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

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

Summary

The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels. As of August 2007, the highest upper income eligibility limit under SCHIP was 350% of the federal poverty level, in one state, New Jersey.

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

Nearly $40 billion was appropriated for SCHIP for FY1998 through FY2007. Annual allotments among the states are determined by a formula that is based on a combination of the number of low-income children and low-income uninsured children in the state, adjusted by a cost factor that reflects the average health service industry wages in the state compared to the national average. Like Medicaid, SCHIP is a federal-state matching program. While the Medicaid federal medical assistance percentage (FMAP) ranged from 50% to 75.89% in FY2007, the enhanced SCHIP FMAP ranged from 65% to 83.12% across states.

All states, the District of Columbia, and five territories have SCHIP programs. As of June 2007, 15 use Medicaid expansions, 18 use separate state programs, and 23 use a combination approach. At the national level, approximately 6.7 million children were enrolled in SCHIP during FY2006 (latest official data). In addition, 12 states reported enrolling about 701,000 adults in SCHIP through program waivers.

Spending was slow in the early years of SCHIP, but that trend changed in more recent years and has led some states to exhaust their federal SCHIP funds. The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) provided a new appropriation of $283 million to address anticipated FY2006 shortfalls in federal SCHIP funding, although two states (Illinois and Massachusetts) still experienced shortfalls. The NIH Reform Act of 2006 (P.L. 109-482) included provisions to delay FY2007 shortfalls until the first part of May. Under P.L. 110-28, Congress appropriated up to $650 million to cover shortfalls in 12 states in FY2007. Before the August recess, Congress passed legislation (H.R. 3162 in the House and S. 1893/H.R. 976 in the Senate) that would provide additional funding for SCHIP for FY2008 and additional years, and would make a number of other changes to both SCHIP and Medicaid.

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Eligibility

In general, Title XXI defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. States can set the upper income level for targeted low-income children up to 200% of the federal poverty level (FPL),[2] or 50 percentage points above the applicable pre-SCHIP Medicaid income level.

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

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

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[1] See CRS Report RS21054, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers*, by Evelyne P. Baumrucker.

[2] In 2007, the poverty guideline in the 48 contiguous states and the District of Columbia is $20,650 for a family of four. ("Annual Update of the HHS Poverty Guidelines," 72 *Federal Register* 3147, January 24, 2007.)

States may cover targeted low-income children by expanding their Medicaid programs in the following ways: (1) by establishing a new optional eligibility group for such children as authorized in Title XXI, and/or (2) by liberalizing the financial rules[3] for any of several existing Medicaid eligibility categories. Many states with Medicaid-expansion SCHIP programs chose the latter, opting to cover targeted low-income children under existing Medicaid eligibility pathways, especially Medicaid's poverty-related child groups, rather than by establishing the Title XXI optional coverage group.[4] Such a strategy reduces the administrative burden of creating and implementing a new coverage group.[5]

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

As of August 2007, the highest upper income eligibility limit under SCHIP was 350% of the FPL (see **Table 1**).[6] New York has submitted a state plan amendment (SPA) to expand SCHIP eligibility to children up to 400% FPL, but it has not yet been approved by the Administration. Twenty-four states had established upper

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

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

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

[6] For determining financial eligibility for SCHIP and Medicaid, certain types and/or amounts of income are not counted. These are called "income disregards." For example, specified dollar amounts may be subtracted from gross income to calculate net income, which is then compared to the applicable income criterion.

income limits at 200% FPL. Another 18 states plus the District of Columbia exceeded 200% FPL. Eight states set maximum income levels below 200% FPL.[7]

Benefits

As noted above, when designing their SCHIP programs, states may cover targeted low-income children under their Medicaid program, create a new separate SCHIP program, or devise a combination of both approaches.

States that use Medicaid-expansion SCHIP programs must provide the full range of mandatory Medicaid benefits, as well as all optional services specified in their state Medicaid plans. As an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (P.L. 109-171; DRA) gives states the option to enroll state-specified groups, including children in SCHIP Medicaid expansions, in new benchmark and benchmark-equivalent benefit plans. These plans are nearly identical to the benefit packages offered through separate SCHIP programs (described below). For any child under age 19 in one of the major mandatory and optional Medicaid eligibility groups, including targeted low-income children, the benefits available through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program must be provided. Under EPSDT, children receive well-child care, immunizations, and other screening services, as well as medical care necessary to correct or ameliorate identified defects, illnesses, or conditions, including optional services states may not otherwise cover in their Medicaid programs.

States that choose to create separate SCHIP programs may elect any of three benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other health benefits plan that the Secretary of Health and Human Services determines will provide appropriate coverage to the targeted population of uninsured children.[8]

A benchmark benefit package is one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage that is offered and generally available to state employees in the state involved, and (3) the

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[7] States may apply resource, or asset, tests in determining financial eligibility, but are not required to do so. In states with a resource test, individuals must have resources for which the dollar value is less than a specified standard amount in order to qualify for coverage. States determine what items constitute countable resources and the dollar value assigned to those countable resources. Assets may include, for example, cars, savings accounts, real estate, trust funds, tax credits, etc. In 2005, asset/resource tests were an eligibility criteria in only four states — Idaho, Missouri, Oregon and Texas (see N. Kaye, et al., *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs,* National Academy for State Health Policy (NASHP), September 2006, [http://www.chipcentral.org/Files/Charting_CHIP_III_9-21-6.pdf], pp. 42-43).

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

health coverage that is offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved.

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

Cost-Sharing

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

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

DRA[9] provides states with a new option for premiums and service-related cost-sharing that may be applied to targeted low-income children under SCHIP Medicaid-expansion programs. For children in families with income under 100% FPL, no premiums are allowed and service-related cost-sharing is limited to nominal amounts. For children in families with income between 100%-150% FPL, no premiums may be imposed; however, service-related cost-sharing may be applied up to 10% of the cost of the item or service rendered. For children in families with income above 150% FPL, premiums are allowed (no limit is specified), and service-related cost-sharing may be applied up to 20% of the cost of the item or service rendered. For all individuals, the total aggregate amount of all cost-sharing cannot exceed 5% of family income (on a quarterly or monthly basis as specified by the state). Preventive services for children are exempt from DRA cost-sharing. The nominal Medicaid cost-sharing amounts in regulation will be indexed by medical care inflation. Special rules apply to cost-sharing for prescription drugs, and for emergency room copayments for non-emergency care. DRA also allows states to condition continuing

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[9] P.L. 109-432 modified DRA by specifying cost-sharing rules for individuals in families with income under 100% FPL. For additional information, see CRS Report RS22578, *Medicaid Cost-Sharing under the Deficit Reduction Act of 2005 (DRA)*, by Elicia J. Herz.

Medicaid eligibility on the payment of premiums. Providers may also be allowed to deny care for failure to pay service-related cost-sharing.

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

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

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

Financing

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

Federal Appropriations and Allotment Among the States and Territories. BBA 97 appropriated a total of approximately $40 billion for SCHIP for FY1998- FY2007.[10] The funding level by fiscal year varies across time. The total annual appropriation for each of FY1998-FY2001 was a little more than $4.2 billion. This annual total dropped to under $3.2 billion in FY2002-FY2004. Then the appropriation rose to about $4.1 billion for FY2005 and FY2006, with a further

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

increase to roughly $5.0 billion in FY2007. The drop in funding for FY2002-FY2004, sometimes referred to as the "SCHIP dip," was written into SCHIP's authorizing legislation due to budgetary constraints applicable at the time the legislation was drafted.

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

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

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

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

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

In the first reallocation legislation for FY1998 and FY1999 (P.L. 106-554), redistribution states (12 in FY1998 and 13 in FY1999) were given access to unspent funds from other states equal to their excess spending above their original allotments during the applicable three-year period. After a set-aside of 1.05% of the total unspent funds for territories that fully exhausted their original allotments (all five), the remaining unused funds were divided among the retention states in proportion to their contribution to the total pool of unspent funds. In contrast, under the second reallocation legislation for FY2000 and FY2001 (P.L. 108-74), a different rule was used. A set-aside of 1.05% of the total unspent funds was made for territories that fully exhausted their original allotments (again, all five). Then, retention states kept one-half of their unused funds. The remaining unspent funds were then distributed among redistribution states (14 for FY2000 and 19 for FY2001) in proportion to their contribution to the total pool of excess spending.[11]

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[11] Finally, P.L. 108-74 also permits certain states to spend their available balances from (continued...)

Because no law was enacted specifying otherwise, the reallocation process followed BBA 97 requirements for unspent FY2002 funds. Under this law, unspent allotments are subject to redistribution among only those states that fully expend their allotments by the applicable three-year deadline, by a method to be determined by the Secretary of Health and Human Services. Six states that were projected to exhaust *all* of their available federal SCHIP accounts (excluding any possible FY2002 redistributed funds) in FY2005, based on their estimated FY2005 expenditures, received FY2002 redistribution money equal to that estimated shortfall. After eliminating these states' initial projected shortfall, the remaining balance of unspent FY2002 funds was then divided among a total of 28 redistribution states, including the six initial shortfall states, based on each such state's percentage of the total excess spending above the FY2002 allotments during the three-year period of availability of these funds.[12] Also according to BBA 97, reallocation pots expire at the end of one year. In the case of reallocated FY2002 funds, the expiration date was the end of FY2005.

For FY2006, the Secretary was required to distribute both unspent FY2003 original allotments and the new appropriation of $283 million from DRA for covering projected shortfalls. The only limitation in attempting to cover states' shortfalls was that the DRA funds could not pay for adult coverage. Without the DRA appropriation, 12 states were projected to face shortfalls, even with the $173 million available from the redistribution of unspent FY2003 original allotments. Based on states' projections at the time, the $283 million appropriation would have nearly eliminated the shortfalls among these 12 states. However, since then, two states (Illinois and Massachusetts) increased their FY2006 SCHIP spending such that they experienced shortfalls totaling approximately $100 million, almost all of that from Illinois.

In FY2007, $147 million in unspent FY2004 original allotments was available for redistribution. In the closing hours of the 109th Congress, a bill was passed to specify how those funds would be redistributed. The National Institutes of Health (NIH) Reform Act of 2006 (H.R. 6164, P.L. 109-482) required that the funds go to states "in the order in which such [shortfall] States realize monthly funding shortfalls ... for fiscal year 2007." The purpose was to delay any state facing a shortfall as far into the year as possible with the available funds. CRS projections indicated that this particular provision would delay shortfalls until the end of March. To delay

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

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

shortfalls even further, the SCHIP provisions of H.R. 6164 called 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 required 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, were at least double what the state projected to spend in federal SCHIP funds in FY2007. This was projected to provide an additional $138 million for shortfall states, delaying any state facing a shortfall of federal SCHIP funds until May 2007. The shortfalls remaining for the rest of the fiscal year were projected at just over $600 million in 12 states. Under P.L. 110-28, Congress appropriated up to $650 million to cover state shortfalls for the remainder of FY2007.

Other Factors Affecting Federal Financing. Like Medicaid, SCHIP is a federal-state matching program. For each dollar of state spending, the federal government makes a matching payment drawn from SCHIP accounts. A state's share of program spending for Medicaid is equal to 100% minus the federal medical assistance percentage (FMAP). The enhanced SCHIP FMAP is equal to a state's Medicaid FMAP increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the FMAP is less than 100%.[13] For example, in states with a Medicaid FMAP of 60%, the enhanced FMAP equals the Medicaid FMAP increased by 12 percentage points (60% + [30% multiplied by 40 percentage points] = 72%.) In this example, the state share is 100% - 72% = 28%.

In other words, the enhanced FMAP means a state's share of expenditures is 30% lower than under the regular FMAP. In the previous example, with the federal government paying 60% of Medicaid expenditures, the state's share was 40%. Under the enhanced FMAP in SCHIP, the state's share is 28% (i.e., 40% x 0.7).

Compared with the Medicaid FMAP, which ranges from 50% to 75.89% in FY2007, the enhanced FMAP for SCHIP ranges from 65% to 83.12%. All SCHIP assistance for targeted low-income children, including coverage provided under Medicaid, is eligible for the enhanced FMAP. The Medicaid FMAP and the enhanced SCHIP FMAP are subject to a ceiling of 83% and 85%, respectively.

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

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

expenditures combined can be used for non-benefit costs including administrative expenses.

General Program Characteristics

All 50 states, the District of Columbia, and five territories have SCHIP programs. As of June 2007, 15 use Medicaid expansions (including all five territories), 18 use separate state programs, and 23 use a combination approach. Three states received authority under the Balanced Budget Act of 1997 to operate previously existing comprehensive state-based plans as their separate SCHIP program. Among other types of separate SCHIP programs, data from 2005[14] indicate that most of the benchmark and benchmark-equivalent plans are based on the state employees' health plan, and most secretary-approved plans are modeled after Medicaid.

SCHIP programs across states are evolving rapidly, as evidenced by the numerous changes states have made to their original state plans over time. As of June 2007, 285 amendments to original state plans had been approved and 10 more were in review.[15] Most states have multiple amendments. The content of the plan amendments varies among states. For example, some states use amendments to extend coverage beyond income levels defined in their original state plans. Others define new copayment standards for program participants. Still others modify benefit packages.

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

For example, states have used this waiver authority to (1) provide services to individuals not traditionally eligible for SCHIP (e.g., parents of Medicaid or SCHIP-eligible children, caretaker relatives, legal guardians, and non-pregnant childless

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[14] CRS analysis of unpublished data from a 2005 survey of state SCHIP programs conducted by the National Academy for State Health Policy (NASHP). For more information about this survey, see [http://www.chipcentral.org/Files/Charting_CHIP_III_9-21-6.pdf].

[15] The source for this information can be found online at [http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/SCHIPStatePlanActivityMap.pdf], as of June 1, 2007.

adults[16]); (2) extend access to premium assistance programs beyond current law constraints; (3) provide access to pregnancy-related services, including prenatal care and labor and delivery, and 60 days of postpartum care for the mother for populations not otherwise eligible for SCHIP (e.g., adult pregnant women); and (4) limit benefit packages for certain groups (e.g., provide access to "bare bones" benefit packages for specified groups, such as employees of small businesses). In addition to waiver authority, states may provide prenatal and labor/delivery services to unborn children through a state plan option that can be used to provide assistance to pregnant women aged 19 and older, and to pregnant individuals who do not qualify for Medicaid or SCHIP because of their immigration status, for example. As of March 2007, 16 states were granted Section 1115 demonstrations under the HIFA initiative, and 13 had approval to finance at least some of their adult coverage groups with unspent SCHIP funds. As of June 2007, 17 states offered pregnancy-related services using SCHIP funds. Of those, 11 states extended coverage through the unborn child state plan option, and 6 states used Section 1115 waiver authority.

Under SCHIP, states may purchase "family coverage" under an employer-sponsored health insurance plan if it is cost-effective relative to the amount paid to cover only the targeted low-income children and does not substitute for coverage under group health plans otherwise provided to the children. In addition, states using SCHIP funds for employer-based plan premiums must ensure that (1) SCHIP minimum benefits are provided, (2) SCHIP cost-sharing ceilings are met, and (3) the children to be enrolled have not had group coverage for a specified period of time (typically four to six months). Because of these requirements, implementation of premium assistance programs under SCHIP is not widespread. Also, as part of the HIFA initiative, states have used both Medicaid and SCHIP funds to pay premium costs for waiver enrollees who have access to employer-sponsored insurance (ESI). ESI programs approved under this waiver authority are not subject to the comprehensiveness, cost-effectiveness, and waiting period tests otherwise applicable to SCHIP's family coverage option. As of March 2007, 10 states reported operating a premium assistance program under SCHIP or Medicaid through waiver authority. (Other states may also be providing premium assistance through state plan amendments.)

Trends in Enrollment and Expenditures

Early enrollment estimates indicated that nearly 1 million children (982,000) were enrolled in SCHIP under 43 operational state programs as of December 1998.[17] Nearly two million children (1,979,450) were enrolled in SCHIP during FY1999

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[16] The Deficit Reduction Act of 2005 (P.L. 109-171) prohibits the use of SCHIP funds for coverage of non-pregnant childless adults in any new waivers approved after February 8, 2006.

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

under 53 operational state programs.[18] The latest official numbers show that SCHIP enrollment reached a total of 6.7 million children in FY2006 (see **Table 1**). Of this total, about 4.7 million were covered in separate state programs, and 2.0 million were targeted low-income children under Medicaid.

Ten states also reported enrollment of about 701,000 adults in SCHIP in FY2006 (see **Table 1**). A substantial share of these adults (about 71%) were parents. A little over one-fourth were childless adults, and the remainder were pregnant women. Finally, in FY2006, adult enrollment exceeded child enrollment in three states (Arizona, Minnesota, and Wisconsin).

Expenditures under SCHIP have been the subject of much debate and controversy almost since the program's inception. Despite the fact that most states began enrolling children in SCHIP in late 1997 or 1998, new programs often take time to get off the ground and participation rates in the early years of SCHIP rose more slowly than expected. As a consequence, spending was slow to ramp up too, as evidenced by the fact that a minority of states (12 to 19, depending on the year) fully expended their original FY1998-FY2001 allotments by the applicable three-year deadlines (see **Table 2**). It was not until FY2005, when the redistribution of unspent FY2002 funds took place, that more than half of the states (28) succeeded in qualifying for a portion of these unused funds because they spent all their own FY2002 allotments within the three-year period of availability. All but seven states exhausted their FY2004 allotments before FY2007. But only selected shortfall states actually received the unspent FY2004 funds, as described above.

Table 3 provides a historical snapshot of SCHIP funding and expenditures for FY1998-FY2005. A total of $30.5 billion of the total federal SCHIP appropriation of nearly $40 billion was made available to states and territories during this period. By the end of FY2005, nearly 77% ($23.4 billion) of these funds was spent. However, an additional $1.4 billion available to 11 states actually expired by the close of FY2005; these expired funds were comprised of unspent FY1998 to FY2002 reallocated monies. The column displaying net funds gained or lost through the reallocation process indicates that 31 states forfeited more funds to redistribution than they received. California (-$1.5 billion) and Texas (-$808 million) had the largest absolute net losses, while New York ($1.8 billion)[19] and New Jersey ($531 million) had the largest absolute net gains.

Table 4 displays available SCHIP funds and reported expenditures for FY2006. During FY2006, several SCHIP accounts were active:

- reallocated FY2003 funds and the new DRA appropriation of $283 million to cover shortfalls, available only in FY2006, and

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

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

- original allotments for FY2004, FY2005, and FY2006, each available for a three-year period.

As noted previously, 12 states (plus the five territories) received additional funds through the reallocation of unspent FY2003 funds and/or the DRA appropriation. After these distributions, and because actual expenditures ended up below states' projections, FY2006 shortfalls of federal SCHIP funds were averted in 10 of the 12 states projected to face shortfalls when DRA was developed. Illinois and Massachusetts experienced FY2006 shortfalls, but stopped claiming SCHIP funds before their balances were entirely depleted, which is why balances remain for them in **Table 4**. Illinois estimated its FY2006 shortfall of federal SCHIP funds at approximately $95 million, and Massachusetts estimated its shortfall at approximately $7 million. The options these states tended to use in response to these shortfalls were (1) to delay claiming until the beginning of FY2007, when the new original allotment was available (although this would 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. Nationally, the end-of-FY2006 balances of federal SCHIP funds totaled approximately $4.6 billion, including $147 million in unspent FY2004 original allotments, which were redistributed to FY2007 shortfall states.

Forthcoming SCHIP Issues

SCHIP has federal appropriations for the current fiscal year, but none are slated for FY2008 and beyond. Before the August recess, Congress passed legislation (H.R. 3162 in the House and S. 1893/H.R. 976 in the Senate) that would provide additional funding for SCHIP for FY2008 and additional years, and would make a number of other changes to both SCHIP and Medicaid. For a detailed description of the proposed changes in each bill, see CRS Report RL34129, *Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R. 976*.

SCHIP Legislative History

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

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

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

2. *CBO Scoring.* — 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 $5.0 billion annually beyond FY2007 would not be scored by CBO as increasing federal government spending above its current baseline.

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

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

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

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

2. *Freeze Each State's Share of Appropriation.* Each state's percentage of the total appropriation available to states for the FY1998 SCHIP allotments was also used for determining the FY1999 allotments.

3. *Change in Allotment Formula Affecting Some Native American Children.* For FY1998 and FY1999, the law changed the annual state allotment formula by stipulating that children with access to health care funded by the Indian Health Service and no other health insurance would be counted as uninsured (rather than as insured as required under the previously existing law).

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

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

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

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

4. *Federal Evaluation.* New funding was also provided for a federal evaluation[20] to identify effective outreach and enrollment practices for both SCHIP and Medicaid, barriers to enrollment, and factors influencing beneficiary drop-out.

5. *Additional Reports and a Clearinghouse.* The law also required (a) an inspector general audit[21] and GAO report on enrollment of Medicaid-eligible children in SCHIP,[22] (b) states to report annually the number of deliveries to pregnant women and the number of infants who receive services under the Maternal and Child Health Services Block Grant or who are entitled to SCHIP benefits, and (c) the Secretary of Health and Human Services to establish a clearinghouse for the consolidation and coordination of all federal databases and reports regarding children's health.

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

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

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

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

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

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

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

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

reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement.

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

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

1. *Special Redistribution Rules for Unspent FY1998 and FY1999 Allotments.* For each of these years separately, a pool of unspent funds is created from the unused allotment amounts of those states that did not fully expend their original allotments within the applicable three-year time frame. From this pool, 1.05% is set aside for the territories that fully exhaust their original allotments. Each such territory receives a percentage of the available 1.05% pool equal to that territory's original allotment divided by the sum of original allotments for such territories. Then the states that *did* fully expend their original allotments within the three-year deadline receive access to redistributed funds from the remaining pool equal to the amount by which their three-year spending exceeds their original allotments.[23] The remaining states that did *not* use all their original allotments for the year retain access to a portion of the remaining funds in the pool, equal to the ratio of such a state's unspent original allotment to the total amount of unspent funds for that fiscal year. These latter states are permitted to use up to 10% of their retained FY1998 funds for outreach activities. This allowance is over and above spending for such activities under the general administrative cap described above. The deadline for spending all redistributed and retained funds from FY1998 and FY1999 is September 30, 2002, although this date was extended by P.L. 108-74 as described below. (See the text for additional information on redistribution of unspent SCHIP funds.)

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

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

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

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

1. *Waiver of Provider Requirements and Medicare+Choice Payment Limits.* The law authorizes the Secretary to temporarily waive conditions of participation and other certification requirements for any entity that furnishes health care items or services to Medicare, Medicaid, or SCHIP beneficiaries in an emergency area during a declared disaster or public health emergency. During such an emergency, the Secretary may waive: (a) participation, state licensing (as long as an equivalent license from another state is held and there is no exclusion from practicing in that state or any state in the emergency area), and pre-approval requirements for physicians and other practitioners; (b) sanctions for failing to meet requirements for emergency transfers between hospitals; (c) sanctions for physician self-referral; and (d) limitations on payments for health care and services furnished to individuals enrolled in Medicare+Choice (M+C) plans when services are provided outside the plan. To the extent possible, the Secretary must ensure that M+C enrollees do not pay more than would have been required had they received care within their plan network.

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

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

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

1. *Study of Migrant Farm Workers.* This law requires the Secretary to conduct a study of the problems experienced by farm workers and their families under Medicaid and SCHIP, specifically, barriers to enrollment, and lack of portability of Medicaid and SCHIP coverage for farm workers eligible in one state who move to other states on a periodic basis. The Secretary must also identify possible strategies to increase enrollment and access to benefits for these families. Strategies to be

examined must include (a) use of interstate compacts to establish portability and reciprocity, (b) multi-state demonstration projects, (c) use of current law flexibility for coverage of residents and out-of-state coverage, (d) development of programs of national migrant family coverage, (e) use of incentives to private coverage alternatives, and (f) other solutions as deemed appropriate. In conducting the study, the Secretary must consult with several groups. The Secretary must submit a report on this study to the President and Congress in October 2003. This report shall address findings and conclusions and provide recommendations for appropriate legislative and administrative action.

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

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

2. *Revision of Methods for Reallocation of Unspent FY2000 and FY2001, and Extension of the Availability of Such Funds.* The law also establishes a new method for reallocating unspent funds from FY2000 and FY2001 allotments. For each of these years separately, a pool of unspent funds is created from the unused allotment amounts of those states that did not fully expend their original allotments within the applicable three-year time frame. From this pool, 1.05% is set aside for the territories that fully exhaust their original allotments. Each such territory receives a percentage of the available 1.05% pool equal to that territory's original allotment divided by the sum of original allotments for such territories. For each year separately, each state that does *not* spend its full original allotment by the three-year deadline retains 50% of its unspent funds. Then the remaining pool is allocated to each state that fully expends (exceeds) its original allotment by the three-year deadline. The redistribution amount for each such state is based on the proportion of its excess spending relative to the total amount of excess spending for all such states. Reallocated funds for FY2000 and FY2001 are available until the end of FY2004 and FY2005, respectively.

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

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

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

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

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

2. *Prohibition against covering non-pregnant, childless adults with SCHIP funds.* The Secretary of HHS is prohibited from approving new 1115 waivers, on or after October 1, 2005, that would use SCHIP funds to provide coverage to non-pregnant, childless adults. The Secretary may continue to approve projects that expand SCHIP to caretaker relatives of Medicaid- or SCHIP-eligible children, and to pregnant adults. Existing waivers that use SCHIP funds to cover non-pregnant, childless adults (including extensions, amendments, and renewals of such waivers) that were approved before enactment of DRA are allowed to continue.

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

National Institutes of Health Reform Act of 2006, P.L. 109-482:[24]

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[24] 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.

1. *Prioritizing Redistribution of Unspent FY2004 Original Allotments*. The Secretary of HHS is required to redistribute unspent FY2004 original allotments to states in the order in which they are projected to exhaust their federal SCHIP funds.

2. *Early, Partial Redistribution of Unspent FY2005 Original Allotments*. An initial redistribution is required of up to half of states' 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, the state's *total* SCHIP balances (from the FY2005-FY2007 original allotments) as of March 31, 2007, must be at least double what the state projects to spend in federal SCHIP funds in FY2007. These funds would also be targeted to shortfall states in the order in which those shortfalls are experienced. The initial redistribution of unspent FY2005 funds does not replace the regular redistribution at the end of the allotment's three-year period of availability. Thus, among the states that forgo half of their unspent FY2005 funds on March 31, 2007, any amount still unspent at the end of FY2007 will be redistributed to other states after having been available for three years.

3. *Limitations on Spending*. The FY2004 and FY2005 redistributed funds available in FY2007 may only be used to cover populations eligible in a state's SCHIP program as of October 1, 2006. The FY2004 and FY2005 redistributed funds may pay only the regular FMAP, rather than the enhanced SCHIP FMAP, for non-pregnant adults enrolled in SCHIP. The Secretary is authorized to alter the amount of FY2004 and FY2005 redistributed funds received by states on the basis of actual end-of-FY2007 expenditures, to account for how actual expenditures may differ from the projections on which the initial redistributions are based, with some limitations. The territories do not receive any FY2004 and FY2005 redistributed funds in FY2007.

4. *Continued authority for qualifying states to use SCHIP funds for certain Medicaid expenditures.* The law allows qualifying states to use any available FY2006 and FY2007 SCHIP funds (in addition to the FY2005 funds) for coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion), up to the 20% allowance. See the discussion of P.L. 108-74 and P.L. 108-127 for more details.

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007, P.L. 110-28:

1. *Elimination of remainder of SCHIP funding shortfalls, tiered match, and other limitation on expenditures.* This law required the Secretary of HHS to allot to certain shortfall states the amount determined by the Secretary to eliminate each such state's estimated FY2007 shortfall, not to exceed a total of $650 million for all such states. Shortfall states are defined as those for which projected FY2007 federal expenditures would exceed the sum of (1) the amount of the state's unspent FY2005 and FY2006 allotments still available by the end of FY2006, (2) the state's FY2007 allotment, and (3) the amounts of redistributed FY2004 and FY2005 funds available to the state in FY2007 (if any). It also eliminated the requirement in NIHRA that redistributed FY2004 and FY2005 funds pay only the regular FMAP for non-pregnant adults in SCHIP.

2. *Prohibition.* P.L. 110-28 also prohibited the Secretary of HHS from taking an administrative action to finalize or otherwise implement Medicaid administrative proposals related to intergovernmental transfers (payments for government providers) and graduate medical education for one year from the date of enactment of this law.

3. *Requirement for use of tamper-resistant prescription pads under the Medicaid Program.* The law requires the use of tamper-resistant pads for Medicaid prescriptions executed after September 30, 2007. It also allows any state operating a Medicaid Pharmacy Plus waiver that would otherwise expire on June 30, 2007, to continue operating the waiver through December 31, 2009.

Table 1. SCHIP Enrollment Data for the 50 States and the District of Columbia, FY2006

State and Program Type	Upper Income Level for Children (% FPL) as of 8/8/07	Number of Children Ever Enrolled during FY2006			Number of Adults Ever Enrolled in SCHIP Demonstrations (and Upper Income Level by Group) during FY2006			
		Medicaid Expansions	Separate SCHIP Programs	Total Children	Pregnant Women	Parents	Childless Adults	Total Adults
Alabama (S)	200%	—	84,257	84,257				
Alaska (M)	175%	22,227	—	22,227				
Arizona (S)	200%	—	96,669	96,669	—	24,769 (200%)	84,969 (100%)[a]	109,738
Arkansas (C)	200%	86,778	3,440	90,218				[b]
California (C)	250%[c]	214,216	1,177,189	1,391,405				
Colorado (S)	200%	—	69,997	69,997	2,625 (200%)	—	—	2,625
Connecticut (S)	300%	—	23,110	23,110				
Delaware (C)	200%	172	10,579	10,751				
District of Columbia (M)	300%	6,332	—	6,332				
Florida (C)	200%	1,877	301,718	303,595				
Georgia (S)	235%	—	343,690	343,690				
Hawaii (M)	300%	22,031	—	22,031				
Idaho (C)	185%	17,858	6,869	24,727	[d]	277 (185%)	105 (185%)	382
Illinois (C)	200%	139,565	177,216	316,781	—	209,622 (185%)	1,492 (185%)[e]	211,114

State and Program Type	Upper Income Level for Children (% FPL) as of 8/8/07	Number of Children Ever Enrolled during FY2006			Number of Adults Ever Enrolled in SCHIP Demonstrations (and Upper Income Level by Group) during FY2006			
		Medicaid Expansions	Separate SCHIP Programs	Total Children	Pregnant Women	Parents	Childless Adults	Total Adults
Indiana (C)	200%	97,213	36,483	133,696				
Iowa (C)	200%	17,756	31,819	49,575				
Kansas (S)	200%	—	48,934	48,934				
Kentucky (C)	200%	41,943	22,918	64,861				
Louisiana (M)	200%	142,389	—	142,389				
Maine (C)	200%	22,167	8,947	31,114				
Maryland (C)	300%	112,123	23,911	136,034				
Massachusetts (C)	300%	126,120	64,520	190,640				
Michigan (C)	200%	61,214	57,287	118,501	—	—	101,919 (35%)	101,919
Minnesota (C)	280%	97	5,246	5,343	—	34,313 (200%)	—	34,313
Mississippi (S)	200%	—	83,359	83,359				
Missouri (M)	300%	106,577	—	106,577				
Montana (S)	150%	—	17,304	17,304				
Nebraska (M)	185%	44,981	—	44,981				
Nevada (S)	200%	—	39,317	39,317				[b]
New Hampshire (C)	300%	671	11,722	12,393				

State and Program Type	Upper Income Level for Children (% FPL) as of 8/8/07	Number of Children Ever Enrolled during FY2006			Number of Adults Ever Enrolled in SCHIP Demonstrations (and Upper Income Level by Group) during FY2006			
		Medicaid Expansions	Separate SCHIP Programs	Total Children	Pregnant Women	Parents	Childless Adults	Total Adults
New Jersey (C)	350%	49,994	92,811	142,805	205 (200%)	88,401 (115%)	—	88,606
New Mexico (M)	235%	25,155	—	25,155	—	2,756 (200%)	3,031(200%)	5,787
New York (C)	250%	51,576	636,786	688,362				
North Carolina (C)	200%	53,180	194,811	247,991				
North Dakota (C)	140%	1,889	4,429	6,318				
Ohio (M)	200%	218,529	—	218,529				
Oklahoma (M)	200%	116,012	—	116,012				
Oregon (S)	185%	—	59,039	59,039	[d]	7,306 (185%)	6,444 (185%)	13,750
Pennsylvania (S)	300%	—	188,765	188,765				
Rhode Island (C)	250%	24,028	1,464	25,492	354 (250%)	20,771 (185%)	—	21,125
South Carolina (M)	150%	68,870	—	68,870				
South Dakota (C)	200%	11,254	3,330	14,584				
Tennessee (C)	250%	—	— [f]	—				
Texas (S)	200%	—	585,461	585,461				
Utah (S)	200%	—	51,967	51,967				
Vermont (S)	300%	—	6,314	6,314				

State and Program Type	Upper Income Level for Children (% FPL) as of 8/8/07	Number of Children Ever Enrolled during FY2006			Number of Adults Ever Enrolled in SCHIP Demonstrations (and Upper Income Level by Group) during FY2006			
		Medicaid Expansions	Separate SCHIP Programs	Total Children	Pregnant Women	Parents	Childless Adults	Total Adults
Virginia (C)	200%	65,536	72,106	137,642	939 (185%)	—	—	939
Washington (S)	250%	—	15,000	15,000				
West Virginia (S)	220%	—	39,855	39,855				
Wisconsin (M)	185%	56,627	—	56,627	—	110,298 (185%)	—	110,298
Wyoming (S)	200%	—	7,715	7,715				
TOTALS		2,026,957	4,706,354	6,733,311	4,123	498,513	197,960	700,596

Sources: Table prepared by CRS based on several sources. For SCHIP upper income levels for children, unpublished set of tables provided by CMS via e-mail on August 8, 2007. For program type and number of children ever enrolled, see *FY 2006 Number of Children Ever Enrolled Year - SCHIP by Program Type*, at [http://www.cms.hhs.gov/NationalSCHIPPolicy/downloads/FY2006StateTotalTable.pdf], plus more recent unpublished information from CMS on the number of children enrolled for Arkansas, New Jersey and Virginia. For the number of adults enrolled in SCHIP demonstrations, *Adult SCHIP Chart FY2006 (030107).xls*, provided by CMS via e-mail on March 8, 2007. For upper income eligibility limits for adults in SCHIP, see the CRS Congressional Distribution Memorandum, *Medicaid and SCHIP Adult Coverage under the Section 1115 Waiver Authority*, by Evelyne P. Baumrucker (available upon request); additional information obtained directly from states when the upper income eligibility levels for adults were below the maximum permitted.

Notes: S — Separate child health program. M — Medicaid expansion program. C — Combination program. FPL — federal poverty level.

a. Arizona started phasing down its use of SCHIP funds for childless adults during FY2005. Since the December 2005 quarter, Arizona has covered childless adults using only Medicaid funds (personal communication with Arizona state officials, June 5, 2007).

b. Arkansas and Nevada did not start enrollment in their demonstrations until FY2007. Arkansas covers parents up to 200% FPL and Nevada covers pregnant women up to 185% FPL and parents up to 200% FPL.

c. California also provides coverage up to 300% in four select counties and for infants covered under the Access for Infants and Mothers (AIM) program.

d. Idaho and Oregon did not report for their pregnant women populations (in both states, covered up to 185% FPL).

e. Childless adults are not a separate eligibility category in Illinois' SCHIP but may be covered through the state's programs for hemophiliacs and its high risk pool.

f. Using SCHIP funds to expand its existing Medicaid Section 1115 waiver demonstration, Tennessee began enrolling children in October 1997 through FY2002. In that year, enrollment reached 10,216. Eligibility for this Medicaid expansion program was limited to older children in families with income up to 100% FPL. As of October 1, 2002, all such children had to be covered under regular Medicaid, that is, they were no longer eligible for SCHIP coverage. Thus, Tennessee has no enrollment in its SCHIP Medicaid expansion program subsequent to FY2002. New groups became eligible for a separate SCHIP program in FY2007, so there was no FY2006 enrollment.

Table 2. States Exhausting Particular SCHIP Allotments

State	Exhausted FY1998 allotment by FY2001	Exhausted FY1999 allotment by FY2002	Exhausted FY2000 allotment by FY2003	Exhausted FY2001 allotment by FY2004	Exhausted FY2002 allotment by FY2005	Exhausted FY2003 allotment by FY2006	Exhausted FY2004 allotment by FY2007
Alabama					Yes	Yes	Yes
Alaska	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Arizona				Yes	Yes	Yes	Yes
Arkansas						Yes	Yes
California						Yes	Yes
Colorado						Yes	Yes
DC						Yes	Yes
Florida				Yes	Yes	Yes	Yes
Georgia				Yes	Yes	Yes	Yes
Hawaii						Yes	Yes
Idaho							Yes
Illinois					Yes	Yes	Yes
Indiana	Yes	Yes				Yes	Yes
Iowa					Yes	Yes	Yes
Kansas			Yes	Yes	Yes	Yes	Yes
Kentucky	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Louisiana					Yes	Yes	Yes
Maine	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maryland	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Michigan					Yes	Yes	Yes
Minnesota			Yes	Yes	Yes	Yes	Yes
Mississippi			Yes	Yes	Yes	Yes	Yes
Missouri	Yes	Yes			Yes	Yes	Yes
Montana					Yes	Yes	Yes
Nebraska				Yes	Yes	Yes	Yes
New Hampshire							Yes
New Jersey		Yes	Yes	Yes	Yes	Yes	Yes
New York	Yes	Yes	Yes	Yes	Yes	Yes	Yes
North Carolina	Yes	Yes		Yes	Yes	Yes	Yes
North Dakota						Yes	Yes
Ohio					Yes	Yes	Yes
Oklahoma						Yes	Yes
Oregon							Yes
Pennsylvania	Yes				Yes	Yes	Yes
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes	Yes
South Carolina	Yes	Yes	Yes			Yes	Yes
South Dakota				Yes	Yes	Yes	Yes
Utah						Yes	Yes
Vermont							Yes
Virginia						Yes	Yes
West Virginia			Yes	Yes	Yes	Yes	Yes
Wisconsin		Yes	Yes	Yes	Yes	Yes	Yes
Wyoming						Yes	Yes
US	12	13	14	19	28	40	44

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

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

(millions of dollars)

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

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

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

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

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

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

(millions of dollars)

State	FY2006 SCHIP original allotments	Available balances from FY2004 and FY2005 original allotments	Net funds gained (forfeited) through reallocation of FY2003 allotments and from DRA appropriation[a]	A Total amount available in FY2006[b]	B FY2006 spending	C = A-B End-of-FY2006 balance
Alabama	$64.2	$90.0		$154.1	$87.4	$66.7
Alaska	$9.1	$15.6		$24.7	$19.5	$5.2
Arizona	$107.4	$24.5		$131.9	$109.0	$22.9
Arkansas	$43.8	$81.8		$125.6	$49.7	$76.0
California	$646.7	$990.2		$1,636.9	$1,150.9	$486.0
Colorado	$58.0	$102.1		$160.0	$60.2	$99.8
Connecticut	$34.5	$64.5	($6.4)	$99.1	$20.5	$78.6
Delaware	$9.0	$16.9	($4.3)	$25.9	$7.0	$18.9
DC	$9.6	$16.6		$26.1	$7.8	$18.3
Florida	$249.3	$403.5		$652.9	$214.1	$438.7
Georgia	$129.5	$80.6		$210.1	$192.3	$17.8
Hawaii	$12.4	$18.7		$31.1	$13.7	$17.4
Idaho	$20.6	$37.7	($0.2)	$58.3	$18.5	$39.8
Illinois	$169.2	$40.9	$117.5	$327.6	$324.3	$3.3
Indiana	$73.0	$119.7		$192.7	$78.8	$113.9
Iowa	$27.0	$20.2	$6.1	$53.3	$47.9	$5.5
Kansas	$27.5	$49.1		$76.6	$48.6	$28.0
Kentucky	$57.8	$93.3		$151.1	$77.1	$74.0
Louisiana	$77.1	$86.6		$163.8	$96.5	$67.2
Maine	$11.9	$21.9		$33.9	$24.5	$9.3
Maryland	$48.7	$80.3	$13.7	$142.7	$138.0	$4.7

State	FY2006 SCHIP original allotments	Available balances from FY2004 and FY2005 original allotments	Net funds gained (forfeited) through reallocation of FY2003 allotments and from DRA appropriation[a]	A Total amount available in FY2006[b]	B FY2006 spending	C = A-B End-of-FY2006 balance
Massachusetts	$59.4	$69.8	$21.9	$151.1	$151.1	$0.0
Michigan	$117.2	$124.2		$241.4	$175.5	$65.9
Minnesota	$39.4	$21.0	$20.1	$80.4	$66.1	$14.3
Mississippi	$49.9	$16.3	$73.6	$139.8	$103.3	$36.4
Missouri	$56.3	$37.1	$8.0	$101.3	$78.1	$23.3
Montana	$12.6	$21.3		$33.8	$17.3	$16.5
Nebraska	$16.8	$0.6	$15.7	$33.2	$21.5	$11.7
Nevada	$41.9	$71.6	($3.9)	$113.4	$27.5	$86.0
New Hampshire	$9.2	$17.3	($4.5)	$26.5	$9.9	$16.6
New Jersey	$89.5	$49.8	$105.6	$244.8	$242.1	$2.7
New Mexico	$42.2	$74.9	($32.8)	$117.1	$31.4	$85.7
New York	$272.5	$486.6		$759.1	$328.5	$430.5
North Carolina	$110.3	$110.3	$2.8	$223.4	$177.1	$46.3
North Dakota	$6.3	$9.0		$15.4	$10.7	$4.7
Ohio	$124.6	$136.5		$261.1	$169.8	$91.3
Oklahoma	$57.4	$83.1		$140.4	$81.1	$59.3
Oregon	$46.9	$85.3	($3.5)	$132.2	$58.4	$73.8
Pennsylvania	$134.1	$195.9		$330.0	$164.4	$165.6
Rhode Island	$9.8	$0.2	$66.1	$76.1	$69.7	$6.5
South Carolina	$55.5	$83.7		$139.3	$49.1	$90.1
South Dakota	$7.8	$7.5	$0.5	$15.9	$10.6	$5.3
Tennessee	$80.4	$136.9	($58.4)	$217.3	$0.0	$217.3
Texas	$454.7	$780.8	($23.8)	$1,235.6	$269.4	$966.2
Utah	$32.2	$51.8		$84.0	$45.3	$38.8
Vermont	$4.8	$8.7	($0.1)	$13.5	$4.8	$8.7
Virginia	$72.3	$105.6		$177.9	$95.9	$82.0
Washington	$64.7	$115.0	($35.5)	$179.7	$36.2	$143.5
West Virginia	$23.3	$41.6		$64.9	$33.7	$31.2
Wisconsin	$55.8	$59.1		$114.9	$88.2	$26.7
Wyoming	$5.9	$11.1		$16.9	$6.4	$10.6

State	FY2006 SCHIP original allotments	Available balances from FY2004 and FY2005 original allotments	Net funds gained (forfeited) through reallocation of FY2003 allotments and from DRA appropriation[a]	A Total amount available in FY2006[b]	B FY2006 spending	C = A-B End-of-FY2006 balance
Puerto Rico	$39.0	$52.6	$4.4	$95.9	$37.8	$58.2
Guam	$1.5	$0.0	$0.2	$1.7	$3.4	($1.7)
Virgin Islands	$1.1	$1.4	$0.1	$2.6	$1.9	$0.7
American Samoa	$0.5	$0.0	$0.1	$0.6	$0.8	($0.2)
N. Mariana Islands	$0.5	$0.0	$0.1	$0.5	$0.5	$0.1
National total	$4,082.4	$5,521.1	$283.0	$10,059.9	$5,453.7	$4,606.2

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

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

b. This column shows the sum of only the positive numbers in the previous three columns. In the third column, the negative numbers in parentheses refer to amounts unspent and forfeited at the end of FY2005, and thus were no longer available to these states at the beginning of FY2006. For states with negative values in the third column, this column is equal to the sum of the first and second columns.