
Revised December 4, 2007

SECOND CHILDREN'S HEALTH BILL MAKES SIGNIFICANT CHANGES TO FOCUS MORE HEAVILY ON POOR CHILDREN

Changes Answer Criticisms of Earlier, Vetoed Bill

by Edwin Park and Judith Solomon

On November 30, Congress sent the President a revised version of bipartisan legislation to strengthen children's health coverage (H.R. 3963). The bill includes substantial changes from the bill the President vetoed in October (H.R. 976) that directly address a number of concerns raised by the earlier bill's opponents. Despite these changes, however, the President is expected to veto the new legislation as well.

According to the Congressional Budget Office, the new bill would cover nearly 4 million uninsured children by 2012, at a cost of about \$35 billion over five years, fully offset by an increase in federal tobacco taxes.¹ Key changes in the second bill include:

1. The second bill focuses even more on covering the lowest-income uninsured children.

Arguing that any legislation to reauthorize the State Children's Health Insurance Program (SCHIP) should "cover poor kids first," opponents of the first bill suggested that it would primarily cover middle-class children.² CBO estimates clearly indicate, however, that the vast majority of the uninsured children who would have received coverage under the first bill have low incomes.³

Nevertheless, the second bill makes two significant changes to further target the increased coverage on the lowest-income uninsured children.

- It would prohibit any state from extending SCHIP coverage to children in families above 300 percent of the poverty line. (The one state that already covers children above that level — New Jersey, which covers about 3,000 children from 300 to 350 percent of the poverty line — would

¹ Congressional Budget Office, "CBO's Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under the Children's Health Insurance Program Reauthorization Act of 2007," October 24, 2007 and Congressional Budget Office, "CBO's Estimate of the Effects on Direct Spending and Revenues of the Children's Health Insurance Program Reauthorization Act of 2007," October 24, 2007.

² See Robert Greenstein, "Poor Children First — Or Last?," Center on Budget and Policy Priorities, October 17, 2007.

³ See Edwin Park, "CBO Estimates Show SCHIP Agreement Would Provide Health Insurance to 3.8 Million Uninsured Children," Center on Budget and Policy Priorities and Congressional Budget Office, "CBO's Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under the House Amendments to the Senate Amendments to H.R. 976, the Children's Health Insurance Program Reauthorization Act of 2007," September 24, 2007. See also Genevieve Kenney et al., "SCHIP Reauthorization: How Will Low-income Children Benefit Under the House and Senate Bills?" Urban Institute, as updated on November 8, 2007 at <http://www.urban.org/publications/411545.html>.

be allowed to continue doing so.)⁴ This provision is significantly more restrictive than the original bipartisan bill. The first bill would have allowed states to continue to expand SCHIP above 300 percent of the poverty line, as under current law, although at a reduced federal matching rate and only if the state met new requirements for participation in Medicaid and SCHIP among eligible low-income children.

- Also of considerable significance, the second bill further targets the financial incentives for enrolling eligible but uninsured children on those with the lowest incomes. The second bill would provide incentives to states *only* for enrolling uninsured children who are eligible for Medicaid and would increase the size of those incentives. It would *drop* the incentives included in the original bipartisan bill for enrolling somewhat higher-income children eligible for SCHIP.

According to CBO estimates, the result of these changes is as follows:

- By 2012, the second bill would cover a total of 3.9 million children who would otherwise be uninsured, a 100,000 increase over the original bill.
- Of these 3.9 million children, 3.4 million — or 87 percent — would have incomes below states' current eligibility limits. (This is 200,000 more than under the original bill.)
- 1.9 million — or essentially half — of these children would be eligible for Medicaid, and most of them would be poor. (This is a 200,000 increase in coverage among the lowest-income uninsured children compared to the original bill.)
- Only 500,000 of the 3.9 million otherwise-uninsured children who would gain coverage under the bill would do so as a result of state actions to broaden their SCHIP eligibility criteria. (This is 100,000 fewer than under the original bill.) All of these 500,000 children would be below 300 percent of the poverty line.

2. The second bill tightens the citizenship documentation option; it would ensure that ineligible undocumented immigrants are not enrolled in Medicaid and SCHIP, without reducing enrollment among eligible citizen children.

Opponents of the first bill falsely claimed that it would somehow extend Medicaid and SCHIP to undocumented immigrants or otherwise allow many ineligible undocumented immigrants to enroll.⁵

The Deficit Reduction Act of 2005 imposed a new citizenship documentation requirement on citizens eligible for Medicaid. The requirement has proved onerous and prevented many poor citizen children who are eligible for Medicaid from enrolling. (A recent survey for the Kaiser Commission on Medicaid and the Uninsured determined that the requirement was a key reason why Medicaid enrollment has declined for the first time in nearly a decade.⁶) The first SCHIP bill gave

⁴ Jocelyn Guyer, "Coverage of Uninsured Children in Moderate-Income Families under SCHIP," Center for Children and Families, Georgetown University Health Policy Institute, October 2007.

⁵ See "Charge that Bipartisan SCHIP Compromise Bill Aids Undocumented Immigrants Is False," Center on Budget and Policy Priorities, September 25, 2007.

⁶ Vernon Smith et al., "As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality," Kaiser Commission on Medicaid and the Uninsured, October 2007. See also Government Accountability Office, "States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens," June 2007; "Medicaid Citizenship Documentation Requirements Deny Coverage to

states a new option to comply with the requirement: for individuals who have already signed a sworn declaration that they are U.S. citizens, state Medicaid agencies could match individuals' names and Social Security numbers with information in the Social Security Administration (SSA) database to ensure that the name and Social Security number were accurate. The bill also extended the citizenship documentation requirement to SCHIP for the first time.

The second bill includes changes that fully address opponents' charges in this area:⁷

- Opponents claimed that some people who are not citizens can have Social Security numbers and that proving the numbers are valid does not prove these people are citizens. The second bill responds to this concern by tightening the new data matching option, requiring states to verify not only names and Social Security numbers with information in the SSA database, but also *citizenship*. States that use the new option would have to submit to SSA the names and Social Security numbers of all Medicaid applicants who declare they are U.S. citizens. SSA would check this information against the SSA database and determine not only whether the name and Social Security number match, but also whether the SSA database shows that the applicant is a citizen.
- If SSA could not confirm the accuracy of the applicant's name, number, and *citizenship*, the individual would have to provide the state with original documents, such as a birth certificate or passport, to prove his or her citizenship, as is required under the citizenship documentation requirement now in place.

3. The second bill accelerates the elimination of SCHIP coverage of childless adults.

Opponents of the first bill criticized it for allowing states to use SCHIP funds to cover adults through waivers.⁸ This criticism ignores the fact that the bill would have significantly *curtailed* SCHIP coverage of adults: it barred the federal government from granting any new waivers to states to cover parents, required states to move SCHIP-covered parents out of SCHIP after two years, and reduced the federal matching rate for such coverage. It also eliminated SCHIP coverage of adults without children after two years.

The second bill would take the further step of eliminating SCHIP coverage of childless adults by the end of calendar year 2008, nine months earlier than under the first bill.

4. The second bill takes additional steps to limit "crowd-out."

Opponents of the first bill have incorrectly claimed that it would not produce much of a gain in coverage but instead would primarily lead children who now have *private* insurance to be switched to

Citizens And Cost Taxpayers Millions," Majority Staff, Committee on Oversight and Government Reform, July 24, 2007; Donna Cohen Ross, "Medicaid Requirement Disproportionately Harms Non-Hispanics, State Data Show," Center On Budget and Policy Priorities, July 10, 2007, and "New Medicaid Citizenship Documentation Requirement Is Taking A Toll," Center on Budget and Policy Priorities, March 13, 2007.

⁷ For a comprehensive analysis of how the second SCHIP bill ensures that ineligible undocumented immigrants do not enroll in Medicaid and SCHIP, see Judith Solomon and Allison Orris, "New Children's Health Legislation Would Not Allow Any Undocumented Immigrants to Enroll in SCHIP or Medicaid," Center on Budget and Policy Priorities, December 3, 2007.

⁸ See, for example, White House, "Press Briefing Via Conference Call by Senior Administration Officials on SCHIP Reauthorization," October 17, 2007.

public programs.⁹ CBO analysis showed this charge was incorrect: nearly two-thirds of the children who would gain SCHIP or Medicaid coverage under the bill by 2012 (3.8 million out of 5.8 million) would otherwise be uninsured. Only slightly more than one-third (34 percent) would otherwise have some form of private coverage.¹⁰

Moreover, as CBO director Peter Orszag and leading health experts have explained, virtually *any* effort to cover more of the uninsured — including tax deductions or credits for the purchase of insurance in the private market — would result in some “crowd-out.” In discussing the first SCHIP bill passed by the House, which also had a crowd-out rate of about one-third, Orszag noted that he “has not seen another plan that adds 5 million kids to SCHIP with a 33 percent crowd-out rate. This is pretty much as good as it is going to get” (except for approaches that would impose mandates on employers, individuals, or states).¹¹

The second SCHIP bill includes changes to further reduce the risk of crowd-out.

- It requires *all* states to adopt best practices developed by the Secretary of Health and Human Services, in consultation with states, on limiting crowd-out. The original bill only required states that expand coverage above 300 percent of the poverty line to adopt such practices.
- As discussed above, the second bill further increases the focus on the lowest-income children. Because such children are highly unlikely to have other access to health insurance, there is less risk of crowd-out at those income levels.
- The bill also encourages states to take up an existing “premium assistance” option, under which states can enroll SCHIP-eligible uninsured children in employer-sponsored health insurance — if their families have access to such coverage — by using SCHIP funds to help families pay the required premiums. The first SCHIP bill included provisions to make it easier for states to implement premium assistance. The second bill goes further, adding a fiscal inducement for states to institute the premium assistance option.¹²

CBO estimates indicate that the second bill produces a slightly lower crowd-out rate than the first, one, of just under 33 percent.

⁹ See “The President’s Comments on Congress’ SCHIP Plan,” Center on Budget and Policy Priorities, September 20, 2007 and Robert Greenstein, “The Administration’s Dubious Claims about the Emerging Children’s Health Insurance Legislation: Myths and Realities,” Revised July 20, 2007.

¹⁰ It is also important to note that this CBO estimate is widely misunderstood. A large share of the SCHIP “crowd-out,” as estimated by CBO, involves children who are uninsured now but who eventually would obtain private coverage if SCHIP coverage were not available. These are *not* children who had private insurance which their families voluntarily dropped for public program coverage. See Leighton Ku, “‘Crowd-Out’ Is Not the Same as Voluntarily Dropping Private Health Insurance for Public Program Coverage,” Center on Budget and Policy Priorities, September 27, 2007.

¹¹ “SCHIP: Governors, Health Officials, Seek Withdrawal of CMS Rules Targeting ‘Crowd-Out’ by SCHIP,” *BNA Health Care Daily*, August 31, 2007.

¹² To qualify for incentive payments for enrolling more of the eligible but uninsured children, states would have to adopt for their Medicaid and SCHIP programs at least five of eight enrollment and retention strategies listed in the bill, one of which is premium assistance. This should result in more states implementing premium assistance programs.