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SCHIP Financing: Funding Projections and State Redistribution Issues

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Summary

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) created the State Children's Health Insurance Program (SCHIP), which has authorized appropriations through FY2007. The purpose of the program is to help states pay for health coverage of uninsured children in families whose income is above levels that would allow them to be eligible for the state's Medicaid program as of March 31, 1997.

At the time of enactment, Congress appropriated to SCHIP nearly $40 billion for the 10-year period of FY1998-FY2007, with each state receiving access to a portion of the annual amount. Because SCHIP is a capped-grant program, it is possible for states to exhaust all of the federal SCHIP funds available to them in a given year.

Prior to FY2006, only one state exhausted all of its available federal SCHIP funds in a single year. Alaska faced shortfalls in FY2000 ($419,000) and FY2001 ($2,000). Rhode Island faced shortfalls in FY2003 ($30,000) and FY2004 ($19 million). These states had the option to file most of their SCHIP claims under regular Medicaid when their SCHIP funds were exhausted. By claiming under Medicaid, however, they received a 17% to 19% smaller federal payment than they would have received under SCHIP for those claims.

Six states faced a shortfall of federal SCHIP funds in FY2005 (Arizona, Minnesota, Mississippi, Nebraska, New Jersey, and Rhode Island). However, the Secretary of Health and Human Services was able to target unspent FY2002 allotments from other states to cover these six states' shortfalls. As a result, no state finished FY2005 with a shortfall of federal SCHIP funds.

The methodology that eliminated the FY2005 shortfalls could not cover the FY2006 projected shortfalls. In an effort to cover the remaining projected shortfalls, Congress appropriated $283 million in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). This eliminated the FY2006 shortfalls in all but two states — Illinois (approximately $95 million) and Massachusetts (approximately $7 million).

In the waning hours of the 109th Congress, the National Institutes of Health (NIH) Reform Act of 2006 (H.R. 6164, P.L. 109-482) was passed, which included SCHIP provisions to address states' shortfalls. The goal of the SCHIP provisions was to delay as long as possible the date in FY2007 on which any state faces a shortfall. The law provides additional funding, projected at $124 million, from other states' unspent FY2005 allotments and is projected to delay shortfalls until the first week of May. Even with the SCHIP provisions of H.R. 6164, the shortfalls for the remainder of the fiscal year are projected at $745 million in 14 states. However, all but three of these states (Georgia, Minnesota, and Mississippi) are permitted to receive Medicaid funds for at least a portion of their shortfall amount.

This report describes federal SCHIP financing and provides state-level projections of FY2007 shortfalls and an analysis of the situation moving forward.

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The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) created the State Children's Health Insurance Program (SCHIP). The purpose of the program is to help states pay for health insurance coverage of uninsured children in families whose income is above the levels that would allow them to be eligible for the state's Medicaid program as of March 31, 1997.[1] States can cover SCHIP enrollees by expanding their Medicaid program or by creating a separate SCHIP program, or by a combination of both.

At the time of enactment, Congress appropriated to SCHIP nearly $40 billion for the 10-year period of FY1998-FY2007, as shown in **Table 1**, with each state entitled to a portion of the annual amount based on a formula.[2] Amounts unspent after three years, also shown in **Table 1**, are available to other states that exhausted that particular year's allotment.[3]

Because SCHIP is a capped-grant program, it is possible for states to exhaust all of the federal SCHIP funds available to them in a given year. For a state to experience such a shortfall, it would have to exhaust all of its available allotments as well as the available funds that had been redistributed to it from other states. Prior to FY2006, no more than one state had ever exhausted all of its available federal SCHIP funds in a single year. Alaska faced shortfalls in FY2000 ($419,000) and FY2001 ($2,000). Rhode Island faced shortfalls in FY2003 ($30,000) and FY2004 ($19 million). These states had the option to file most of their SCHIP claims under regular Medicaid when their SCHIP funds were exhausted. By claiming under Medicaid, however, they received a 17% to 19% smaller federal payment than they would have received under SCHIP for those claims. No state experienced a shortfall in FY2005. Shortfalls were experienced by Illinois ($95 million) and Massachusetts ($7 million) in FY2006. Fourteen states are projected to face shortfalls in FY2007, totaling $745 million. This report describes federal SCHIP financing and provides state-level projections of shortfalls and the impact of proposals to reduce or eliminate them.

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[1] For a more in-depth overview of the program, see CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz and Chris L. Peterson.

[2] For information on the formula for determining states' SCHIP original allotments, see CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson.

[3] In this report, "balances," "spending," and "expenditures" refer only to the federal dollars available, paid or claimed through the enhanced SCHIP match; states' matching expenditures are not provided or discussed in this report.

Table 1. National Figures on Federal SCHIP Financing

(in millions of dollars)

Fiscal year	SCHIP allotments	Allotments unspent after 3 years	Spending	Total amount of shortfalls	Number of shortfall states	Funds expiring
1998	$4,235		$122			
1999	$4,247		$922			
2000	$4,249		$1,929	[a]	1	
2001	$4,249	$2,034	$2,672	[a]	1	
2002	$3,115	$2,819	$3,776			
2003	$3,175	$2,206	$4,276	[a]	1	
2004	$3,175	$1,749	$4,645	$19	1	$1,281
2005	$4,082	$643	$5,089			$128
2006	$4,082	$173	$5,556	$102	2	
2007	$5,040	$147	*$6,395*	*$745*	*14*	

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

Note: Projected amounts are italicized.

a. Less than $1 million.

If Congress intends to cover state shortfalls of federal SCHIP funds in FY2007, legislative action would be needed. If, however, Congress decides that the intent of the original legislation was to ensure states did not treat the program as an open-ended entitlement, no action would be necessary. States with annual SCHIP spending well in excess of their annual allotments would then face the consequences of that spending through the shortfall of federal funds.

Beyond FY2007, assuming that annual allotments continue at the FY2007 level of $5 billion,[4] many more states are poised to exhaust their federal SCHIP funds beyond FY2007. This is because 34 states are projected to spend more than they received in their FY2007 annual allotment. More than half of these do not face FY2007 shortfalls because of balances remaining from prior years. But with no other changes, as those balances are used up and projected spending continues to exceed the annual allotments, additional shortfalls are inevitable in the long run. Thus, in the future, the funding formula may therefore determine not only how the annual allotments are distributed among states but, in the process, how potential shortfalls are distributed among states.

[4] In making its cost estimates, the Congressional Budget Office (CBO) is required to assume that programs in existence on or before the enactment of BBA97 (which would include SCHIP) that lack future appropriations but with current-year outlays of at least $50 million will continue operating at the last appropriated level. SCHIP's last appropriated level is approximately $5 billion in FY2007. Thus, legislation that simply appropriates $5 billion annually beyond FY2007 would not be scored by CBO as increasing federal government spending above its current baseline.

SCHIP Financing and Spending Overview

States that set up an SCHIP program are entitled to federal reimbursement, up to a cap, for a percentage of the incurred costs of covering enrolled individuals. This percentage, which varies by state, is called the enhanced Federal Medical Assistance Percentage (FMAP). It is based on the FMAP used for the Medicaid program but is higher in SCHIP than in Medicaid. In other words, the federal government contributes more toward the coverage of individuals in SCHIP (65% to 83% in FY2007) than it does for those covered under Medicaid (50% to 76% in FY2007).[5]

States are reimbursed for their SCHIP costs up to a capped amount. Nationally, the total annual federal allotments range from $3.1 billion (FY2002) to $5.0 billion (FY2007). The amount available to each state is determined annually through a formula that takes into account factors such as the state's number of low-income uninsured children.[6] State allotment amounts are published annually in the *Federal Register* for each upcoming fiscal year.

BBA 97 established that a state's allotment for a given year is available for use for three years. For example, each state's FY2003 allotment was available through FY2005 (September 30, 2005). At the end of the three years, if there is still a balance in that "pot" of money, BBA 97 requires that the Secretary of Health and Human Services redistribute that money to those states which had exhausted that pot. Those states that exhausted a given year's pot are called redistribution states for that year. Under BBA 97, redistributed funds are available to those states for one year, after which the money expires, reverting back to the Treasury. Congress intervened to permit states to retain a portion of their FY1998-FY2001 original allotments unspent after three years. Congress also specified how the funds not retained would be redistributed. Any balances remaining from the FY1998-FY2000 reallocated funds expired at the end of FY2004. Of the FY1998-FY2000 reallocated funds, $1.28 billion expired at the end of FY2004, as shown in **Table 1**.

FY2005. Beginning with the redistribution of unspent FY2002 funds that went to other states in FY2005, the original BBA 97 provisions applied to redistribution. This meant that no state would retain any leftover FY2002 balance after having had access to it for three years. Moreover, the amounts would be redistributed as determined by the Secretary. As in previous reallocations, the territories received 1.05% of the total unspent funds from states' FY2002 allotments.[7] The remainder of the redistribution took place as follows: States that were projected to exhaust all

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[5] Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2006 Through September 30, 2007," 70 *Federal Register* 71856, November 30, 2005, and 71 *Federal Register* 28041, May 15, 2006.

[6] For information on the formula for determining states' SCHIP original allotments, see CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson.

[7] The five territories (and commonwealths) are American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

of their available federal SCHIP balances in FY2005, based on their estimated FY2005 expenditures and their own available balances of federal SCHIP funds, received redistribution money equal to that estimated shortfall. These six states were Arizona, Minnesota, Mississippi, Nebraska, New Jersey, and Rhode Island. The remaining balance of unspent FY2002 funds was divided among the 28 redistribution states, including the six that had received funds to cover their initial projected shortfalls.

As a result of this redistribution, no state experienced a shortfall of federal SCHIP funds in FY2005. Also according to BBA 97, this reallocation pot expired at the end of one year. As a result, at the end of FY2005, $56 million of these redistributed funds reverted to the Treasury. This amount, combined with the expired FY2001 reallocation funds, totaled $128 million in federal SCHIP funds that expired at the end of FY2005.

FY2006. The initial redistribution of unspent FY2003 original allotments and the allocation of the $283 million DRA appropriation for SCHIP, both of which were to be available for spending in FY2006 only, were announced by the Centers for Medicare and Medicaid (CMS) on April 21, 2006.[8] The amounts from both accounts were determined by the HHS Secretary, based on his broad discretion to allocate the funds to the FY2006 shortfall states.[9]

DRA said that "the Secretary shall allot to each shortfall State described in paragraph (2) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State." Paragraph (2) of §2104(d) defined shortfall states as those that projected their FY2006 expenditures to exceed the amounts available from (i) their balances of the FY2004 and FY2005 original allotments, (ii) the redistribution of funds from other states' unspent FY2003 original allotments, and (iii) the newly available FY2006 original allotment. Taking these funds into account, a shortfall of approximately $283 million was projected for the states. This was the basis for the $283 million appropriated in DRA.

However, DRA also included a provision that the territories would receive 1.05% of the $283 million appropriation (approximately $3 million). This percentage was consistent with the share the territories historically received of the total annual original allotment and redistribution funds. The $3 million from the DRA funds for the territories meant that the Secretary would not be able to eliminate

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[8] Centers for Medicare & Medicaid Services, "State Children's Health Insurance Program (SCHIP); Redistribution of Unexpended SCHIP Funds From the Appropriation for Fiscal Year 2003; Additional Allotments to Eliminate SCHIP Fiscal Year 2006 Funding Shortfalls; and Provisions for Continued Authority for Qualifying States to Use a Portion of Certain SCHIP Funds for Medicaid Expenditures," 71 *Federal Register* 20697-20707, April 21, 2006.

[9] The funds from FY2003 available for redistribution could have gone to all redistribution states (those that had exhausted their FY2003 original allotment), but the Secretary targeted this redistribution to shortfall states, as was done in the redistribution of unspent FY2002 funds. In that year's redistribution, however, there was enough money to cover the shortfalls and provide funds to all redistribution states. For the redistribution of FY2003 funds, all the money went only to the states projected to face shortfalls.

the states' shortfalls altogether, based on the projections at the time. In addition, the DRA funds came with restrictions: "Additional allotments provided under this subsection [the $283 million] are only available for amounts expended under a State plan approved under this title for child health assistance for targeted low-income children." This prohibited states from using the DRA funds to pay for benefits provided to adult SCHIP enrollees. Both of these factors — the DRA appropriation carved out for territories and the prohibition against spending on adults — raised the prospect that the Secretary would be unable to "eliminate the estimated shortfall." Based on the states' FY2006 spending projections used at that time (from November 2005), DRA and FY2003 redistributed funds were provided to a dozen states, with four that covered adults (Illinois, Minnesota, New Jersey, and Rhode Island) projected to still experience shortfalls totaling just under $3 million.

By the end of FY2006, all but two of the states that initially projected shortfalls experienced lower federal SCHIP spending than what they had projected when DRA was developed. As a result, Illinois and Massachusetts, which experienced higher-than-projected SCHIP expenditures, were the only states to experience federal SCHIP shortfalls in FY2006. Both states stopped claiming SCHIP funds before exhausting every dollar in their SCHIP accounts, leaving nominal balances. But Illinois estimated that its shortfall of federal SCHIP funds in FY2006 was approximately $95 million and Massachusetts' was approximately $7 million. In other words, these are the amounts of additional federal SCHIP spending these two states would have had in FY2006 if the funds were available. The options these states tended to use in response to these shortfalls was (1) to delay claiming until the beginning of FY2007, when the new original allotment was available (although this would merely add to their FY2007 shortfall), and/or (2) to receive Medicaid funding for eligible claims, although at the regular FMAP rather than the enhanced SCHIP FMAP.

Projections of States' FY2007 Federal SCHIP Shortfalls

In FY2007, $147 million in unspent *FY2004* original allotments will be redistributed. In the closing hours of the 109th Congress, a bill was passed to specify how those funds are to be redistributed. The National Institutes of Health (NIH) Reform Act of 2006 (H.R. 6164, P.L. 109-482) requires that the funds go to states "in the order in which such [shortfall] States realize monthly funding shortfalls ... for fiscal year 2007." The purpose is to delay any state facing a shortfall as far into the year as possible with the available funds. CRS projections indicate that this particular provision would delay shortfalls until the end of March. To delay shortfalls even further, the SCHIP provisions of H.R. 6164 call for an initial redistribution of up to half of unspent *FY2005* original allotments as of March 31, 2007 (capped at $20 million per state) — after 2½ years of availability. For a state to forgo unspent FY2005 funds on that date, H.R. 6164 requires not only that the state have unspent FY2005 balances but that the state's *total* SCHIP balances (from the FY2005-FY2007 original allotments) as of March 31, 2007, are at least double what the state projects to spend in federal SCHIP funds in FY2007. CRS projects this provision will provide an additional $124 million for shortfall states and will delay the exhaustion of federal SCHIP funds by any state until the first week of May

2007. The shortfalls remaining for the rest of the fiscal year are projected at $745 million in 14 states.[10]

Table 2 shows states' federal SCHIP balances as of the beginning of FY2007 along with projections of the impact of the SCHIP provisions of H.R. 6164 on the initial redistribution of unspent FY2005 funds on March 31, 2007. Taking these projections into account, as well as states' own projections of total federal SCHIP spending, **Table 2** also shows states' projected total end-of-year balances of federal SCHIP funds. The shortfall states are shaded in the table and show negative balances in the last column. For the most recent information on states' SCHIP upper-income eligibility levels and their number of children and adult enrollees, see **Table 1** of CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz and Chris L. Peterson, available at [http://www.congress.gov/erp/rl/pdf/RL30473.pdf].

No single factor can be pinpointed as causing shortfalls among all of these states. For example, there are five shortfall states that cover adults — but not all shortfall states cover adults, and not all states that cover adults face shortfalls. A relatively high FMAP means that for the same amount of *total* SCHIP expenditures (including the state's share) a state will exhaust its federal SCHIP balances faster than a state with the same total expenditures but with a relatively low FMAP. The list of shortfall states includes those with the highest FMAP in the country (Mississippi) and five states with the lowest allowable FMAP. Similarly, the upper-income eligibility levels among the shortfall states range from a relatively low 175% of poverty to the nation's highest level of 350% of poverty. Shortfall states with relatively low upper-income eligibility levels believe their shortfalls are at least partly the fault of the SCHIP funding formula and the data on which it is based.[11]

Another of the many contributing factors to the multi-state FY2007 projected shortfalls is the relatively small amount of money available for redistribution in FY2007. The largest amount unspent from any original allotment after three years was $2.8 billion, as shown in **Table 1**. This was from the FY1999 allotment, available for redistribution in FY2002. Since that year, the amount available for redistribution has steadily declined. The unspent FY2004 funds available for redistribution to the shortfall states in FY2007 is projected to be $147 million — a mere 5% of the unspent FY1999 original allotment. This decline has resulted from states that once surrendered a much larger amount of funds to redistribution increasing their own federal SCHIP spending, primarily through increased enrollment.

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[10] For additional detail on the legislation and its projected impact on SCHIP, see CRS Report RS22553, *SCHIP Provisions of H.R. 6164 (NIH Reform Act of 2006)*, by Chris L. Peterson.

[11] See comments from state officials in CRS Congressional Distribution memorandum, "Status of Federal SCHIP Financing Among Nine States Reporting Identical Lower- and Upper-Income SCHIP Eligibility Levels," by Chris L. Peterson, September 12, 2006, available upon request. For information on the formula for determining states' SCHIP original allotments, see CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson.

Table 2. Projected Redistribution, Spending, and Balances of Federal SCHIP Funds, FY2007

(millions of dollars)

A	B	C	D	E	F	G	H	I=H-G
State	**Projected redistribution of unspent FY2004 allotments[a]**	**Balance of FY2005 original allotments**	**Balance of FY2006 original allotments**	**FY2007 SCHIP original allotments**	**Projected redistribution of unspent FY2005 allotments on 3/31/07[b]**	**Projected total amount available in FY2007**	**States' FY2007 spending estimate[c]**	**Projected end-of-FY2007 balance**
Alabama		$2.6	$64.2	$74.3		$141.0	$98.6	$42.4
Alaska			$5.2	$11.5	$1.0	$17.7	$30.2	($12.5)
Arizona			$22.9	$127.9		$150.8	$115.1	$35.6
Arkansas		$32.2	$43.8	$49.3		$125.3	$54.3	$70.9
California			$486.0	$790.8		$1,276.8	$1,103.3	$173.5
Colorado		$41.8	$58.0	$71.5	($5.0)	$166.3	$63.5	$102.8
Connecticut	($7.5)	$36.6	$34.5	$39.9	($11.8)	$99.2	$25.9	$73.3
Delaware	($0.8)	$9.0	$9.0	$11.1	($2.4)	$26.7	$8.4	$18.3
DC		$8.7	$9.6	$11.7	($2.0)	$28.0	$9.3	$18.7
Florida		$189.4	$249.3	$296.1	($20.0)	$714.8	$258.9	$455.9
Georgia			$17.8	$165.9		$183.7	$312.1	($128.5)
Hawaii		$5.0	$12.4	$15.3		$32.7	$19.4	$13.2
Idaho		$19.2	$20.6	$24.3	($4.5)	$59.6	$20.3	$39.3
Illinois	$68.5		$3.3	$209.8	$54.4	$335.9	$578.5	($242.6)
Indiana		$40.9	$73.0	$93.5		$207.3	$84.0	$123.4
Iowa			$5.5	$36.2		$41.7	$56.7	($15.1)
Kansas		$0.5	$27.5	$36.5		$64.6	$50.0	$14.6
Kentucky		$16.2	$57.8	$70.1		$144.1	$81.2	$62.9
Louisiana			$67.2	$89.6		$156.8	$98.6	$58.3
Maine			$9.3	$15.2		$24.5	$25.0	($0.5)
Maryland	$2.4		$4.7	$67.0	$14.7	$88.8	$151.1	($62.4)
Massachusetts	$30.8		$0.0	$73.3	$20.6	$124.8	$212.5	($87.7)
Michigan			$65.9	$149.4		$215.3	$175.6	$39.7
Minnesota			$14.3	$48.6		$62.9	$78.7	($15.8)
Mississippi			$36.4	$60.5		$96.9	$120.6	($23.7)
Missouri			$23.2	$72.1		$95.4	$98.7	($3.3)
Montana		$4.0	$12.6	$15.7		$32.2	$17.2	$15.0
Nebraska			$11.7	$21.9		$33.6	$33.7	($0.1)
Nevada	($3.7)	$40.4	$41.9	$52.1	($12.4)	$121.9	$31.1	$90.8
New Hampshire		$7.4	$9.2	$10.8	($1.2)	$26.2	$10.2	$16.0
New Jersey	$32.0		$2.7	$105.2	$27.3	$167.2	$286.5	($119.3)
New Mexico	($1.4)	$42.2	$42.2	$52.0		$136.4	$55.4	$81.0

A	B	C	D	E	F	G	H	I=H-G
State	**Projected redistribution of unspent FY2004 allotments[a]**	**Balance of FY2005 original allotments**	**Balance of FY2006 original allotments**	**FY2007 SCHIP original allotments**	**Projected redistribution of unspent FY2005 allotments on 3/31/07[b]**	**Projected total amount available in FY2007**	**States' FY2007 spending estimate[c]**	**Projected end-of-FY2007 balance**
New York		$158.1	$272.5	$340.8		$771.3	$337.8	$433.6
North Carolina			$46.3	$136.1		$182.4	$169.4	$12.9
North Dakota			$4.7	$7.7		$12.4	$11.4	$1.0
Ohio			$91.3	$158.0		$249.3	$202.5	$46.9
Oklahoma		$2.0	$57.4	$70.8		$130.2	$82.4	$47.7
Oregon		$26.9	$46.9	$56.7		$130.5	$67.1	$63.4
Pennsylvania		$31.5	$134.1	$173.6		$339.1	$177.2	$162.0
Rhode Island	$13.2		$6.5	$14.0	$6.4	$40.0	$70.3	($30.3)
South Carolina		$34.6	$55.5	$70.7	($3.9)	$156.9	$53.5	$103.4
South Dakota			$5.3	$10.4		$15.6	$13.9	$1.7
Tennessee	($58.0)	$78.9	$80.4	$97.5	($20.0)	$236.8	$22.9	$213.9
Texas	($61.5)	$450.0	$454.7	$558.0	($20.0)	$1,442.7	$452.8	$989.9
Utah		$6.5	$32.2	$40.5		$79.2	$39.0	$40.2
Vermont		$3.9	$4.8	$5.8	($1.1)	$13.4	$3.5	$9.9
Virginia		$9.7	$72.3	$94.1		$176.1	$108.3	$67.8
Washington	($14.1)	$64.7	$64.7	$79.9	($20.0)	$189.3	$27.1	$162.2
West Virginia		$7.9	$23.3	$27.5		$58.7	$37.1	$21.7
Wisconsin			$26.7	$69.6		$96.2	$99.1	($2.8)
Wyoming		$4.7	$5.9	$6.9		$17.5	$8.1	$9.4
Puerto Rico		$16.5	$41.7	$48.1		$106.3	$40.2	$66.0
Guam				$1.8		$1.8	$3.6	($1.8)
Virgin Islands			$0.6	$1.4		$2.0	$2.1	($0.1)
American Samoa				$0.6		$0.6	$0.8	($0.2)
N. Mariana Islands			$0.1	$0.6		$0.6	$0.5	$0.2
US	**$0.0**	**$1,391.8**	**$3,069.5**	**$5,040.0**	**$0.0**	**$9,648.2**	**$6,395.3**	**$3,252.9[d]**

Source: Congressional Research Service (CRS), based on states' projections and data from the Centers for Medicare and Medicaid Services (CMS).

a. Projected redistribution of FY2004 original allotments unspent after three years ($146.9 million from seven states) projected to go to five shortfall states. FY2004 original allotments are not available for FY2007 spending; only redistributed amounts are available. Thus, negative amounts in this column do not reduce total available shown for FY2007.

b. Projected redistribution of FY2005 original allotments available on March 31, 2007 ($124.4 million from 13 states) projected to go to six shortfall states.

c. Data reported by states to CMS as of December 2006, except for territories, which are based on FY2006 expenditures

d. This is comprised of $4.00 billion in balances projected to be held by states and territories at the end of FY2007, less $746.5 million in shortfalls (including three territories' combined projected shortfall of $2.0 million).

Table 3. Projected Shortfalls Net of Potential Federal Medicaid Funding, FY2007

(in millions of dollars)

Projected FY2007 shortfall states	A % of FY2006 SCHIP spending eligible for Medicaid fallback	B Shortfall	C Potential federal Medicaid funding	D = B - C Net shortfall
Alaska	90%	$12.5	$10.2	$2.3
Georgia	0%	$128.5	$0	$128.5
Illinois	11%	$242.6	$49.8	$192.8
Iowa	30%	$15.0	$12.7	$2.3
Maine	67%	$0.5	$0.5	$0.1
Maryland	85%	$62.4	$48.0	$14.4
Massachusetts	67%	$87.7	$67.5	$20.2
Minnesota	0%	$15.8	$0	$15.8
Mississippi	0%	$23.7	$0	$23.7
Missouri	97%	$3.3	$2.8	$0.5
Nebraska	90%	$0.1	$0.1	$0.0
New Jersey	18%	$119.3	$39.7	$79.6
Rhode Island	98%	$30.3	$23.8	$6.5
Wisconsin	24%	$2.8	$2.3	$0.5
Total		**$744.5**	**$257.3**	**$487.2**

Source: Congressional Research Service (CRS) SCHIP Projection Model and data from the Centers for Medicare and Medicaid Services (CMS).

Note: Column C is estimated on the basis of states maximizing the amount of their shortfalls eligible for a Medicaid fallback. In addition to the amounts in Column A, the potential Medicaid funding also reflects the difference between states' enhanced (SCHIP) FMAP and regular (Medicaid) FMAP.

Net shortfalls. Of the 14 states that CRS currently projects to experience shortfalls in FY2007, all but three (Georgia, Minnesota, and Mississippi) have the ability to draw down federal Medicaid funds as a fallback provision. This can occur in one of two ways:

First, states with Medicaid expansion programs that have exhausted their available federal SCHIP allotments may fall back to Medicaid to finance coverage for such children by accessing federal Medicaid funds at the regular Medicaid FMAP rate. The 11 shortfall states that are able to revert to Medicaid have all or a portion of their SCHIP programs through such a Medicaid expansion. Georgia, Minnesota, and Mississippi have their enrollees in SCHIP programs entirely separate from Medicaid and therefore cannot revert to Medicaid funds when their SCHIP funds are exhausted.[12]

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[12] Officially, Minnesota is a combination state — that is, it has both a Medicaid-expansion and a separate SCHIP program. However, eligibility in its Medicaid-expansion program is for a very limited population: 0- to 2-year-olds with income of 275%-280% of poverty. The state's separate SCHIP program covers adults only. In its FY2006 expenditure report, Minnesota reported no Medicaid-expansion expenditures.

Second, some states have CMS approval under Section 1115 waiver authority to draw federal Medicaid funds in the portion of their SCHIP program that is not a Medicaid expansion. In general, Section 1115 of the Social Security Act provides the Secretary of Health and Human Services (HHS) with broad authority to waive certain statutory requirements in the Medicaid (and/or SCHIP) program(s) allowing states to conduct research and demonstration programs that further the goals of Title XIX (and/or XXI). Costs associated with waiver programs must be budget neutral to the federal government over the life of the waiver program. To meet this budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the state's existing Medicaid program under current law program requirements. Massachusetts and Rhode Island are the two shortfall states with Section 1115 waiver authority to draw federal Medicaid funds once their federal SCHIP funds are exhausted.[13]

Although Section 1115 waivers provide states with flexibility, the federal government's financial liability is limited through budget-neutrality caps. For example, in FY2007, Massachusetts is projected to come quite close to hitting their cap on total Medicaid spending. As a result, if the state experiences a shortfall of federal SCHIP funds in FY2007, it may not be able to use its Medicaid fallback. For Rhode Island, this is not a concern; its cap is based on per-capita spending rather than total spending.

North Carolina is another state that took financing-related action due to the prospects of shortfalls. Prior to 2006, North Carolina had all of its SCHIP enrollees in a separate SCHIP program. However, as of January 2006, North Carolina is now a "combination state" because it created a Medicaid-expansion SCHIP program for the former 0-to-5-year-old separate-SCHIP enrollees. As a result, North Carolina can draw down the regular federal matching rate (FMAP) from Medicaid funds for at least these children. Even though North Carolina did not face a shortfall in FY2006, the state began drawing down Medicaid funds at the regular FMAP (instead of SCHIP funds at the enhanced FMAP) for those 0-to-5-year-olds, as of January 2006. This was done because state officials anticipated exhausting their federal SCHIP funds in FY2007. As a result of this action, North Carolina's projected federal SCHIP spending for FY2007 has fallen by nearly $100 million (from $265 million projected in May 2006 to $169 million projected in November 2006), and the state is no longer projected to face an FY2007 shortfall.[14]

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[13] For example, the following is from Rhode Island's waiver term and conditions: "In order to continue operation of the [Section 1115] demonstration if the State exhausts the available Title XXI [SCHIP] Federal funds for the claiming period, the State will continue to provide coverage to its approved Title XXI State plan population and the demonstration population with Title XIX [Medicaid] funds until further Title XXI Federal funds become available."

[14] Previous versions of this report projected 17 states would face federal SCHIP shortfalls in FY2007. The three states no longer projected to face FY2007 shortfalls are Louisiana, North Carolina, and South Dakota. One reason is that all three states experienced FY2006 federal SCHIP expenditures that were lower than what they had projected. In addition, the current FY2007 expenditure projections from North Carolina (as discussed above) and Louisiana are much lower than they had projected before.

Long-Term Projections of States' Federal SCHIP Shortfalls

As previously mentioned, 34 states are projected to spend more than they received in their FY2007 annual allotment. More than half of these do not face FY2007 shortfalls because of balances remaining from prior years. But with no other changes, as those balances are used up and projected spending continues to exceed the annual allotments (assuming CBO's baseline of $5 billion annual allotments into the future), additional shortfalls are inevitable in the long run.

Table 4 and **Figure 1** project long-run shortfalls of federal SCHIP funds, using states' projected FY2008 spending, increased annually by projected increases in national per-capita health care spending. Current projections after 2006 are that per-capita health care spending will increase by 6.1% to 6.5%.[15] Thus, the numbers in **Table 4** and **Figure 1** hold enrollment constant at states' FY2008 projected levels. Even with annual spending increases reflecting only increases in per-capita health care spending, and with annual allotments continuing at $5 billion and the BBA 97 redistribution structure, 42 states are projected to face shortfalls totaling $6.6 billion in FY2017. Over the five-year period of FY2008-FY2012, the total shortfalls are projected at $12.1 billion. Over the 10-year period of FY2008-FY2017, the total shortfalls are projected at $38.3 billion.

These projections assume no change in behavior by states. Undoubtedly, some states would take actions to reduce the size of their projected federal SCHIP shortfalls, depending on a number of factors, including the extent to which they have a Medicaid fallback. If federal SCHIP spending needed to be reduced, states could drop enrollees or otherwise restrict eligibility, convert SCHIP enrollees into traditional Medicaid (using flexibility from DRA and other Medicaid provisions), decrease plan benefits, and/or raise cost-sharing. A state may also decide that once it exhausts its federal SCHIP funds, it will continue to cover its enrollees at 100% state cost. On the other hand, a state may decide to drop all of its separate SCHIP program enrollees. Thus, any long-run projections of shortfalls, and projections of their impact on enrollment, will be highly speculative.

Increasing the total allotment levels by per-capita growth in health care spending would reduce projected shortfalls in FY2008 by 10%, compared to baseline assumptions. The FY2012 shortfalls would be reduced by 38%, but would still amount to an estimated $2.1 billion in 28 states. Thus, *if* one's goal is to eliminate future shortfalls, then increasing the $5 billion allotment into the future by per-capita growth in health care expenditures and using the current-law formula for dividing that among states (which does *not* take states' actual SCHIP spending or enrollment into account) would not accomplish that goal by itself.[16]

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[15] Christine Borger et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs* Web exclusive, February 22, 2006, pp. w61–w73. The updated projections are slated for publication on February 21, 2007.

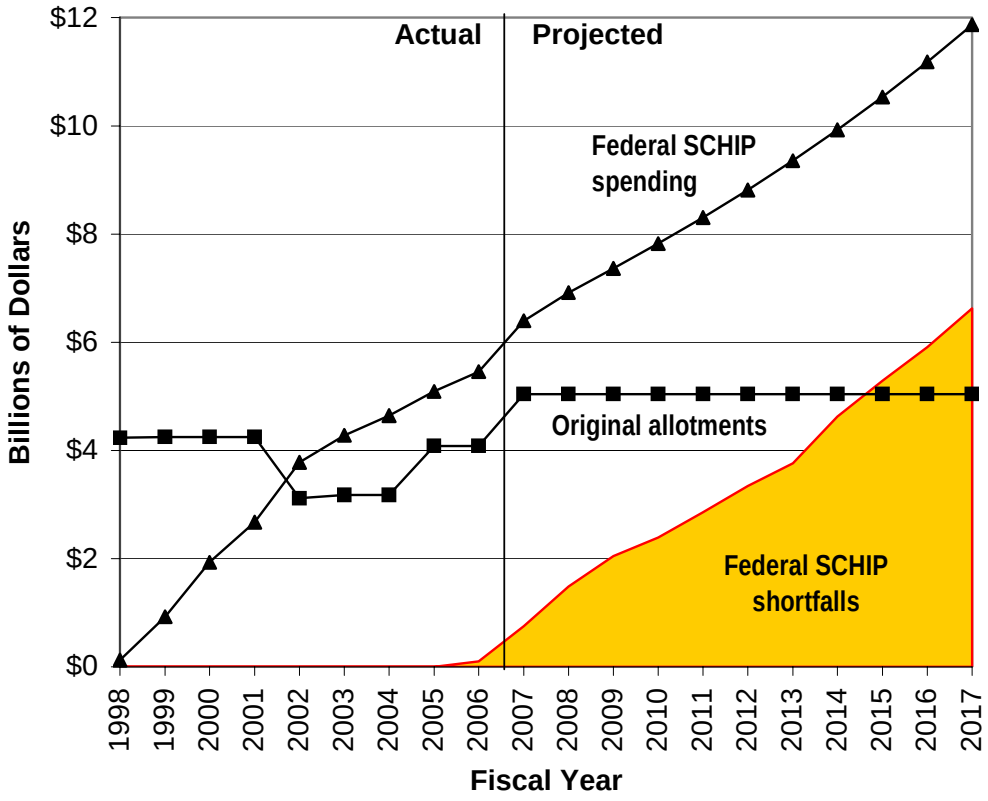
[16] Issues regarding the SCHIP funding formula are discussed in CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson.

Table 4. Long-Term Projections of States' Federal SCHIP Shortfalls (Baseline Assumptions)

(in millions of dollars)

Fiscal year	SCHIP allotments	Allotments unspent after 3 years	Spending	Total amount of shortfalls	Number of shortfall states	Funds expiring
2008	$5,040	$54	$6,913	$1,483	20	
2009	$5,040	$92	$7,363	$2,050	23	
2010	$5,040	$139	$7,823	$2,391	29	
2011	$5,040	$149	$8,303	$2,853	34	
2012	$5,040	$143	$8,813	$3,340	35	
2013	$5,040	$130	$9,354	$3,765	35	
2014	$5,040	$119	$9,927	$4,627	38	
2015	$5,040	$114	$10,537	$5,288	39	
2016	$5,040	$110	$11,183	$5,911	40	
2017	$5,040	$105	$11,869	$6,625	42	
2008-2012	$25,200	$576	$39,215	$12,117		
2008-2017	$50,400	$1,154	$92,085	$38,333		

Figure 1. Federal SCHIP Financing



Source: Congressional Research Service (CRS) SCHIP Projection Model.
Note: Shortfalls are also based on states' own prior-year balances (not shown). Projected spending is based on states' FY2007 and FY2008 prjections, increased annually by national projected increases in per-capita health care spending from Christine Borger et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs* Web exclusive, February 22, 2006, pp. w61–w73.

Analysis and Options

SCHIP was created in BBA 97 as a capped grant program to states. Fixed annual balances of federal funds are available to states, which they can exhaust. This contrasts with Medicaid, SCHIP's older and much larger companion in providing health insurance to low-income individuals, which was created as an individual entitlement program that states cannot exhaust.[17]

Although it is theoretically possible for states to be in a chronic state of shortfall of federal SCHIP funds, this was largely avoided through FY2005 using the funds within SCHIP's original appropriation and redistribution structure. In an attempt to cover shortfalls projected for FY2006, Congress appropriated an additional $283 million.

The shortfalls in FY2007 are projected at approximately $745 million. If an appropriation were used to address this shortfall, as was done for the FY2006 shortfall, a much larger amount would be required. In addition, because of CBO's scoring requirements, any change to the FY2007 SCHIP appropriation would also be reflected in all future years, making this option appear even more costly, at least on paper. In his FY2006 and FY2007 budget, the President proposed shortening the period of availability of the FY2005 original allotment from three years to two years. This would use funds currently in SCHIP without requiring an additional appropriation. The potential drawback to this option is that these funds would be coming directly from other states' balances of federal SCHIP funds (nearly $1.4 billion from 29 states, as shown in column C of **Table 2**).

Redistribution and appropriation are two alternatives available for eliminating states' shortfalls of SCHIP funds. In addition, the SCHIP program could be turned into an open-ended entitlement, perhaps by folding it into the Medicaid program. This would spare the administration and Congress from having to periodically rearrange funds or funding methodologies to cover shortfalls. However, states would likely oppose folding SCHIP into Medicaid if it meant reverting to the regular FMAP and following all of Medicaid's other myriad rules (although many of these rules can now be bypassed, due to DRA[18]). Some federal policymakers may oppose this approach because treating SCHIP as an individual entitlement could result in greater federal outlays than would occur under SCHIP as a capped grant program.

Although the SCHIP program has been successful in covering millions of uninsured children, and has therefore been politically popular, more states are poised to exhaust their federal SCHIP funds as their projected spending exceeds their annual allotment of federal SCHIP funds. If Congress decides to prevent these shortfalls, legislative action would be needed. If, however, Congress decides that the intent of

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[17] States have to provide matching funds, though, since Medicaid is a joint federal-state program. States also have some flexibility in determining eligibility and benefit levels. A state's ability to draw federal Medicaid funds may be limited if the state is operating under a Section 1115 waiver, as previously discussed.

[18] See for example CRS Report RS22578, *Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)*, by Elicia J. Herz, January 25, 2007.

the original legislation was to ensure that states did not treat the program as an open-ended entitlement, no action would be necessary through FY2007. States with annual SCHIP spending well in excess of their annual allotments would then face the consequences of that spending through a shortfall of federal funds.