Federal SCHIP Financing: Testimony Before the Senate Finance Health Subcommittee

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Chairman Hatch, Senator Rockefeller and other members of the Subcommittee, my name is Chris Peterson, and I am a Specialist in Social Legislation with the Congressional Research Service (CRS). I am pleased to be here to talk about the federal financing of the State Children's Health Insurance Program (SCHIP). In particular, I want to focus on some policy levers that could be used to affect the FY2007 shortfalls and the program's reauthorization. But to illuminate some of those future issues, a quick look back is necessary. **Table 1** summarizes SCHIP's federal financing for the current authorization of FY1998 to FY2007.

Table 1. Federal SCHIP Financing, FY1998-2007
(dollars in millions)

Fiscal Year	Original Allotments	Redistribution: Allotments unspent after 3 years	Spending	Shortfalls	Number of Shortfall States
1998	$4,235		$122		
1999	$4,247		$922		
2000	$4,249		$1,929	*	1
2001	$4,249	$2,034	$2,672	*	1
2002	$3,115	$2,819	$3,776		
2003	$3,175	$2,206	$4,276	*	1
2004	$3,175	$1,749	$4,645	$19	1
2005	$4,082	$643	$5,089		
2006	$4,082+$283 DRA+$173		$5,981	$2.75	4
2007	$5,040	$96	$6,342	$944	18

Source: CRS SCHIP Projection Model (See CRS Report RL32807).

* Less than $1 million.

Notes: Original allotments, redistribution and spending includes territories. FY2006 and FY2007 are projections, based on states' estimates provided to the Centers for Medicare and Medicaid Services (CMS) in November 2005. "$283 DRA" is the $283 million appropriation made through the Deficit Reduction Act of 2005 (P.L. 109-171).

The first column shows the federal SCHIP allotments made to states[1] and territories[2] every year over the program's history. These levels were originally set in the Balanced Budget Act of 1997 (BBA97, P.L. 105-33) at $40 billion over the 10-year period and have been altered only slightly since.[3]

BBA97 also put in place a formula that determines what each state's share of the total original allotment would be. This formula has also been largely unaltered and takes into account each state's number of low-income children, *uninsured*

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[1] Including the District of Columbia.

[2] Puerto Rico, Guam, Virgin Islands, American Samoa, and the Northern Mariana Islands.

[3] Twenty million dollars was added to the FY1998 amount in §162 of P.L. 105-100. 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.

low-income children, as well as states' average wages for employees in the health services sector as compared to the national average.

These SCHIP original allotments are available to states for three years, after which unspent funds are available for redistribution to other states. As you can see in the next column, in the first few years of redistribution, a lot of unspent money was at stake, and Congress intervened to change how these funds were distributed. However, as the amount up for redistribution has dropped over time, Congress has left the redistribution process up to the Secretary of Health and Human Services (HHS). These funds now go entirely toward states' projected initial shortfalls.[4] Looking ahead, less redistribution money[5] means states must place greater reliance on their own original allotments. Thus, both the national level of original allotments and the way it is divided among the states becomes increasingly critical.

The next column shows states' spending of federal SCHIP dollars, with amounts ever increasing since 1998. Based on states' projected spending, FY2006 appeared to be the first year in which numerous states faced shortfalls, totaling approximately $283 million. The first Senate-passed version of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) would have closed that shortfall, or come very close, without requiring an additional appropriation. It did so by reducing the period of availability of certain allotments (FY2004 and FY2005) from the standard three years to two years. In the end, however, Congress opted simply to appropriate $283 million to close these shortfalls.

As you can see in the lower right-hand corner of **Table 1**, CRS has projected a shortfall of just under $1 billion for 18 states in FY2007. As with the FY2006 numbers, these estimates are based on states' projections from November 2005. The Centers for Medicare and Medicaid Services (CMS) has projections from states six months more recent. I retain the earlier numbers (1) because it was the basis of the distribution of the DRA funds and (2) because it illustrates some fairly significant

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[4] A shortfall exists when all of a state's available federal SCHIP funds are exhausted in a given fiscal year (that is, when a state's projected spending for the year exceeds its available federal funds). The definition of "initial shortfall" is slightly different. "Initial shortfall" is the amount of a state's projected shortfall in a fiscal year *not including* redistribution funds available in that year. For example, for FY2006, the Centers for Medicare and Medicaid Services (CMS) had to determine how much of unspent FY2003 original allotments as well as the Deficit Reduction Act appropriation of $283 million would be distributed to which states. This was done on the basis of the initial shortfalls for the year.

[5] According to preliminary projections from the CRS SCHIP Projection Model (and assuming baseline original allotments into the future of $5 billion per year), funds available for redistribution will rise between FY2008 and FY2010. In FY2010, the preliminary projections estimate available redistribution funds to reach approximately $325 million. The post-FY2010 projections show declining redistribution amounts. The $325 million in redistribution estimated for FY2010 is still much less than amounts available historically in the current authorization shown in Table 1. The increases between FY2008 and FY2010 come from the redistribution of unspent FY2005-FY2007 original allotments — allotments of greater amounts than those from the so-called "CHIP dip," when total allotment levels were at their lowest, from FY2002 to FY2004 (and slated for redistribution in FY2005 to FY2007 respectively). Even with the modest increase in available redistribution funds between FY2008 and FY2010, preliminary projections indicate only increasing total shortfalls from FY2007 onward under baseline assumptions.

changes in state projections in a relatively short amount of time. This could be due to states altering their SCHIP programs, local economic factors, or the way states produce their projections. Regardless, a much larger appropriation would be required to eliminate the 2007 shortfall, compared to what was needed for 2006.

The President's Budget resurrected the idea of shortening the period of availability of original allotments, specifically just the FY2005 allotment. While CRS projects this would eliminate the projected shortfalls in FY2007,[6] the longer-term outlook regardless of action specific to 2007 indicates the possibility of more states facing shortfalls. Currently, 40 states spend more annually than they receive in their annual original allotment. Many of them do *not* face shortfalls currently because they have prior-year balances, redistributed funds, as well as the DRA appropriation to draw from. However, as more states spend more than they receive in their original allotments with less money available from other SCHIP accounts, more states face the prospect of chronic shortfalls over time. For example, continuing the FY2007 original allotment amount of $5 billion annually into the future[7] and increasing states' projected spending only by per-capita growth in health care expenditures,[8] 35 states could face shortfalls totaling nearly $4 billion in FY2013, based on estimates from the CRS SCHIP Projection Model.

Ten years ago, when SCHIP was created, it could not be predicted what various states would do, let alone whether they would exhaust their federal SCHIP funds years down the road. Now, however, we have years of experience, which raises new questions for reauthorization. For example, should the allotment formula incorporate states' spending or enrollment information that did not exist a decade ago? If allotments are inadequate to cover states' projected spending, spending and enrollment information that was not available a decade ago will also enable analysts like myself to make projections about which states might face what size shortfalls, based on whatever criteria Congress considers.

The continued potential for shortfalls then raises more fundamental questions about SCHIP, such as, how much responsibility does the federal government have to address shortfalls in this capped-grant program? If the goal is to prevent any state from experiencing shortfalls, Congress could choose to permit states to draw down federal SCHIP funds on an uncapped basis, or to appropriate additional funds to close shortfalls, as was done in DRA. Otherwise, the three major financial levers moving forward all pertain to the original allotments — their total level, how each state's share is determined, and how long the states have access to the funds.

These are difficult questions, and CRS looks forward to continuing to work with this subcommittee on these issues.

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[6] See tables 4 and 5 of CRS Report RL32807, included for the record.

[7] Congressional Budget Office (CBO) baseline assumptions, that the program will continue at its last appropriated level.

[8] Christine Borger et al., "Health Spending Projections Through 2015: Changes On The Horizon," *Health Affairs* Web exclusive , pp. W61-73, at [http://content.healthaffairs.org/cgi/reprint/25/2/w61.pdf, subscription required].

[For the record, two CRS reports are included along with the written testimony — CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson, May 8, 2006; and CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson, April 18, 2006.]

Additional Comments and Analysis

The two CRS reports I have included for the record describe in greater detail many of the federal financing issues I touched on in the preceding comments. I want to highlight some of the more critical points from those reports that I did not have time to make in my testimony. In addition, since the publication of those two reports, CRS has done additional analyses that I am providing here, which I hope the Subcommittee will also find informative. First, I look at the potential use for current-law Medicaid funding to reduce some of the FY2007 projected shortfalls in some states. Next, we analyze a few possible options for altering the SCHIP allotment formula. The first of those options looks at possible alternatives to the Current Population Survey as a source of data in the allotment formula. It is followed by an analysis of the estimated impact of excluding estimates of *uninsured* low-income children from the formula. Finally, we provide estimates of incorporating historical spending data into the allotment formula, projecting what impact this would have on shortfalls. Of course, the fact that I am providing these analyses should not be interpreted as any kind of recommendation for or against anything discussed.

Potential for Medicaid Funding to Narrow Shortfalls

States can cover SCHIP enrollees by expanding their Medicaid program or by creating a separate SCHIP program, or by a combination of both. If a state has a Medicaid-expansion SCHIP program, it can rely on Medicaid funds once its federal SCHIP funds are exhausted. Although the federal matching rate is lower for Medicaid than for SCHIP, these states experiencing shortfalls would at least receive most of the federal funds they would have received from SCHIP if the funds were available.[9] Of the 18 states projected to exhaust their federal SCHIP funds in FY2007, four (Georgia, Minnesota, Mississippi, and North Carolina) appear to have no alternative for federal funds besides SCHIP. This is because their SCHIP programs are separate from Medicaid. In the other 14 states, some portion of the SCHIP federal funds could be paid by Medicaid.[10] As shown in Table 3 of CRS Report RL32807, 14 are projected to be able to use federal Medicaid funds to ameliorate their projected FY2007 shortfalls. According to these projections, nearly $350 million in potential Medicaid funding would reduce the $944 million shortfall to just under $600 million.[11]

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[9] This refers to only the portion of a state's SCHIP program that is a Medicaid expansion.

[10] Rhode Island operates its SCHIP as a combination program. After the state has exhausted its available SCHIP allotment, in addition to reverting to regular Medicaid funds to provide coverage for their Medicaid expansion population, Rhode Island has CMS approval under the Section 1115 waiver authority to use regular Medicaid funds to provide coverage to its SCHIP state plan and Section 1115 waiver populations until further Title XXI federal funds become available.

[11] This is why SCHIP proposal in the President's Budget would likely close the $944 million shortfall yet was estimated by HHS and CBO to increase outlays by only roughly $600 million in FY2007 (Department of Health and Human Services, *Fiscal Year 2007 Budget in Brief*, available at [http://www.hhs.gov/budget/07budget/2007BudgetInBrief.pdf] and Congressional Budget Office, *Preliminary Analysis of the President's Budget Request for 2007* (Mar. 3, 2005), available at

Analysis of Certain Options for SCHIP Allotment Formula

Possible Alternatives to the Current Population Survey. Under current law, the formula for annually determining each state's share of original allotments uses data from the U.S. Census Bureau's Current Population Survey (CPS).[12] Specifically, the CPS provides estimates for each state of (1) the number of children whose family income is at or below 200% of the federal poverty threshold, and (2) the number of children who are *uninsured* and below 200% of the federal poverty threshold. At the time of BBA97, the CPS was the only federal data source that could provide such estimates for all the states.

Since survey estimates come from only a sample of the population, the estimates could differ from the results of a complete census using the same survey questions. It is possible to estimate this "sampling error" based primarily on the survey's sample size (that is, the number of respondents). Because sample sizes can be small in less populous states, results from multiple years are often averaged together to reduce the sampling error. Current law specifies that the CPS estimates used in the SCHIP allotment formula be based on a three-year average. For example, states' FY2006 original allotments were based on state-level CPS data from 2001, 2002 and 2003. Even with three-year averages, the variation from sampling error in the state-level estimates has led, according to one source, to "funding fluctuations [that] present significant problems for states as they develop budget priorities."[13]

One possible alternative to the CPS that was not available a decade ago is the U.S. Census Bureau's American Community Survey (ACS). The ACS is patterned after and replaces the "long form" of the decennial census. The "long form" questions, along with additional ones, are now being asked every year rather than every 10 years. The survey is now fully implemented and is mailed to 3 million addresses, covering every county in the country.[14] In contrast, the CPS obtains data from approximately 100,000 households.[15]

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[11] (...continued)
[http://www.cbo.gov/showdoc.cfm?index=7055&sequence=0&from=7]).

[12] In particular, the estimates are from what is officially known as the Annual Social and Economic (ASEC) Supplement of the CPS. It had been called the March supplement to the CPS because the health insurance questions were asked in March, but now that they are asked February through April the name was changed.

[13] Michael Davern et al., "State Variation in SCHIP Allocations: How Much Is There, What Are Its Sources, and Can It Be Reduced," *Inquiry*, vol. 40, no. 2, Summer 2003, pp. 184-197.

[14] U.S. Census Bureau, "Design and Methodology: American Community Survey," Washington, DC, May 2006, at [http://www.census.gov/acs/www/Downloads/tp67.pdf]. The ACS uses mail-out/mailback questionnaires with computer-assisted nonresponse follow-up interviews either in person or over the phone. Households' participation in the survey is mandatory, meaning that households are required by law to respond to the survey.

[15] U.S. Census Bureau, "Current Population Survey: 2005 Annual Social and Economic (ASEC) Supplement," Washington, DC, at [http://www.census.gov/apsd/techdoc/cps/cpsmar05.pdf]. The CPS uses computer-assisted interviews, either in person or over the phone. Households' participation in the survey is

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Table 2 shows estimates provided by the Census Bureau displaying state-level estimates of low-income children (below 200% of the federal poverty threshold) from the CPS and the ACS in 2004. The table also shows the standard errors of those estimates. Standard errors are measures of the magnitude of sampling error — so, smaller is better. Because the ACS's sample size is so much larger than that of the CPS, the ACS standard errors from a single year are still much lower than the three-year averages from the CPS. Moreover, the ACS data shown in **Table 2** are from 2004, before the ACS full sample was implemented. In 2004, the ACS sample size was 800,000 addresses. The ACS currently in the field is fully implemented with 3 million addresses, so ACS standard errors with more recent data will be even lower.

Currently, the ACS does not ask about individuals' health insurance. Thus, although the ACS can be used to estimate the number of low-income children, it cannot estimate the number of *uninsured* low-income children. The Census Bureau recently completed testing a number of health insurance questions for possible inclusion in the ACS. The data are currently being compiled for review by the Census Bureau. Even if the results appear solid and a decision is made to include a health insurance question(s) in the ACS, it will be a couple of years before that data would be available.

There are well-documented, fundamental concerns with the CPS's estimates of the uninsured, which have been acknowledged by the Census Bureau.[16] Recently, some researchers suggested that the CPS be modified to address these concerns or that HHS's National Health Interview Survey (NHIS) be expanded to provide uninsured estimates for all the states.[17]

Analysis of Impact of Excluding Uninsured from Allotment Formula. In FY1998 and FY1999, the SCHIP allotment formula's "number of children" relied solely on the number of *uninsured* low-income children. As SCHIP

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[15] (...continued)
voluntary.

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

[17] Genevieve Kenney et al., "Toward a More Reliable Federal Survey for Tracking Health Insurance Coverage and Access," *HSR: Health Services Research*, vol. 43, no. 1, part 1, June 2006, pp. 918-945. Regarding the ACS, the authors said, "In this review, we have focused on the federal surveys that currently measure health insurance coverage. However, the American Community Survey (ACS), which planned to sample three million households nationwide in 2005, could be modified to include questions on health insurance coverage and related topics (currently, it collects information that draws almost exclusively from the Census Long Form). Given the scale of this ongoing effort and the potential for developing annual estimates for areas of over 65,000 inhabitants (and the ability to develop estimates for smaller areas based on 3 or 5 years of data) at low marginal cost, it makes sense to explore the feasibility of at least expanding the content of the ACS to incorporate key information on health insurance coverage at a minimum. At the same time, however, it will be important that any new estimates derived from the ACS complement existing estimates and not create more confusion about the extent and nature of the uninsured problem in this country" (p. 940).

began to cover more low-income children, the formula relied 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" funding-formula component was based on 75% of the number of *uninsured* low-income children and 25% of the number of all low-income children. 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.

Because of concerns with the CPS health insurance estimates and the decreasing emphasis on those estimates in the SCHIP allocation formula, **Table 3** is included to illustrate the potential impact on states' share of the FY2006 total original allotment level available to states had the allotment formula excluded the number of uninsured low-income children. One policy rationale for doing this would be as follows: The more successful a state is in reducing its number of uninsured through its SCHIP program, the less money it receives because of the inclusion of the number of uninsured low-income children in the allotment formula. On the other hand, states with a relatively high number of uninsured low-income children could argue that they need greater federal SCHIP allotments in order to expand coverage but that removing the uninsured piece of the formula would cause the state to receive a lower allotment.

According to the estimates shown in Table 3, if *uninsured* low-income children had not been part of the formula for the FY2006 original allotments, 33 states (including the District of Columbia) would have received an increase in their allotment, with an average increase of about 4%. Ten states would have experienced a decrease of an average of 3% from the current-law formula. Eight states would have experienced no change.[18]

Projections of Impact of Incorporating Historical Spending into Allotment Formula. As I mentioned in my testimony, historical state spending data is an additional option for possible inclusion in the allotment formula that was not available at SCHIP's inception. Based on the CRS SCHIP Projection Model, **Table 4** shows the impact on future projected shortfalls (FY2008-FY2012) of basing half of states' allotments for those years on actual FY2005 expenditures and half on the current formula.[19] FY2005 is the most recent year in which there is complete expenditure data. The projections of incorporating historical spending assume the same level of appropriations in SCHIP as in the baseline projections mentioned earlier (e.g., the total level for annual allotments continues at $5 billion, as in FY2007). The difference from the baseline projections of incorporating historical spending is how the allotments are distributed among the states.

The impact of incorporating historical (FY2005) state spending in the allotment formula is projected to reduce total state shortfalls in FY2008 by 22%. By FY2012, however, this option would reduce shortfalls by only 1% compared to

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[18] Eleven of the 18 FY2007 projected shortfall states would have received an increase, ranging from 0.4% (Illinois) to 9.6% (Maine). Three would have seen no change (Massachusetts, Minnesota and North Carolina) and two would have experienced a decrease (Georgia, 1.2%, and New Jersey, 2.4%).

[19] Projections for the "current formula" assume that the share of the total annual appropriation states were allotted in FY2006 will continue into the future.

baseline assumptions. This is because as the states with the most spending in FY2005 (and most likely to be shortfall states in the near future) receive a greater share of the allotments, less money is allotted to other states. By FY2012, those states that receive less money as a result experience shortfalls they otherwise would not have, or the shortfalls they were projected to experience under baseline assumptions are larger.[20] Over the five-year period (FY2008-2012), incorporating historical spending resulted in a total reduction in projected shortfalls by less than 10%.[21]

Conclusion. While there may or may not be advantages to altering the allotment formula in the ways just described, the impact of these changes on projected shortfalls tend to be rather modest, particularly in the long run. If one's goal in the federal financing of SCHIP is to prevent shortfalls, these tweaks to the allotment formula would be inadequate. Regardless, changes to the allotment formula could be made on the basis of improving the methods for determining how original allotments are distributed to states, even if the impact on the funds states' receive tends to be relatively modest.

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[20] Projections were also run basing the estimates on FY2004 historical spending and on FY2006 projected spending rather than FY2005 spending. Using the FY2004 and the FY2006 numbers both had little impact on the total shortfall by FY2012 compared to the projections using FY2005 spending. Projections were also run basing the *entirety* of the allotment formula on the spending data. Essentially, this doubled the percentages in Table 4, still resulting in little overall impact in FY2012.

[21] The total shortfalls over the five-year period would be reduced approximately $1.1 billion, from $12.1 billion projected under baseline assumptions to $11.0 billion under the option of incorporating historical spending.

Table 2. Estimates and Standard Errors of the Number of Low-Income Children from the American Community Survey (ACS) and the Current Population Survey (CPS), 2004
(numbers in thousands)

| State | Number of Low-Income Children | | | Standard Error of the Estimate (lower is better) | | |
	ACS	CPS	3-year average CPS[a]	ACS	CPS	3-year average CPS
Alabama	513	506	486	14	53	35
Alaska	58	70	67	5	8	5
Arizona	757	728	685	24	69	47
Arkansas	369	343	352	14	35	24
California	4,216	4,371	4,218	50	169	126
Colorado	396	390	396	22	50	30
Connecticut	212	206	221	10	31	19
Delaware	68	69	66	3	9	6
DC	59	66	62	3	8	5
Florida	1,716	1,699	1,678	28	100	70
Georgia	1,048	1,092	953	20	79	59
Hawaii	104	88	103	7	12	9
Idaho	180	170	169	8	18	12
Illinois	1,191	1,235	1,256	22	86	60
Indiana	635	677	603	17	62	39
Iowa	254	256	244	14	32	20
Kansas	248	264	247	9	32	19
Kentucky	468	449	456	13	50	32
Louisiana	645	594	603	16	57	40
Maine	102	95	107	6	14	9
Maryland	365	416	373	14	50	31
Massachusetts	379	386	434	13	46	33
Michigan	986	1,014	958	19	76	51
Minnesota	359	297	311	11	41	27
Mississippi	421	403	404	11	39	27
Missouri	550	534	501	19	56	36
Montana	106	104	105	4	11	8
Nebraska	156	172	156	4	20	13
Nevada	277	243	246	14	29	17
New Hampshire	72	66	66	4	11	7
New Jersey	571	485	549	19	54	37
New Mexico	281	251	269	10	28	19
New York	1,884	1,937	1,974	32	109	74
N. Carolina	991	920	939	29	73	51
N. Dakota	51	56	55	3	7	4
Ohio	1,106	1,070	1,034	39	78	54
Oklahoma	409	387	411	15	43	29
Oregon	378	361	345	12	44	27
Pennsylvania	1,071	1,053	1,034	17	78	52
Rhode Island	94	100	91	4	13	7
S. Carolina	481	469	446	15	51	32
S. Dakota	74	75	73	2	8	5
Tennessee	614	587	601	18	58	43

State	Number of Low-Income Children			Standard Error of the Estimate (lower is better)		
	ACS	CPS	3-year average CPSª	ACS	CPS	3-year average CPS
Texas	3,148	3,168	3,193	41	146	107
Utah	296	298	285	12	29	19
Vermont	43	39	42	2	6	4
Virginia	597	566	557	19	57	42
Washington	581	580	567	16	59	41
West Virginia	186	177	197	10	19	13
Wisconsin	452	499	471	24	54	34
Wyoming	46	41	45	2	6	4
United States	**30,265**	**30,122**	**29,704**	**183**	**378**	**263**

Source: U.S. Census Bureau, with 3-year averages calculated by the Congressional Research Service

a. Average of estimates covering 2002-2004, which will be used in determining, in part, states' share of the total FY2007 original allotment.

Notes: "Low-income children" are those with family income at or below 200% of the federal poverty threshold. A description of the original allotment formula is in CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson, April 18, 2006.

Table 3. Estimated Impact on States' FY2006 SCHIP Original Allotments If the Number of *Uninsured* Low-Income Children Were Not in the Allotment Formula

State	Estimated Impact
Alabama	+4.4%
Alaska	+3%
Arizona	-5.4%
Arkansas	+5.5%
California	-1.1%
Colorado	-1.8%
Connecticut	+1.4%
Delaware	+4.1%
DC	+7.2%
Florida	-3.6%
Georgia	-1.2%
Hawaii	0%
Idaho	0%
Illinois	+0.4%
Indiana	+1.4%
Iowa	+5.2%
Kansas	+4.2%
Kentucky	+2.2%
Louisiana	+0.9%
Maine	+9.6%
Maryland	+2%

State	Estimated Impact
Massachusetts	0%
Michigan	+7.2%
Minnesota	0%
Mississippi	+3.3%
Missouri	+9.5%
Montana	-0.1%
Nebraska	+7%
Nevada	-7%
New Hampshire	+8.7%
New Jersey	-2.4%
New Mexico	0%
New York	+5.6%
N. Carolina	0%
N. Dakota	+4.9%
Ohio	+4%
Oklahoma	0%
Oregon	+0.5%
Pennsylvania	+1.7%
Rhode Island	+9.6%
S. Carolina	+5.4%
S. Dakota	+6.1%
Tennessee	+6%
Texas	-8.5%
Utah	+2%
Vermont	+1.8%
Virginia	+2.3%
Washington	0%
West Virginia	+8.3%
Wisconsin	+1.1%
Wyoming	-0.2%

Source: Congressional Research Service

Notes: "Uninsured low-income children" are those with family income at or below 200% of the federal poverty threshold and without health insurance. Excluding the number of uninsured low-income children was estimated to have no impact on Hawaii, Massachusetts, Minnesota, North Carolina and Washington because these states' share of the national allotment is lowered by the statutory ceiling, that their share cannot be 45% greater than their share in FY1999. New Mexico and Oklahoma were also estimated to be unaffected by the change, but because these states' share of the national allotment is raised by one of the three floors — specifically that their share cannot be below 70% of their share in FY1999. These states hit their respective ceilings and floors regardless of whether the number of uninsured low-income children is included. Two additional states were estimated to hit the statutory ceiling because of the change. The increase to Vermont's and Wisconsin's share of the total allotment was estimated to be high enough because of the change that they would hit the ceiling. The changes shown in the table reflect the statutory provision ensuring that their share does not exceed 145% of their FY1999 share. A description of the original allotment formula is in CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson, April 18, 2006.

Table 4. Reduction in Total Projected Shortfalls in Federal SCHIP Funds If Half of States' Allotments Are Based on FY2005 Spending

Fiscal Year	Reduction in Shortfalls
2008	22%
2009	14%
2010	12%
2011	7%
2012	1%

Source: Congressional Research Service (CRS) SCHIP Projection Model

Notes: The projections assume the same level of appropriations in SCHIP as in the baseline projections (e.g., the total level of annual allotments continues at $5 billion, as in FY2007). The half of states allotments not based on FY2005 spending is based on each state's share of the total FY2006 original allotment, which is also the basis of the distribution of the allotments under the baseline scenario. The difference from the baseline projections of this option is not in the total amount appropriated but in how the allotments are distributed among the states.