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The Truth About SCHIP Shortfalls

Nina Owcharenko

Congress should not reward state officials' irresponsibility. Lawmakers should take a hard look at efforts to bail out those states facing funding shortfalls in their State Children's Health Insurance Programs (SCHIP). Policymakers must consider the underlying issues contributing to these shortfalls—specifically, some states' chronic fiscal mismanagement, excessive income eligibility limits, and extensive coverage of adults. Congress should resist rewarding states that have ignored the program's intent and exceeded the program's scope.

Shortfalls. Unlike Medicaid, the entitlement program for the indigent and poor, SCHIP was designed as a block grant program. The 1997 law appropriated $40 billion over 10 years to assist states in helping low-income, uninsured children with health care coverage. States receive a fixed federal contribution each year. State allotments are based on a formula that includes the number of low-income, uninsured children and the cost of health care in the state. Each state can access its annual allotment for three years. After the three-year period, any unused funds are subject to a redistribution process, whereby unused funds are reallocated to states that have exhausted their original allotments.

Shortfall states are those states expected to exhaust all their available funds. According to the Congressional Research Service, 14 states are projected to have a shortfall in fiscal year 2007: Alaska, Georgia, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, Rhode Island, and Wisconsin.[1]

Previous Bailouts. State overspending of allotments is not a new phenomenon, but it was less obvious in the past because shortfall states usually received unspent funds from other states. Today, however, fewer states are leaving funds unspent, resulting in a smaller pool of funds to be redistributed. In FY 2001, 39 states had unspent allotments, while 12 had spent their original allotments.[2] In FY 2006, only 11 states had unspent allotments, compared to 40 states that had exhausted their allotments.[3] Moreover, in FY 2001, over $2 billion in unused allotments was available for redistribution, compared to $173 million in FY 2006.[4] Shortfall states are repeatedly requesting additional federal dollars to bail them out.

FY 2006: To address FY 2006 shortfalls, Congress recently approved $283 million in new spending in the Deficit Reduction Act for bailouts of 12 projected shortfall states.[5] At the end of FY 2006, the unused funds from FY 2003 also became available for redistribution. Four of the 12 states expecting shortfalls received an additional bailout of $172 million through the redistribution process.[6]

FY 2007: Congress has also already acted to address projected shortfalls for FY 2007. The

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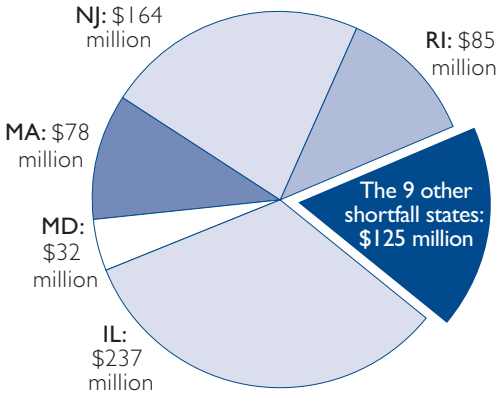
National Institutes of Health Reform Act, passed in the waning days of the 109th Congress, released FY 2004 funds that will soon expire and part of unspent FY 2005 funds to bail out some of the 14 states facing shortfalls in FY 2007.[7] These funds, however, were not distributed under the usual procedure of redistributing funds among all shortfall states. The legislation instead directed the Secretary of Health and Human Services to distribute these funds to those states facing shortfalls earlier in the fiscal year. Five of the 14 states projected to face shortfalls in FY 2007 received redistributed FY 2004 funds, and six (including the five states receiving FY 2004 funds) received the partial FY 2005 funds.[8] Even with this infusion of additional funds, all 14 states expect to face shortfalls for FY 2007.[9]

Analyzing the bailouts from FY 2006 and FY 2007 reveals a pattern. Besides possible flaws in its formula, SCHIP's funding structure encourages states to exceed their original allotments at the expense of more fiscally prudent states and, as recent activity has proven, can lead to pressure for Congress to bail out states with shortfalls.

Illinois, New Jersey, and Rhode Island have all received more funding in each of the four bailouts, and Maryland and Massachusetts are not much further behind, receiving funds three of the four times. In addition, these states have also received the lion's share of the funds: Illinois has received $236.6 million; New Jersey, $164.4 million; Rhode Island, $84.9 million; Maryland, $31.5 million; and Massachusetts, $77.8 million.[10] Eighty-three percent of all bailout funding has gone to these five states.[11]

Chart 1 WM 1381

FY 2007 Shortfall States: Bailouts for FY 2006 and FY 2007



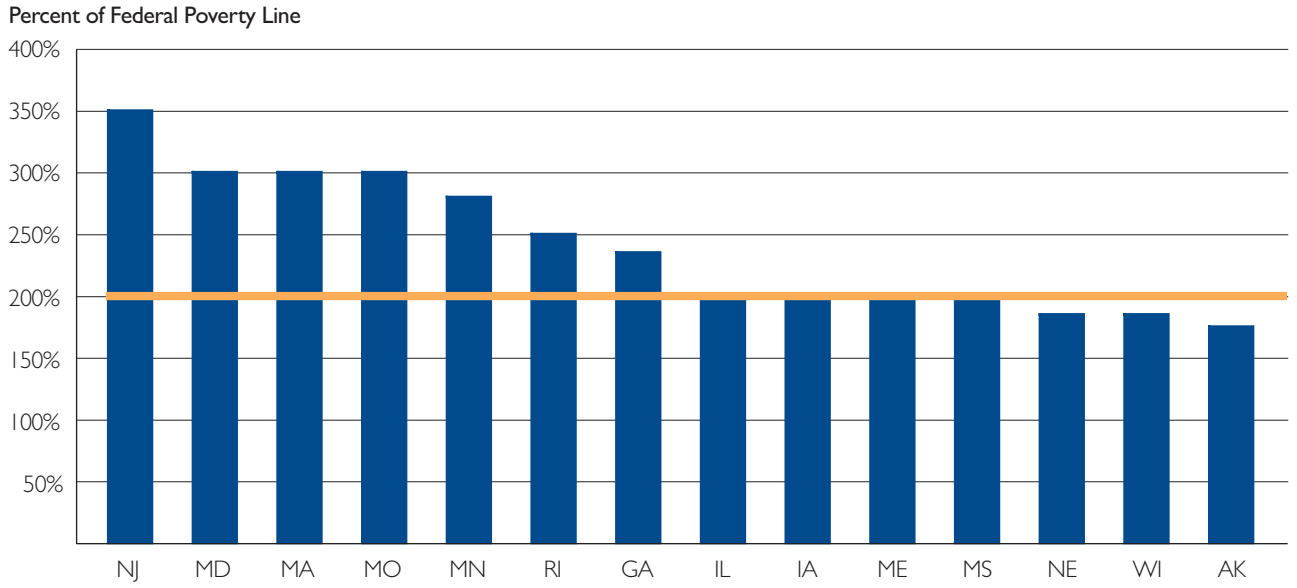
Total bailout for all shortfall states: $720 million

Source: Heritage Foundation calculations based on Chris Peterson, "SCHIP Financing: Funding Projections and States Redistribution Issues," Congressional Research Service Report for Congress RL32807, May 8, 2006, p.11, and Chris Peterson, "SCHIP Provisions of H.R. 6164 (NIH Reform Act of 2006)," Congressional Research Service *Report for Congress* RS22553, December 13, 2006, p. 5.

1. Chris Peterson, "SCHIP Provisions of H.R. 6164 (NIH Reform Act of 2006)," Congressional Research Service *Report for Congress* RS22553, December 13, 2006, p. 5.
2. Kathryn G. Allen, "Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences in Implementing SCHIP and Considerations for Reauthorization," United States Government Accountability Office Testimony GAO-07-447T, February 17, 2007, p. 29, at *www.gao.gov/new.items/d07501t.pdf*.
3. Figure includes shortfall states that exhausted *all* their allotments. *Ibid.*
4. Chris Peterson, "Federal SCHIP Financing: Testimony Before the Senate Finance Health Subcommittee," Congressional Research Service, July 25, 2006, p. 1.
5. DRA funds were limited to removing shortfalls for children, but redistributed FY 03 funds were allocated to states that also cover adults. Chris Peterson, "SCHIP Financing: Funding Projections and State Redistribution Issues," Congressional Research Service *Report for Congress* RL32807, May 8, 2006, p. 11.
6. *Ibid.*
7. Peterson, "SCHIP Provisions of H.R. 6164."
8. *Ibid,* p. 5.
9. *Ibid.*
10. Calculations based on Peterson, "SCHIP Financing: Funding Projections and States Redistribution Issues," p. 11 and "SCHIP Provisions of H.R. 6164," p. 5.

Chart 2 WM 1381

SCHIP Eligibility Levels in Shortfall States as a Percentage of the Federal Poverty Line



Source: Shortfall states based on projections in Chris Peterson, "SCHIP Provisions of H.R. 6164 (NIH Reform Act of 2006)," Congressional Research Service *Report for Congress* RS22553, December 13, 2006, and eligibility data (as of July 2006) provided by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Centers for Medicaid and State Operations, October 5, 2006.

Other Characteristics of the Shortfall States. Two other characteristics should also be examined when considering further bailouts of shortfall states.

Income Eligibility. The original intent of SCHIP was to help low-income, uninsured children whose families earned too much for Medicaid but not enough to purchase private coverage. The law defines as "low income" those children whose family's income is below 200 percent of the Federal poverty line (FPL), or $40,000 for a family of four.[12] Of the 14 projected shortfall states, seven have set SCHIP eligibility above 200 percent of the FPL.[13] Of those seven, four states (Maryland, Massachusetts, Missouri, and New Jersey) are at or above 300 percent of FPL, or $60,000 for a family of four.[14] Four states are at 200 percent of the FPL, and three states (Alaska, Nebraska, and Wisconsin) are below 200 percent of the FPL.[15]

Adult Eligibility. Moreover, some of the projected FY 2007 shortfall states use SCHIP funds to cover adults.[16] Five of the 14 shortfall states—Illinois, Minnesota, New Jersey, Rhode Island, and Wisconsin—cover parents, pregnant women, or childless adults.[17] According to the General Accountability Office, "Adults accounted for an average of 55% of

11. Of the remaining shortfall states, Mississippi has received the most, with a one-time infusion of $73.6 million through the Deficit Reduction Act.
12. U 42 U.S.C. § 1397jj. An exception was made for states with Medicaid eligibility levels at or close to 200 percent of FPL by allowing them to expand SCHIP coverage to children in families earning 50 percent above the state's Medicaid eligibility level.
13. Based on shortfall projections in Peterson, "SCHIP Provisions of H.R. 6164," p. 5, and eligibility data (as of July 2006) provided by the U.S. Health and Human Services, Centers for Medicare and Medicaid Services, Centers for Medicaid and States Operations, October 5, 2006.
14. *Ibid.*
15. *Ibid.*
16. As of January 2007, 15 states cover adults through waivers. See Allen, "Children's Health Insurance," p. 21.

enrollees in the shortfall states" in FY 2005.[18] While the Deficit Reduction Act prohibited the Secretary of Health and Human Services from approving any *new* state waivers to cover childless adults, existing waiver states are exempt. As a way to prioritize those shortfall states that remained focused on children, states were prohibited from applying DRA redistribution funds toward coverage of non-pregnant adults, but the redistributions since then have not been limited in this way.[19]

Conclusion. SCHIP was not designed to be an entitlement program with an open-ended commitment from the federal government. The redistribution process and recent infusions of additional federal funding rewards overreaching, fiscally irresponsible states that exceed SCHIP guidelines.

Before Congress provides another bailout, federal policymakers should consider its effects. At the very least, Congress should differentiate between shortfall states that remain within the original intent of the law and those states that exploit its funding structure and the scope of the program at the expense of federal taxpayers.

States know their federal SCHIP contributions and should plan accordingly. If they choose to exceed these fiscal allocations or the boundaries of the program, they should be prepared to use their own dollars to pay for it.

—Nina Owcharenko is Senior Policy Analyst for Health Care in the Center for Health Policy Studies at The Heritage Foundation.

17. *Ibid,* p. 22.

18. Allen, "Children's Health Insurance," p. 32.

19. Peterson, "SCHIP Financing," p. 8.