Order Code RL33366

CRS Report for Congress

SCHIP Original Allotments: Description and Analysis

Updated March 12, 2007

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Prepared for Members and
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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). In BBA 97, Congress authorized and appropriated funds totaling nearly $40 billion for FY1998-FY2007, with each state receiving access to a portion of the annual amount. Each state's portion — the original allotment — is calculated based on a formula that has been altered only one time since the program's inception.

SCHIP currently has no appropriations past FY2007. As new appropriations are considered, the focus regarding SCHIP original allotments will be on (1) setting the *national* annual appropriations for SCHIP, and (2) deciding how those funds will be allotted to individual *states*. Some of the issues are technical — for example, whether a better data source exists for estimating the number of low-income children. Other issues raise more fundamental questions about the program.

Since FY2002, states' total spending of federal SCHIP funds has exceeded the annual appropriations for original allotments. However, between FY2002 and FY2005, shortfalls of federal SCHIP funds were largely avoided because of leftover prior-year balances and the targeted redistribution of other states' unspent funds. However, the funds available for redistribution have been shrinking over the past several years. Because such amounts were projected to be inadequate to prevent shortfalls in FY2006, Congress appropriated an additional $283 million in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) for projected shortfall states. Shortfalls in 14 states in FY2007 are projected to total nearly $750 million. With less money available through redistributions and prior-year balances, the amounts states receive in their own original allotments become increasingly important.

Increasing the national SCHIP appropriations to match states' projected spending would not necessarily prevent shortfalls. This is because the current formula for allotting those funds among states does not take into account states' SCHIP spending or their likelihood of facing shortfalls. As Congress considers the level of future SCHIP appropriations, it may also examine whether the formula for distributing those funds to states should be revised.

If the current allotment level and formula continue into the future, then in a few years most states will face chronic shortfalls of federal SCHIP funds. However, such shortfalls are an inherent characteristic of a capped-grant program such as SCHIP. The federal government's responsibility to prevent or lessen these shortfalls will be among the issues Congress grapples with in determining the national appropriation level and state distribution of future original allotments.

This report describes how SCHIP original allotments have operated and discusses issues and options Congress might consider for the future.

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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). In general, this program allows states[1] to cover targeted low-income children with no health insurance in families with incomes above Medicaid eligibility levels. In BBA 97, Congress authorized and appropriated annual funding levels totaling nearly $40 billion for FY1998-FY2007, with each state receiving access to a portion of the annual amount. Each state's portion — the original allotment[2] — is calculated based on a formula that has been altered only one time since the program's inception.

Each year's original allotment is available for three years. At the end of the three-year period of availability, states' unspent balances are redistributed to other states that have exhausted that allotment, with some exceptions. This report does *not* analyze the impact or amounts of redistributed funds. Nor does this report quantify projected state shortfalls of federal SCHIP funds. Other CRS reports delve into these issues.[3] This report is narrowly focused on states' original allotments as derived from (1) the federal SCHIP appropriations and (2) the allotment formula. Other SCHIP issues are presented only to the extent that they inform the discussion of original allotments.

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

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

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

Description of Original Allotments

National SCHIP Appropriations

BBA 97 established SCHIP under a new Title XXI of the Social Security Act. Section 2104(a) specified the total appropriations available in every fiscal year from FY1998-FY2007. The only change to these numbers affecting states since BBA 97 was to add $20 million to the total FY1998 appropriation.[4] The current-law numbers in Section 2104(a) are shown in column A of **Table 1**. For SCHIP's first four years, BBA 97 held the total appropriation constant. However, for FY2002-FY2004, the annual appropriation was $1.125 billion less than in FY1998-FY2001. This drop in funding, sometimes referred to as the "CHIP dip," was written into BBA 97 due to budgetary constraints applicable at the time the legislation was drafted.

Sections 4921 and 4922 of BBA 97 called for $60 million to be used from the total SCHIP appropriation each year from FY1998-FY2002 for special diabetes grants.[5] These subtractions to the total original allotments available to states and territories are shown in column B of **Table 1**. Since FY2003, these two diabetes programs have been funded by direct appropriations, not from the SCHIP appropriations.

Except for the $20 million adjustment to the total FY1998 SCHIP appropriation, all legislative changes to the total SCHIP appropriation since BBA 97 have affected only the five territories.[6] BBA 97 called for the territories to receive 0.25% of the amounts shown in column A of **Table 1**. The FY1999 Omnibus Appropriations Act (P.L. 105-277) appropriated $32 million for the territories' SCHIP original allotment for FY1999, in addition to the 0.25% of the total appropriation. The $32 million was approximately 0.75% of the $4.275 billion in column A of **Table 1**. The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (P.L. 106-113) specified additional amounts to be appropriated to the territories for FY2000-FY2007. The amounts specified for these years were exactly 0.8% of the total appropriations shown in column A of **Table 1**. Thus, for FY2000-FY2007, territories were slated to receive a total of 1.05% of the amounts specified in §2104(a), although only the 0.25% portion would reduce the amount of original allotments available to the states specifically.[7] Column C of **Table 1** shows the additional appropriations for the territories from these provisions.

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

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

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

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

Column D of **Table 1** displays the total amount of federal SCHIP original allotments provided to the states and territories under current law. For comparative purposes, column E shows the total spending of federal SCHIP funds in each of those years (projected for FY2007). The spending is applied against *all* available federal SCHIP funds, not just that year's original allotment. Thus, even though the national spending of federal SCHIP funds has exceeded the total annual allotments since FY2002, state shortfalls of federal SCHIP funds have largely been avoided because of the redistribution of other states' unspent funds.[8]

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

	A	B	C	D = A-B+C	E
		Subtract	Add		
FY	Allotments specified in §2104(a)	Special diabetes grants	For territories per §2104(c)(4)	Original allotments to states and territories	Total spending
1998	$4,295,000,000	$60,000,000		$4,235,000,000	$121,800,000
1999	$4,275,000,000	$60,000,000	$32,000,000	$4,247,000,000	$921,800,000
2000	$4,275,000,000	$60,000,000	$34,200,000	$4,249,200,000	$1,928,800,000
2001	$4,275,000,000	$60,000,000	$34,200,000	$4,249,200,000	$2,671,600,000
2002	$3,150,000,000	$60,000,000	$25,200,000	$3,115,200,000	$3,776,200,000
2003	$3,150,000,000		$25,200,000	$3,175,200,000	$4,276,400,000
2004	$3,150,000,000		$25,200,000	$3,175,200,000	$4,644,700,000
2005	$4,050,000,000		$32,400,000	$4,082,400,000	$5,089,500,000
2006	$4,050,000,000		$32,400,000	$4,082,400,000	$5,453,700,000
2007	$5,000,000,000		$40,000,000	$5,040,000,000	$6,395,300,000
Total	$39,670,000,000	$300,000,000	$280,800,000	$39,650,800,000	$35,279,700,000

Source: Social Security Act §2104 and CRS SCHIP Projection Model.

Notes: Section numbers refer to Title XXI of the Social Security Act. The special diabetes grants are described in Public Health Service Act §330B and §330C. Numbers rounded to the nearest $100,000. Spending is included for comparative purposes and is from all federal SCHIP funds — reallocated funds (that is, amounts from the redistribution and retention of unspent funds after original allotments' three-year period of availability) as well as from original allotments. Spending projections for FY2007 is based on states' own estimates, provided to the Centers for Medicare and Medicaid Services in November-December 2006. The territories do not provide these estimates.

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

Allotment Formula

A primary purpose of funding formulas like the SCHIP allotment formula is to distribute funds based on "need," defined as "the potential cost of the program based on the size of the target population and the cost of providing services."[9] The target population and the cost of providing services were included in the original SCHIP allotment formula, using data available at the time, as two factors: the *number of children* and a *state cost factor*.[10] Once calculated, these two factors are multiplied by each other for each state, with the results added for a national total. Each state's percentage of the total, subject to floors and ceilings, is then multiplied by the total allotment funds available to states in that year. The result is the amount allotted to each state for that fiscal year.

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

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

A low-income child is an individual under the age of 19 whose family income is at or below 200% of the poverty line.[11] The weight attached to each of the two factors varies by fiscal year. For FY1998 and FY1999, the "number of children" in each state relied solely on the number of *uninsured* low-income children, as shown in **Table 2**. As SCHIP began to cover more low-income children, the formula was designed to rely less on the number of *uninsured* low-income children and more on the number of *all* low-income children. FY2000 was the transition year, in which the "number of children" used 75% of the number of *uninsured* low-income children and 25% of the number of *all* low-income children, as illustrated in **Table 2**.[12] For FY2001 onward, the "number of children" is weighted evenly between the number of *uninsured* low-income children and the number of *all* low-income children in each state.

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[9] Lynn A. Blewett and Michael Davern, "Distributing SCHIP Funds: A Critical Review of the Design and Implementation of the SCHIP Funding Formula," *Journal of Health Politics, Policy and Law*, forthcoming May 2007, vol. 32, no. 3.

[10] §2104(b). The territories' original allotment amounts are based on §2104(c)(2). Of the total amount of original allotments available to territories, each territory receives a fixed percentage: Puerto Rico receives 91.6%, Guam 3.5%, the Virgin Islands 2.6%, American Samoa 1.2%, and the Northern Mariana Islands 1.1%. These percentages are specified in law and have been unaltered since BBA 97.

[11] For 2005, this measure of poverty for a family of three with two children was $15,735 [http://www.census.gov/hhes/www/poverty/threshld/thresh05.html]. At 200% of this level, the amount would be $31,470.

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

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

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

Source: Social Security Act §2104(b).

The source of data for these state-level estimates is the March supplement of the Current Population Survey (CPS), which is administered by the U.S. Census Bureau. The CPS is a monthly survey of households that provides estimates of employment and unemployment in the U.S. Between February and April, respondents are asked additional questions about their work experience, income, noncash benefits, migration and health insurance status in the previous year. Because the supplement is no longer given only in March, it has been renamed the Annual Social and Economic (ASEC) Supplement, though many analysts continue to call it the March supplement.

Since survey estimates come from only a sample of the population, the estimates could differ from the results from a complete census using the same survey questions. It is possible to estimate this "sampling error" based on the sample size (that is, the number of respondents). Because sample sizes can be relatively small in less populous states, results from multiple years are often averaged together to reduce the sampling error. Current law specifies that for estimating the SCHIP original allotment's "number of children," an average of the most recent *three* years is used.[13]

The original allotments for FY2007 were announced on July 28, 2006.[14] The "number of children" for these allotments was based on ASEC data from 2002, 2003, and 2004. Data for 2005, collected in the 2006 ASEC, were not released until

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[13] §2104(b)(2)(B).

[14] U.S. Department of Health and Human Services, "State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2007," 71 *Federal Register* 42854, July 28, 2006.

August 29, 2006. Regardless, that later data could not be used for calculating the FY2007 original allotments. The law specifies that the original allotment for a fiscal year must be based on "the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the calendar year in which such fiscal year begins."[15] FY2007 began (October 1, 2006) in calendar year 2006. Thus, the Centers for Medicare and Medicaid Services (CMS) interpreted the law to mean that, for the FY2007 original allotments, the CPS data can be no more recent than those available on December 31, 2005. On that date, the 2005 ASEC, providing data from 2004, was the most recent officially available. Thus, the FY2007 original allotments were based on data averaged over the three-year period 2002-2004.

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

The law specifies that the wage data are to be obtained from the Bureau of Labor Statistics (BLS) of the Department of Labor, using three-year averages for the same years used to calculate the "number of children." The law also defines the "health services industry" as employers with a Standard Industrial Classification (SIC) code of 8000.[16] However, in 2002, BLS replaced SIC with the North American Industry Classification System (NAICS). Although the mapping between the two systems for the health services industry was not identical, the NAICS wage data codes "represent approximately 98 percent of the wage data that would have been provided under the related SIC code 8000."[17] The NAICS codes now used are 621 (ambulatory health care services), 622 (hospitals), and 623 (nursing and residential care facilities). These three codes are under the broader category (62) for health care and social assistance. The only NAICS code from this category not used for the state cost factor is 624 (social assistance).[18]

The source of data BLS uses for calculating the average wages is from mandatory reports filed quarterly by every employer on their unemployment insurance contributions. BLS provides the data directly to CMS. Because the data cover all employers subject to unemployment insurance coverage under federal law

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[15] §2104(b)(2)(B).

[16] §2104(b)(3)(B).

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

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

(nearly 99% of employers), it is not technically a survey, but rather a census.[19] As a result, using a three-year average does not reduce sampling error, since censuses do not have sampling error. Rather, the three-year average results in consistent reporting periods for both the "number of children" and the state cost factor.

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

FY	Floor: state's minimum share of national appropriation (greatest applicable factor applies)			Ceiling: state's maximum share
	Share that equals $2,000,000	90% of last year's share	70% of 1998-1999 share	145% of 1998-1999 share
1998	X			
1999	X			
2000	X	X	X	X
2001	X	X	X	X
2002	X	X	X	X
2003	X	X	X	X
2004	X	X	X	X
2005	X	X	X	X
2006	X	X	X	X
2007	X	X	X	X

Source: Social Security Act §2104(b)(4).

Note: The "X" represents factors applicable for that fiscal year. Once a state's original allotment based on **Table 2** is calculated, it is tested against the applicable floors and ceilings in this table. The tests are evaluated in terms of the state's share (or percentage) of the total SCHIP appropriation, *not* on the dollar amounts. P.L. 105-277 required the FY1999 share be the same as the FY1998 share.

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

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

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

funding for the year available to the states. **Table 4** shows how all of these factors were applied to calculate states' and territories' FY2007 original allotments.

Although Title XXI requires that FY1999 be the basis for the historical comparisons in calculating the floors and ceiling, the SCHIP law could also have set FY1998 as the base year, and the impact of the floors and ceiling would be no different. This is because P.L. 105-277 required that states' share of the FY1999 SCHIP appropriation be the same as their share for FY1998. According to one source:

> The reason behind this intervention into the formula allocation process was that a preliminary calculation based on the average number of low-income uninsured children as measured in the 1995, 1996, and 1997 [CPS] March supplements showed substantial variation from the estimates based on the 1994, 1995, and 1996 March supplements. ... What is notable is that 23 of the 51 states would have had double-digit percentage changes in their shares of the national allocation, with one state's share falling by 41.7 per cent and another's rising by nearly the same amount. Seeing these results affecting such a highly visible program, it is no surprise Congress acted.[20]

Table 4. Application of SCHIP Allotment Formula to Derive FY2007 Original Allotments

State or territory	A Number of children (000s)	B State cost factor	C=A*B Product	Pre-adjusted proportion	Adjusted proportion	Allotment
Alabama	277	0.9701	268.2199	1.4815%	1.4896%	$74,295,313
Alaska	40	1.0542	41.6420	0.2300%	0.2313%	$11,534,589
Arizona	424	1.0887	461.5930	2.5496%	2.5636%	$127,858,497
Arkansas	195	0.9129	178.0092	0.9832%	0.9886%	$49,307,483
California	2533	1.1271	2854.8962	15.7688%	15.8554%	$790,789,213
Colorado	255	1.0621	270.8420	1.4960%	1.4345%	$71,544,798
Connecticut	128	1.1251	144.0124	0.7954%	0.7998%	$39,890,581
Delaware	39	1.0369	39.9198	0.2205%	0.2217%	$11,057,552
D.C.	34	1.2432	42.2701	0.2335%	0.2348%	$11,708,552
Florida	1036	1.0322	1068.8561	5.9037%	5.9362%	$296,066,768
Georgia	574	1.0433	598.8366	3.3076%	3.3258%	$165,874,160
Hawaii	57	1.1199	63.2741	0.3495%	0.3071%	$15,314,228
Idaho	100	0.8823	87.7868	0.4849%	0.4875%	$24,316,412
Illinois	750	1.0594	794.0428	4.3858%	4.2059%	$209,767,107
Indiana	352	0.9600	337.4418	1.8638%	1.8741%	$93,469,355
Iowa	141	0.9309	130.7962	0.7224%	0.7264%	$36,229,776
Kansas	143	0.9258	131.9224	0.7287%	0.7327%	$36,541,720
Kentucky	267	0.9480	253.1272	1.3981%	1.4058%	$70,114,712
Louisiana	355	0.9123	323.4215	1.7864%	1.7962%	$89,585,836
Maine	59	0.9284	54.7733	0.3025%	0.3042%	$15,171,887
Maryland	221	1.0939	241.7411	1.3352%	1.3426%	$66,960,838

[20] John L. Czajka and Thomas B. Jabine, "Using Survey Data to Allocate Federal Funds for the State Children's Health Insurance Program (SCHIP)," Journal of Official Statistics, Vol. 18, No. 3, 2002, pp. 417-418, available online at [http://www.jos.nu/Articles/abstract.asp?article=183409].

State or territory	A Number of children (000s)	B State cost factor	C=A*B Product	Pre-adjusted proportion	Adjusted proportion	Allotment
Massachusetts	244	1.1083	269.8654	1.4906%	1.4704%	$73,334,995
Michigan	532	1.0137	539.2999	2.9788%	2.9951%	$149,382,856
Minnesota	181	1.0218	184.9443	1.0215%	0.9747%	$48,613,498
Mississippi	237	0.9215	218.3966	1.2063%	1.2129%	$60,494,559
Missouri	279	0.9352	260.4401	1.4385%	1.4464%	$72,140,346
Montana	64	0.8877	56.8115	0.3138%	0.3155%	$15,736,459
Nebraska	87	0.9084	79.0326	0.4365%	0.4389%	$21,891,551
Nevada	159	1.2093	192.2753	1.0620%	1.0437%	$52,056,449
New Hampshire	37	1.0518	38.9149	0.2149%	0.2161%	$10,779,193
New Jersey	335	1.1338	379.8138	2.0979%	2.1094%	$105,206,164
New Mexico	160	0.9445	151.1252	0.8347%	1.0435%	$52,045,406
New York	1123	1.0961	1230.3754	6.7959%	6.8332%	$340,806,655
North Carolina	562	0.9771	549.1038	3.0329%	2.7292%	$136,117,313
North Dakota	32	0.8729	27.9339	0.1543%	0.1551%	$7,737,529
Ohio	595	0.9587	570.3984	3.1505%	3.1679%	$157,996,958
Oklahoma	249	0.8767	218.2966	1.2057%	1.4201%	$70,828,185
Oregon	203	1.0090	204.8210	1.1313%	1.1375%	$56,734,200
Pennsylvania	615	1.0196	626.5640	3.4608%	3.4798%	$173,554,494
Rhode Island	50	1.0096	50.4811	0.2788%	0.2804%	$13,982,960
South Carolina	254	1.0042	255.0648	1.4088%	1.4166%	$70,651,421
South Dakota	41	0.9230	37.3810	0.2065%	0.2076%	$10,354,308
Tennessee	348	1.0125	351.8472	1.9434%	1.9541%	$97,459,570
Texas	2080	0.9685	2014.4123	11.1264%	11.1876%	$557,980,188
Utah	166	0.8805	146.1615	0.8073%	0.8117%	$40,485,868
Vermont	23	0.9231	20.7706	0.1147%	0.1154%	$5,753,333
Virginia	329	1.0338	339.6114	1.8758%	1.8861%	$94,070,318
Washington	318	0.9897	314.2298	1.7356%	1.6017%	$79,883,308
West Virginia	111	0.8990	99.3412	0.5487%	0.5517%	$27,516,914
Wisconsin	263	1.0077	264.5260	1.4611%	1.3948%	$69,563,162
Wyoming	27	0.9458	25.0636	0.1384%	0.1392%	$6,942,463
State totals			**18,104.7276**	**100.0000%**	**100.0000%**	**$4,987,500,000**
Total amount available to states = $5 billion less 0.25% for territories =						
Puerto Rico					91.6%	$48,090,000
Guam					3.5%	$1,837,500
Virgin Islands					2.6%	$1,365,000
American Samoa					1.2%	$630,000
N. Mariana Islands					1.1%	$577,500
Total amount available to territories = 0.25% of $5 billion + $40 million =						**$52,500,000**
Total original allotments to states and territories						**$5,040,000,000**

Source: U.S. Department of Health and Human Services, "State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2007," 71 *Federal Register* 42854, July 28, 2006.

Analysis of SCHIP Original Allotments: Issues and Options

The last row of **Table 5** shows that the FY2007 SCHIP appropriation to states was nearly $5 billion. However, states' spending of federal SCHIP funds in FY2007 is projected at $6.3 billion, 27% more than the FY2007 original allotments. Spending is projected to exceed FY2007 allotments in 34 states. Prior-year balances prevent 20 of these states from facing shortfalls, so that only the remaining 14 states are projected to experience shortfalls in FY2007.

Table 5. FY2007 Original Allotments and Projected Federal SCHIP Spending, by State

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

State	Original allotment	Projected spending	Spending as a percent of original allotment
Tennessee	$97.5	$22.9	24%
Washington	$79.9	$27.1	34%
Nevada	$52.1	$31.1	60%
Vermont	$5.8	$3.5	61%
Connecticut	$39.9	$25.9	65%
South Carolina	$70.7	$53.5	76%
Delaware	$11.1	$8.4	76%
DC	$11.7	$9.3	80%
Texas	$558.0	$452.8	81%
Idaho	$24.3	$20.3	83%
Florida	$296.1	$258.9	87%
Colorado	$71.5	$63.5	89%
Indiana	$93.5	$84.0	90%
Arizona	$127.9	$115.1	90%
New Hampshire	$10.8	$10.2	95%
Utah	$40.5	$39.0	96%
New York	$340.8	$337.8	99%
Pennsylvania	$173.6	$177.2	102%
New Mexico	$52.0	$55.4	106%
Montana	$15.7	$17.2	110%
Louisiana	$89.6	$98.6	110%
Arkansas	$49.3	$54.3	110%
Virginia	$94.1	$108.3	115%
Kentucky	$70.1	$81.2	116%
Oklahoma	$70.8	$82.4	116%
Wyoming	$6.9	$8.1	117%
Michigan	$149.4	$175.6	118%
Oregon	$56.7	$67.1	118%
North Carolina	$136.1	$169.4	124%
Hawaii	$15.3	$19.4	127%
Ohio	$158.0	$202.5	128%
Alabama	$74.3	$98.6	133%
South Dakota	$10.4	$13.9	135%
West Virginia	$27.5	$37.1	135%
Kansas	$36.5	$50.0	137%

State	Original allotment	Projected spending	Spending as a percent of original allotment
Missouri	$72.1	$98.7	137%
California	$790.8	$1,103.3	140%
Wisconsin	$69.6	$99.1	142%
North Dakota	$7.7	$11.4	148%
Nebraska	$21.9	$33.7	154%
Iowa	$36.2	$56.7	157%
Minnesota	$48.6	$78.7	162%
Maine	$15.2	$25.0	165%
Georgia	$165.9	$312.1	188%
Mississippi	$60.5	$120.6	199%
Maryland	$67.0	$151.1	226%
Alaska	$11.5	$30.2	262%
New Jersey	$105.2	$286.5	272%
Illinois	$209.8	$578.5	276%
Massachusetts	$73.3	$212.5	290%
Rhode Island	$14.0	$70.3	503%
State total	**$4,987.5**	**$6,348.1**	**127%**

Source: Congressional Research Service (CRS) analysis of data from the Centers for Medicare and Medicaid Services (CMS), including states' November-December 2006 projections of FY2007 federal SCHIP spending.

Although the last SCHIP appropriation scheduled under current law is $5.0 billion in FY2007, the Congressional Budget Office (CBO) is required to assume that the program continues in perpetuity at the last appropriated level.[21] Thus, legislation that simply appropriates $5.0 billion annually beyond FY2007 would not be scored by CBO as increasing federal government spending above CBO's current baseline. If the FY2007 level and distribution of original allotments remain the same and states continue their current projected spending, inevitably all 34 states with projected spending exceeding their original allotments would face shortfalls. If states increase their spending, even to account for health care inflation, additional states could face chronic shortfalls. Under baseline assumptions, CBO projects that 43 states would face shortfalls by FY2017.[22]

The prospect of chronic long-term SCHIP shortfalls in the majority of states raises fundamental questions about the role of the federal government in a program that was created as a capped matching grant to states. Two potentially conflicting policy goals of the current structure of SCHIP include its efforts (1) to expand (or

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[21] Section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177, also known as Gramm-Rudman-Hollings), as amended by Section 10209 of BBA 97. The BBA 97 conference report (105-217) describes the amendment as follows: "The conference agreement amends section 257 to provide that only those programs with current year outlays in excess of $50 million and that were in existence on or before the date of enactment of the Balanced Budget Act of 1997 are assumed to continue for the purposes of the baseline." Since SCHIP was in BBA 97, this provision applies.

[22] Congressional Budget Office, *Fact Sheet for CBO's March 2007 Baseline: State Children Health Insurance Program*, February 23, 2007.

prevent the loss of) health insurance coverage, and (2) to limit and control federal spending for that coverage. One contention is that inadequate original allotments are one reason for states' shortfalls of federal SCHIP funds. For example, Iowa's SCHIP director said, "The SCHIP funding formula is flawed in that it allocates funds to states based on inaccurate data, penalizes states for insuring more children, and inadequately distributed funding over the 10 years during which the program was authorized."[23]

The sections below discuss some specific options for altering the current allotment formula, including changes related to the Iowa SCHIP director's comments. However, it must be noted that to eliminate states' shortfalls by altering original allotments, both the total amount of original allotments and how they are distributed to states would likely have to be altered.

Allotment Formula

The allotment formula for determining each state's share of the national SCHIP appropriation was set in BBA 97. In the absence of established SCHIP programs on which to base states' allotments, Congress used the previously discussed *number of children* and the *state cost factor*. In essence, Congress decided that SCHIP allotments should be based on the number of low-income (below 200% of poverty) children in each state, with variation in the extent to which the number includes all low-income children or just those who were uninsured. Having established the *number of children* as the basis for states' share of the total appropriation, the state cost factor provided an adjustment designed to reflect the cost of health care in each state. The remainder of this section of the report discusses possible changes to the existing components of the formula, as well as additional options based on new information not available a decade ago.

Number of Children. What is the target population of SCHIP, and does the current SCHIP allotment formula accurately target funds to that population? According to Title XXI, the target population is "uninsured, low-income children."[24]

In the first two years of SCHIP, the *number of children* was defined in the formula as the number of uninsured low-income children, based on the CPS estimates. Theoretically, perhaps only uninsured low-income children *eligible for SCHIP* should have been included (for example, excluding uninsured low-income children who were eligible for Medicaid). However, "the potential magnitude of the error that would accompany state-specific estimates of this group makes it difficult to argue" that such estimates should have been used instead.[25]

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[23] Anita Smith, director of Iowa's SCHIP program, quoted in the 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.

[24] §2101(a)

[25] John L. Czajka and Thomas B. Jabine, "Using Survey Data to Allocate Federal Funds for (continued...)

If the "number of children" had continued with its FY1998-1999 structure, then if a state had enrolled *all* its uninsured low-income children in SCHIP, the formula would have caused the state to ultimately receive no more SCHIP funds. Thus, the formula came to rely equally on the number of *uninsured* low-income children and the *total* number of low-income children.

However, by including the *total* number of low-income children, states are allotted SCHIP funds for other low-income children who are not part of the target population (for example, those with private health insurance). Again, although it may be desirable to use more detailed estimates, such a step comes at the risk of increasing sampling error and bias with the CPS data. Some researchers suggested a "more obvious solution of adding the children enrolled in SCHIP to the estimated number of uninsured low-income children."[26] This would focus the formula on states' current child enrollees as well as potentially eligible uninsured low-income children. However, their "more obvious solution" would include *all* child enrollees in the formula, even though some states cover children in their SCHIP programs well above 200% of poverty. Moreover, as the researchers state, "[i]ntroducing administrative estimates into the allocation formula would place reliance on the fund recipients — the states — to estimate a component of need, which then affected the size of their allocations."[27]

More generally, some states have suggested that the portion of the formula that includes the number of uninsured low-income children be dropped altogether. One argument is that this portion of the formula creates a perverse incentive. As one state official said, "Efforts to reduce the number of uninsured children by increasing enrollment in one of a state's government-sponsored programs would appear to potentially have a negative impact on the SCHIP allocation a state may receive in a given fiscal year."[28] By dropping the uninsured estimates from the calculation for the *number of children*, no state's original allotment would change by more than 10%, according to a previous CRS analysis of states' FY2006 original allotments.[29] Nevertheless, the tension is in how much the formula should be geared toward

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[25] (...continued)
the State Children's Health Insurance Program (SCHIP)," Journal of Official Statistics, Vol. 18, No. 3, 2002, pp. 417-418, available online at [http://www.jos.nu/Articles/abstract.asp?article=183409].

[26] John L. Czajka and Thomas B. Jabine, "Using Survey Data to Allocate Federal Funds for the State Children's Health Insurance Program (SCHIP)," Journal of Official Statistics, Vol. 18, No. 3, 2002, p. 424, available online at [http://www.jos.nu/Articles/abstract.asp?article=183409].

[27] Ibid.

[28] George L. Hoover, Deputy Commissioner, Pennsylvania's CHIP and Adult Basic Programs, quoted 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.

[29] Table 3 of "Federal SCHIP Financing: Testimony Before the Senate Finance Health Subcommittee," Chris L. Peterson, Congressional Research Service (CRS), July 25, 2006, at [http://finance.senate.gov/hearings/testimony/2005test/072506cptest.pdf].

financing current SCHIP enrollees versus the potential enrollees (uninsured low-income children) specified in the statute.

Outside of the question of the overall structure of this portion of the formula is the issue of whether the current formula uses the best available data. For example, there are well-documented concerns with the CPS's estimates of the uninsured, which have been acknowledged by the Census Bureau.[30] Some states have reported that their own estimates of the uninsured do not correspond with the CPS estimates.[31]

During BBA 97, the CPS was the only source of data that could provide state-level estimates of the number of low-income children and of those who were uninsured in all the states. Even so, the high sampling error in many states requires the use of three-year averages of the CPS estimates. Congress appropriated an additional $10 million annually to expand the CPS sample size by about 34,500 households beginning with 2002 survey data. Even so, concerns remain regarding the substantial variation and unpredictability in states' allotments, partly driven by the relatively large standard errors associated with the CPS estimates.[32]

Table 6 and **Table 7** illustrate some of this variation. Table 6 shows states' share of the total appropriation available in FY1998 and FY2007. The table also shows how much more, or less, states would have received in their FY2007 original allotments had the percentage been based on the FY1998 percentages rather than those from FY2007. If the FY2007 original allotments had been based on the FY1998 percentages, approximately $500 million allotted to 33 states in FY2007 would have gone to the other 18 states instead. The differences shown in Table 6 include not only changes in the CPS-derived number of children, but also in the state cost factor. The table does not ascertain how much of the changes are due to actual changes in state-level circumstances rather than sampling error or other potential measurement issues.[33]

Since BBA 97, the Census Bureau has developed a new source of data that can provide state-level estimates of low-income children — the American Community Survey (ACS). The ACS is mailed to 3 million addresses annually, compared to the CPS's sample of approximately 100,000 households. As a result, use of the ACS would lead to less year-to-year variation in states' allotments due to the smaller CPS sample.[34] However, the ACS does *not* currently obtain estimates of the uninsured.

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[30] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," Current Population Reports P60-299, Washington, DC, 2005, available at [http://www.census.gov/prod/2005pubs/p60-229.pdf], p. 16.

[31] David Bergman, *Perspectives on Reauthorization: SCHIP Directors Weigh In*, National Academy for State Health Policy, June 2005, p. 5, available at [http://www.nashp.org/Files/CHIP25_final.pdf].

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

[33] The changes were also limited by the floors and ceiling.

[34] Table 2 of "Federal SCHIP Financing: Testimony Before the Senate Finance Health (continued...)

Thus, the ACS cannot estimate the number of *uninsured* low-income children that is currently part of the SCHIP allotment formula. The Census Bureau recently completed testing a number of health insurance questions for possible inclusion in the ACS, and preliminary results indicate the test questions performed well. However, even if a decision is made to include a health insurance question(s) in the ACS, it will be a couple of years before the data would be available.

Table 7 shows a comparison of the estimates and margins of error of estimates of low-income children based on the CPS and the ACS. Even using a three-year average on the CPS estimates, its margins of error are higher than the single-year ACS estimates. This is a function of the ACS's much larger sample of people. Although the CPS provides estimates of *uninsured* low-income children, which the ACS currently does not, the CPS margins of error by state are quite high, exceeding 50% in some states, as shown in **Table 7**. Such margins of error may raise additional questions as to whether it is an appropriate basis for distributing billions of federal SCHIP dollars.

Some states have expressed concern that the CPS estimates, even for the *total* number of low-income children, are lower than states' Medicaid and SCHIP enrollment counts of low-income children — and that the ACS estimates are not much better.[35] However, for program eligibility purposes, states often count income differently than surveys. In determining eligibility for Medicaid and SCHIP, states have the flexibility to disregard certain amounts and types of income. Estimates from the CPS and ACS do not reflect such disregards. In the CPS and the ACS, income is counted identically across states for statistical purposes. As a result, states using income disregards would be expected to have more enrollees below certain income amounts than if the surveys' gross income were used.

The income disregards differ by state. Thus, even in states reporting the same upper-income eligibility level, a person who is ineligible in one state might be eligible in another because of different income disregards. Indeed, even *within* a particular state, a person with a particular amount of gross income may be eligible for SCHIP while another person with the same amount of gross income may be ineligible because of the type of income they have and how the disregards apply. Thus, although the surveys have acknowledged limitations in the estimates they provide, there would also be potential drawbacks to using states' enrollment data. The policy question is which of these (along with other possible factors) would best allot the SCHIP appropriations consistent with Congress's goals.

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[34] (...continued)
Subcommittee," Chris L. Peterson, Congressional Research Service (CRS), July 25, 2006, at [http://finance.senate.gov/hearings/testimony/2005test/072506cptest.pdf]. Other comparisons in the characteristics of the ACS and CPS are available on pages 6-7 of that document.

[35] 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, pp. 4-5 and 10-11 regarding North Carolina.

Table 6. Variation from SCHIP Allotment Formula: Impact if FY2007 Allotments Were Based on FY1998 Proportion; States Triggering Formula Floor or Ceiling (FY1998-FY2007)

State	FY1998	FY2007	Difference in FY2007 allotment if based on FY1998 share	# of years state hit SCHIP formula floor	# years state hit SCHIP formula ceiling
Alabama	2.04%	1.49%	$27,213,856	2	0
Alaska	0.16%	0.23%	-$3,400,539	0	1
Arizona	2.76%	2.56%	$10,042,266	0	0
Arkansas	1.13%	0.99%	$7,256,459	1	0
California	20.23%	15.86%	$218,272,362	1	0
Colorado	0.99%	1.43%	-$22,203,557	0	3
Connecticut	0.83%	0.80%	$1,384,881	1	0
Delaware	0.19%	0.22%	-$1,548,994	2	2
DC	0.29%	0.23%	$2,549,336	2	0
Florida	6.40%	5.94%	$22,970,208	1	0
Georgia	2.95%	3.33%	-$18,690,497	0	0
Hawaii	0.21%	0.31%	-$4,752,691	0	6
Idaho	0.38%	0.49%	-$5,567,568	0	1
Illinois	2.90%	4.21%	-$65,100,137	0	2
Indiana	1.67%	1.87%	-$10,216,774	1	0
Iowa	0.77%	0.73%	$2,095,626	0	0
Kansas	0.73%	0.73%	-$346,196	0	0
Kentucky	1.18%	1.41%	-$11,160,403	0	0
Louisiana	2.41%	1.80%	$30,532,763	2	0
Maine	0.30%	0.30%	-$428,770	0	0
Maryland	1.46%	1.34%	$5,801,318	1	0
Massachusetts	1.01%	1.47%	-$22,759,137	0	6
Michigan	2.17%	3.00%	-$41,249,727	0	1
Minnesota	0.67%	0.97%	-$15,086,947	0	5
Mississippi	1.33%	1.21%	$5,643,684	0	0
Missouri	1.22%	1.45%	-$11,130,951	0	0
Montana	0.28%	0.32%	-$1,874,816	1	0
Nebraska	0.35%	0.44%	-$4,343,199	1	0
Nevada	0.72%	1.04%	-$16,155,449	0	1
New Hampshire	0.27%	0.22%	$2,749,509	3	0
New Jersey	2.09%	2.11%	-$812,966	0	0
New Mexico	1.49%	1.04%	$22,305,174	8	0
New York	6.05%	6.83%	-$38,993,803	0	0
North Carolina	1.88%	2.73%	-$42,243,305	0	4
North Dakota	0.12%	0.16%	-$1,786,030	0	3
Ohio	2.74%	3.17%	-$21,351,771	0	0
Oklahoma	2.03%	1.42%	$30,354,937	8	0
Oregon	0.93%	1.14%	-$10,544,056	0	0
Pennsylvania	2.78%	3.48%	-$34,875,991	0	0
Rhode Island	0.25%	0.28%	-$1,368,082	1	0
South Carolina	1.50%	1.42%	$4,389,991	1	0
South Dakota	0.20%	0.21%	-$269,860	0	0
Tennessee	1.57%	1.95%	-$19,353,984	0	0
Texas	13.29%	11.19%	$104,772,413	2	0
Utah	0.57%	0.81%	-$11,864,829	0	0
Vermont	0.08%	0.12%	-$1,579,106	0	4

State	FY1998	FY2007	Difference in FY2007 allotment if based on FY1998 share	# of years state hit SCHIP formula floor	# years state hit SCHIP formula ceiling
Virginia	1.62%	1.89%	-$13,412,301	0	0
Washington	1.10%	1.60%	-$24,791,372	0	5
West Virginia	0.56%	0.55%	$355,084	1	0
Wisconsin	0.96%	1.39%	-$21,588,567	0	2
Wyoming	0.18%	0.14%	$2,162,510	0	0
State total	**100.0%**	**100.0%**	**$0**	**19 states**	**15 states**

Source: Congressional Research Service (CRS).

Table 7. Estimates of Uninsured and of All Low-Income Children, by State

	Current Population Survey (CPS)						American Community Survey (ACS)		
	3-year average (2003, 2004, and 2005)						2005		
	Number of low-income *uninsured* children			Number of low-income children			Number of low-income children		
State	Estimate	Margin of error		Estimate	Margin of error		Estimate	Margin of error	
United States	5,532	241	±4%	29,982	539	±2%	30,323	218	±1%
Alabama	48	22	±45%	493	71	±14%	550	15	±3%
Alaska	10	4	±39%	68	10	±14%	67	6	±9%
Arizona	187	49	±26%	761	94	±12%	756	21	±3%
Arkansas	37	16	±42%	339	47	±14%	363	12	±3%
California	835	110	±13%	4,190	237	±6%	4,217	49	±1%
Colorado	110	35	±32%	397	65	±16%	424	15	±3%
Connecticut	37	18	±48%	213	41	±19%	221	13	±6%
Delaware	13	6	±45%	68	12	±17%	67	6	±9%
DC	7	4	±56%	62	10	±16%	61	5	±9%
Florida	431	71	±16%	1,677	139	±8%	1,760	27	±2%
Georgia	196	51	±26%	993	110	±11%	1,030	25	±2%
Hawaii	8	4	±49%	92	16	±17%	96	9	±10%
Idaho	28	10	±35%	168	24	±14%	174	7	±4%
Illinois	230	53	±23%	1,233	118	±10%	1,201	31	±3%
Indiana	95	31	±33%	640	80	±13%	622	19	±3%
Iowa	33	16	±48%	235	41	±18%	246	9	±4%
Kansas	34	16	±46%	260	41	±16%	269	10	±4%
Kentucky	68	25	±37%	452	67	±15%	464	14	±3%
Louisiana	88	31	±36%	575	76	±13%	590	17	±3%
Maine	11	6	±53%	109	20	±18%	106	7	±6%
Maryland	73	29	±40%	416	67	±16%	383	19	±5%
Massachusetts	50	24	±47%	431	67	±15%	397	16	±4%
Michigan	88	31	±36%	968	102	±11%	970	22	±2%
Minnesota	45	22	±48%	307	55	±18%	371	13	±3%
Mississippi	71	24	±33%	416	53	±13%	432	13	±3%

State	Current Population Survey (CPS) 3-year average (2003, 2004, and 2005) Number of low-income *uninsured* children Estimate	Margin of error		Number of low-income children Estimate	Margin of error		American Community Survey (ACS) 2005 Number of low-income children Estimate	Margin of error	
Missouri	71	29	±41%	531	74	±14%	583	16	±3%
Montana	24	8	±33%	105	16	±15%	100	7	±7%
Nebraska	19	10	±52%	151	25	±17%	161	9	±5%
Nevada	63	20	±31%	246	37	±15%	245	12	±5%
New Hampshire	7	6	±84%	66	14	±21%	72	7	±10%
New Jersey	125	37	±30%	550	76	±14%	603	19	±3%
New Mexico	61	18	±29%	272	39	±14%	273	11	±4%
New York	248	55	±22%	1,966	149	±8%	1,801	33	±2%
North Carolina	179	45	±25%	955	102	±11%	978	20	±2%
North Dakota	10	4	±39%	55	10	±18%	51	4	±8%
Ohio	153	43	±28%	1,043	108	±10%	1,088	25	±2%
Oklahoma	86	27	±32%	406	59	±14%	429	14	±3%
Oregon	63	25	±40%	366	57	±16%	359	14	±4%
Pennsylvania	175	45	±26%	1,053	106	±10%	1,054	24	±2%
Rhode Island	10	6	±59%	93	16	±17%	84	7	±8%
South Carolina	66	25	±39%	461	67	±14%	500	15	±3%
South Dakota	9	4	±44%	73	12	±16%	79	5	±7%
Tennessee	101	35	±35%	611	84	±14%	647	20	±3%
Texas	927	114	±12%	3,246	204	±6%	3,235	41	±1%
Utah	52	18	±34%	288	39	±14%	292	12	±4%
Vermont	3	2	±65%	41	8	±19%	45	4	±10%
Virginia	88	33	±38%	560	80	±14%	571	18	±3%
Washington	72	29	±41%	568	80	±14%	555	19	±3%
West Virginia	20	10	±49%	187	27	±15%	195	9	±5%
Wisconsin	60	25	±42%	483	71	±15%	446	14	±3%
Wyoming	6	4	±65%	41	8	±19%	40	4	±10%

Source: Congressional Research Service (CRS) analysis of published Current Population Survey (CPS) data, available at [http://www.census.gov/hhes/www/hlthins/lowinckid.html], and of American Community Survey (ACS) data provided upon request by the U.S. Census Bureau. Margins of error calculated using 95% confidence intervals.

State Cost Factor. Technical adjustments to this factor could be considered. For example, the state cost factor is calculated based in part on wages paid in the states' nursing and residential care facilities. However, if the factor is to adjust for the health care costs of children in the state, wages in nursing and residential care facilities may not be critical. They could be dropped from the calculation or weighted in a way that is more reflective of children's utilization.

BLS has other employer surveys that could also provide similar information. However, the currently used source of data is a virtual census of employers, which may be preferable to a survey. Because it is a census, a three-year average may not

be necessary, as with the CPS estimates for the *number of children*. Using a single year would also mean that the most recently available data could be the basis of the factor, rather than also incorporating two previous years.

Floors and Ceilings. The key questions for floors and ceilings in formula grant programs is whether they are needed and, if based on prior-year information, what year(s) should be the base. The floors and ceilings in SCHIP were added to ensure in part that no state's share of the appropriation went below or above certain historical levels — to provide some stability and predictability in their federal SCHIP financing. **Table 6** shows that 19 states have had their allotments raised and 15 states have had their allotments lowered because of the statutory floors and ceilings.

The historical floors and the ceiling are tied to states' FY1999 (and the identical FY1998) share of the national SCHIP appropriation. While this ensures some predictability in states' share of the national SCHIP appropriations, those years were also when the CPS sample size was smaller than it has been since, predating the sample expansion. The changes in the estimates since FY1999 may be because of improvements in the CPS. However, the floors and ceiling limit states' allotments to the share of the appropriation in those early years.

Six of the 15 states that have ever had their allotments lowered because of the ceiling are projected to experience a shortfall in FY2007. These states might argue that their federal SCHIP financial status would be better if the ceiling were not in place. Thus, future consideration of floors and ceilings might consider whether they are useful and, if so, whether a different base year(s) should be incorporated.

Conclusion

SCHIP has been lauded for the health insurance it provides to children and for the flexibility states have in designing their SCHIP programs. With SCHIP's final appropriation slated to occur in this fiscal year (FY2007), the possibility of enacting new appropriations might also be used by Congress to examine some of the issues surrounding both the national SCHIP appropriation levels and the allotment formula.

States' projected shortfalls of federal SCHIP funds is one issue that has received recent legislative attention. FY2006 was the first year in which several states faced the prospect of shortfalls, projected initially at $283 million. In response, Congress appropriated an additional $283 million for SCHIP in FY2006. To eliminate shortfalls in FY2007 and beyond, additional funds will be needed beyond the annual $5 billion in appropriations assumed in the current baseline. Original allotments — both their national level and their distribution among the states — have become increasingly critical to states in operating their SCHIP programs, determining not only how much federal money states receive but, for a given level of states' projected spending, what size shortfall states are projected to face. As a result, future original allotments could be set and distributed using information not known or available when the program was created a decade ago.