	$134.3	$8.6
Arizona	$856.1	$25.0	$856.6	
Arkansas	$357.5	($134.0)	$130.5	$11.2
California	$5,454.4	($1,454.9)	$3,009.3	
Colorado	$349.9	($54.9)	$193.0	
Connecticut	$263.3	($82.9)	$109.5	
Delaware	$69.7	($25.0)	$23.5	
DC	$78.5	($24.3)	$37.7	
Florida	$1,780.4	$49.6	$1,426.5	
Georgia	$952.9	($36.9)	$835.4	
Hawaii	$80.7	($23.9)	$38.1	
Idaho	$141.5	($20.3)	$83.3	
Illinois	$1,087.1	($228.0)	$818.2	
Indiana	$492.1	$66.6	$439.0	
Iowa	$221.8	($10.8)	$190.8	
Kansas	$219.3	$31.6	$201.7	
Kentucky	$381.4	$239.9	$429.4	$98.5
Louisiana	$637.1	($127.3)	$423.2	
Maine	$94.0	$49.7	$115.8	$5.9
Maryland	$383.3	$389.9	$684.9	$8.1
Massachusetts	$386.5	$216.5	$501.9	$31.3
Michigan	$798.0	($152.6)	$521.3	
Minnesota	$255.5	$39.4	$273.9	
Mississippi	$386.4	$80.8	$450.9	
Missouri	$411.8	$41.2	$415.9	
Montana	$96.5	($5.2)	$70.0	
Nebraska	$125.9	$0.1	$125.4	
Nevada	$252.1	($59.2)	$117.5	
New Hampshire	$80.3	($30.0)	$28.6	
New Jersey	$660.0	$530.6	$1,140.9	
New Mexico	$374.1	($144.3)	$88.9	$33.1
New York	$2,067.0	$1,788.2	$2,417.5	$951.1

States and territories	FY1998-FY2005 original SCHIP allotments	Net funds gained (forfeited) through reallocation of FY1998-FY2002 original allotments[a]	Federal SCHIP expenditures through the end of FY2005	Amount of expired FY1998-FY2002 reallocated SCHIP funds through the end of FY2005
North Carolina	$710.5	$165.1	$765.2	
North Dakota	$44.9	($7.5)	$28.4	
Ohio	$955.4	($14.2)	$804.7	
Oklahoma	$509.0	($170.7)	$255.3	
Oregon	$335.7	($112.0)	$134.9	
Pennsylvania	$934.4	($33.1)	$705.5	
Rhode Island	$71.7	$114.3	$185.9	
South Carolina	$451.1	$144.0	$359.1	$152.2
South Dakota	$58.9	($1.0)	$50.4	
Tennessee	$549.7	($189.1)	$68.0	$97.3
Texas	$3,469.5	($808.1)	$1,856.8	
Utah	$209.3	($11.4)	$146.1	
Vermont	$31.9	($6.2)	$16.8	
Virginia	$525.4	($133.6)	$286.2	
Washington	$414.1	($142.3)	$109.8	$11.5
West Virginia	$167.8	$24.7	$150.9	
Wisconsin	$354.8	$141.5	$437.2	
Wyoming	$51.7	($18.7)	$22.0	
Puerto Rico	$261.0	$90.9	$299.3	
Guam	$10.0	$3.5	$13.5	
Virgin Islands	$7.4	$2.6	$8.6	
American Samoa	$3.4	$1.2	$6.2	
N. Mariana Islands	$3.1	$1.1	$8.3	
Total	$30,528	$0	$23,431	$1,409

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

Note: Data are not additive across columns. For example, original allotments for FY2004 and FY2005 remain available to states beyond FY2005, while other accounts have closed or expired.

a. These reallocations were first active in FY2001-FY2005, respectively.

Table 4. Status of FY2006 Federal SCHIP Funds, by State and Territory

(millions of dollars)

State	Original FY2006 SCHIP allotments	Available balances from original FY2004 and FY2005 allotments	Net funds gained (forfeited) through reallocation of unspent FY2003 original allotments plus DRA appropriation [a]	Total amount available in FY2006 [b]	States' FY2006 spending estimate [c]
Alabama	$64.2	$90.0		**$154.1**	$95.0
Alaska	$9.1	$15.6		**$24.7**	$23.8
Arizona	$107.4	$24.5		**$131.9**	$110.5
Arkansas	$43.8	$81.8		**$125.6**	$47.2
California	$646.7	$990.2		**$1,636.9**	$1,147.0
Colorado	$58.0	$102.1		**$160.0**	$51.4
Connecticut	$34.5	$64.5	($6.4)	**$99.1**	$18.7
Delaware	$9.0	$16.9	($4.3)	**$25.9**	$7.1
DC	$9.6	$16.6		**$26.1**	$8.2
Florida	$249.3	$403.5		**$652.9**	$374.9
Georgia	$129.5	$80.6		**$210.1**	$201.6
Hawaii	$12.4	$18.7		**$31.1**	$13.6
Idaho	$20.6	$37.7	($0.2)	**$58.3**	$26.7
Illinois	$169.2	$40.9	$117.5	**$327.6**	$328.5
Indiana	$73.0	$119.7		**$192.7**	$81.4
Iowa	$27.0	$20.2	$6.1	**$53.3**	$53.3
Kansas	$27.5	$49.1		**$76.6**	$50.4
Kentucky	$57.8	$93.3		**$151.1**	$78.1
Louisiana	$77.1	$86.6		**$163.8**	$135.2
Maine	$11.9	$21.9		**$33.9**	$24.0
Maryland	$48.7	$80.3	$13.7	**$142.7**	$142.7
Massachusetts	$59.4	$69.8	$21.9	**$151.1**	$151.1
Michigan	$117.2	$124.2		**$241.4**	$176.7
Minnesota	$39.4	$21.0	$20.1	**$80.4**	$80.6
Mississippi	$49.9	$16.3	$73.6	**$139.8**	$139.8
Missouri	$56.3	$37.1	$8.0	**$101.3**	$101.3
Montana	$12.6	$21.3		**$33.8**	$15.9
Nebraska	$16.8	$0.6	$15.7	**$33.2**	$33.2
Nevada	$41.9	$71.6	($3.9)	**$113.4**	$28.2
New Hampshire	$9.2	$17.3	($4.5)	**$26.5**	$8.6
New Jersey	$89.5	$49.8	$105.6	**$244.8**	$245.7

State	Original FY2006 SCHIP allotments	Available balances from original FY2004 and FY2005 allotments	Net funds gained (forfeited) through reallocation of unspent FY2003 original allotments plus DRA appropriation [a]	Total amount available in FY2006 [b]	States' FY2006 spending estimate [c]
New Mexico	$42.2	$74.9	($32.8)	**$117.1**	$34.2
New York	$272.5	$486.6		**$759.1**	$395.0
North Carolina	$110.3	$110.3	$2.8	**$223.4**	$223.4
North Dakota	$6.3	$9.0		**$15.4**	$14.3
Ohio	$124.6	$136.5		**$261.1**	$179.1
Oklahoma	$57.4	$83.1		**$140.4**	$69.8
Oregon	$46.9	$85.3	($3.5)	**$132.2**	$21.9
Pennsylvania	$134.1	$195.9		**$330.0**	$151.7
Rhode Island	$9.8	$0.2	$66.1	**$76.1**	$76.8
South Carolina	$55.5	$83.7		**$139.3**	$59.1
South Dakota	$7.8	$7.5	$0.5	**$15.9**	$15.9
Tennessee	$80.4	$136.9	($58.4)	**$217.3**	$3.6
Texas	$454.7	$780.8	($23.8)	**$1,235.6**	$365.5
Utah	$32.2	$51.8		**$84.0**	$38.2
Vermont	$4.8	$8.7	($0.1)	**$13.5**	$2.8
Virginia	$72.3	$105.6		**$177.9**	$96.4
Washington	$64.7	$115.0	($35.5)	**$179.7**	$38.5
West Virginia	$23.3	$41.6		**$64.9**	$37.3
Wisconsin	$55.8	$59.1		**$114.9**	$96.3
Wyoming	$5.9	$11.1		**$16.9**	$6.7
Puerto Rico	$39.0	$52.6	$4.4	**$95.9**	$41.9
Guam	$1.5	$0.0	$0.2	**$1.7**	$2.0
Virgin Islands	$1.1	$1.4	$0.1	**$2.6**	$1.5
American Samoa	$0.5	$0.0	$0.1	**$0.6**	$0.7
N. Mariana Islands	$0.5	$0.0	$0.1	**$0.5**	$1.4
National total	$4,082.4	$5,521.1	$283.0	**$10,059.9**	$5,974.4

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

a. Redistributed FY2003 funds and the Deficit Reduction Act of 2005 (DRA) appropriation of $283 million for SCHIP are active only during FY2006. States with blank cells in this column exhausted their FY2003 allotments by the three-year deadline and did not face shortfalls in FY2006. In prior reallocations, all such states received a portion of unspent funds available for redistribution. The unspent FY2003 funds went only to states expected to have shortfalls in FY2006.

b. This column shows the sum of only the positive numbers in the previous three columns. In the third column, the negative numbers in parentheses refer to amounts unspent and forfeited at the

end of FY2005, and thus were no longer available to these states at the beginning of FY2006. For states with negative values in the third column, this column is equal to the sum of the first and second columns.

c. Data reported by states to CMS as of December 2005.