

The Failure of SCHIP Reauthorization: What Next?

Timely Analysis of Immediate Health Policy Issues

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Summary

As efforts to reauthorize the State Children's Health Insurance Program (SCHIP) failed in 2007, Congress settled on a short-term extension of the program. The issues that proved contentious in the SCHIP reauthorization debate—namely, the proper role of the government in health care, whether SCHIP should cover higher-income children, how to ensure that undocumented children will not be covered, and how the program should be funded—will likely be revisited when Congress again takes on SCHIP reauthorization later in 2008 or early in 2009, when the extension is set to expire. Instead of seeing the reductions in uninsurance among children that were projected under the vetoed SCHIP reauthorization bills, the number of uninsured children will likely increase, at least in the short run. Without strong growth in public coverage, more children are apt to join the ranks of the uninsured, which increased by 1 million over the past two years.

Introduction

After two presidential vetoes of legislation aimed at reauthorizing SCHIP for five years, the president and Congress ultimately agreed to an 18-month extension of the program in December 2007 (S.2499). While the extension did not make any changes in policy, it did include additional funding designed to address anticipated shortfalls across states.^{1,2} SCHIP was established over a decade ago in 1997 to provide health insurance coverage for children in families whose incomes were too high to qualify for coverage under Medicaid, but who lacked access to affordable private health insurance coverage.³ Though an optional program, all states expanded coverage under SCHIP, with an estimated 6.7 million children and 700,000 adults having coverage under SCHIP at some point during 2006.⁴ State programs vary in terms of their structure and characteristics (e.g., cost sharing arrangements and income eligibility levels), reflecting the flexibility over program design that was built into the SCHIP statute.

Context for SCHIP Reauthorization

SCHIP reauthorization was being debated at a time when a growing number of states were planning policy changes aimed at increasing insurance coverage for children, with some states striving for "universal" (100 percent) coverage.^{5,6} In almost all cases, SCHIP was proposed as a key building block for expanding coverage to more children.⁷ Debate over SCHIP gained additional urgency as the Census Bureau announced in August 2007 that the number of uninsured children had risen by 700,000 between 2005 and 2006, for a cumulative increase of 1 million children in two years.⁸

The backdrop for SCHIP reauthorization was, on balance, a very positive assessment of what the program had achieved in its first 10 years. Numerous evaluations concluded that SCHIP has been successful in achieving the goals of reducing uninsurance among children and improving their access to care.^{9,10} The number of uninsured children declined

following the expansion of SCHIP coverage and the accompanying outreach and enrollment simplification efforts for both Medicaid and SCHIP, with declines concentrated among children in low-income families—the target group for Medicaid and SCHIP.¹¹ The improving coverage picture for children stood in stark contrast to what was occurring for adults over this same time period, when their uninsured rates were rising.¹² Both national and numerous state-level studies found that SCHIP reduced unmet health needs among children and improved their access to primary care.¹³

While there was a general consensus that SCHIP has been a success, there were also concerns that SCHIP has fallen short in a number of areas.¹⁴ In particular, there were concerns about the adequacy of overall SCHIP funding, the formula used to allocate SCHIP funds across states, the unpredictable nature of available federal funds for particular states, the uninsured children eligible for SCHIP but not yet enrolled, and the absence of consistent reporting on quality of care under the program.¹⁵ There was also controversy over the use of SCHIP funds to cover adults and higher-income children, over citizen and identity documentation requirements in Medicaid and SCHIP, and about the proper role of the government in health care.¹⁶

SCHIP Reauthorization Timeline

Table 1 shows key events relevant to SCHIP reauthorization and their timing.¹⁷ In February 2007, the president introduced his budget proposal which

TABLE 1: SCHIP Reauthorization Timeline**2007****February**

5 President releases FY 2008 budget, which includes \$4.8 billion in new SCHIP funding over five years

May

25 President signs H.R. 2206, approving an additional \$650 million for SCHIP funding in FY 2007 to prevent shortfalls

August

1 House passes H.R. 3162, The Child Health and Medicare Protection Act of 2007 (225-204)

2 Senate passes S.1893/H.R. 976, The Children’s Health Insurance Program Reauthorization Act of 2007 (68-31)

17 CMS Directive released

September

21 House and Senate leaders announce agreement on conference bill (H.R. 976)

25 House passes the conference bill, H.R. 976 (265-159-1)

27 Senate passes the conference bill, H.R. 976 with House amendments (67-29)

October

3 President vetoes H.R. 976

18 House fails to override veto of H.R. 976 (273-156)

25 House passes H.R. 3963, The Children’s Health Insurance Program Reauthorization Act of 2007 (265-142)

November

1 Senate passes H.R. 3963 (64-30)

December

12 President vetoes H.R. 3963

18 Senate passes S. 2499, The Medicare, Medicaid, and SCHIP Extension Act of 2007 (Unanimous Consent)

19 House passes S. 2499 (411-3)

29 President signs S.2499 into law (PL 110-173)

2008**January**

23 Veto override vote of H.R. 3963 fails in House (260-152)

February

4 President releases FY 2009 budget, which includes \$19.7 billion in new SCHIP funding over five years

Sources: Roll call votes, www.whitehouse.gov

Note: SCHIP is the State Children’s Health Insurance Program. Roll call votes for bills are in parentheses after the bill name and in the format (Yays-Nays-Present)

included \$4.8 billion in additional allotments over five years for SCHIP above the baseline annual funding level of about \$5 billion, which was significantly lower than the \$13.4 billion projected by the Congressional Budget Office (CBO) to be needed to maintain SCHIP coverage over that time frame.¹⁸ Moreover, once the Medicaid funding impacts associated with the president’s proposal were taken into account, the CBO projected an SCHIP spending increase of even less than \$4.8 billion—just \$2 billion over five years.¹⁹

As 2007 wore on, a number of states faced imminent shortfalls in federal SCHIP funding. To avoid the funding shortfalls projected in 14 states, the president signed legislation (H.R. 2206) in May 2007 that included an additional \$650 million for SCHIP for the remainder of FY 2007.

In August 2007, the Senate and House both passed bills to reauthorize SCHIP that included \$35 billion and \$50 billion in spending above baseline, respectively, over five years (for Medicaid and SCHIP).

Both bills included changes to the funding formula to more closely align state-specific needs with the federal allotments and to give states two years (instead of three) to use an allotment. At the same time that Congress was debating SCHIP reauthorization, the Centers for Medicare and Medicaid Services (CMS) issued a directive on August 17, 2007 that placed new conditions on states’ ability to use federal funds to cover children in families with incomes above 250 percent of the federal poverty level (FPL).²⁰

The first conference bill (H.R. 976) that passed included the Senate's proposed federal funding level but combined policy options (described below) from both the Senate and House bills.²¹ A second conference bill, the Children's Health Insurance Program Reauthorization Act of 2007 (H.R. 3963) was subsequently passed, which attempted to address concerns about the first bill related to the use of SCHIP funds to cover adults and higher-income children and documentation requirements. The second conference bill included additional outlays of \$35.4 billion over five years above baseline funding that was to be offset by a 61 cent increase in the federal tax on cigarettes and tax increases on other tobacco products.²²

The CBO projected that the second conference bill would lead to a 5.8 million increase in average monthly enrollment—4.1 million in SCHIP and 1.7 million in Medicaid.²³ An estimated 73 percent of the children who would benefit from the bill had incomes below 200 percent of the FPL, and many of them had incomes below the FPL.²⁴ It was also projected that this bill would reduce the number of uninsured children by 3.9 million and the number of children with private coverage by 2 million, over and above baseline levels, producing an estimated crowd-out rate of about a third.²⁵

In order to achieve enrollment gains in both Medicaid and SCHIP, particularly among children eligible but not enrolled, provisions were included that aimed at reducing barriers to enrollment, including \$100 million for new outreach grants each year starting in 2010, enhanced funding for translation/interpretation services, new auto-enrollment options for states, and bonus payments to states for increasing enrollment among Medicaid-eligible children or for implementing premium assistance programs.²⁶ The bill also imposed citizenship and identity documentation requirements not previously found in SCHIP but allowed states new options for verifying citizenship in both Medicaid and SCHIP.

In addition, the bill included measures aimed at improving the quality of pediatric care and child health status.

The second conference bill introduced new restrictions on the use of federal SCHIP funds to cover adults and higher-income children. It phased out coverage for childless adults and parents under SCHIP more quickly than the first conference bill. Like the first conference bill, it nullified the August 17 CMS directive, but it also attempted to preclude states (with the exception of New Jersey, which was allowed to continue its previous coverage up to 350 percent of the FPL) from using federal funds to cover children over 300 percent of the FPL in SCHIP.²⁷ All states were required to submit state plan amendments addressing crowd out within two years of enactment of the Act, complying with "best practices" guidelines to be promulgated by CMS.

The president vetoed both conference bills, giving numerous reasons for his vetoes—namely that SCHIP funds would still be used to cover adults, that SCHIP would be covering too many higher-income children, that many children would end up dropping private insurance to enroll in public coverage, that it would raise taxes, and that it would move toward the "goal of government-run health care for every American."²⁸ Both veto override attempts failed; the veto override vote of the second conference bill was attempted in the House of Representatives on January 23, 2008 and failed by 13 votes (Democrats voted 229 to 2 in favor and Republicans voted 44 to 154). No veto override was attempted in the Senate since the veto override attempt had failed in the House. The bill had passed the Senate by a vote of 64 to 30, which would have been sufficient to override the veto.²⁹

Short-term SCHIP Extension

The Medicare, Medicaid, and SCHIP Extension Act of 2007 that the president signed on December 29 extended SCHIP through March 31,

2009. It includes an additional \$1.6 billion in federal funding for FY 2008, over and above the \$5 billion in baseline funding, targeted at states with shortfalls.^{30,31} Recent estimates based on projected spending levels for FY 2008 suggest that this will be sufficient to address all the shortfalls that are anticipated for FY 2008, with some room for unanticipated shortfalls. According to these projections, 19 states will need to rely on the additional federal funds to keep their programs going. Even more states may need to tap into these federal resources to maintain their programs in FY 2008 if their actual spending levels are slightly higher than their projected levels. Five states have projected spending levels that are over 90 percent of the federal funding they have available through current allotments, and another four states have projected spending levels between 80 and 90 percent of their available allotments. In contrast, 15 states have projected SCHIP spending levels that are much lower, ranging from just 13 to 53 percent of their available allotments, and thus are unlikely to need any additional federal funding since their current federal allotments should be able to cover their spending.³² The extension also provides funding for the Current Population Survey (CPS) to continue fielding the larger sample size in its March Supplement, which was designed to improve the accuracy of the formula used to allocate federal SCHIP funds across states, and includes some additional funds for FY 2009.

What Next?

To the extent that SCHIP continues to operate under the extension bill, there are a number of reasons why it is likely that fewer children will gain public coverage than would have under the five-year SCHIP reauthorization bills that passed. First, fewer federal resources (i.e., new annual allotments) are available for SCHIP in FY 2008 under the extension bill than were proposed in the second conference bill—\$6.6 billion compared to at least

\$9.125 billion. This means that states will have access to fewer federal resources over the next year to expand their programs. Thus, despite the additional federal SCHIP funding for FY 2008 over and above baseline levels, the available federal funds are not sufficient to cover many additional SCHIP-eligible children or to support significant expansions in eligibility to higher income levels.

Second, the extension did not include any of the policy changes (e.g., performance payments for Medicaid enrollment gains, revised documentation requirements, outreach grants, and express lane eligibility) that could have sparked increased enrollment and retention in Medicaid in 2008 and beyond. This is an issue because more uninsured children are eligible for Medicaid than SCHIP, but states receive a lower matching rate for covering them and may be reluctant to expand their Medicaid enrollment given the looming state budget deficits.³³ Therefore, it is unlikely that states will move aggressively in the short run to enroll more of the uninsured children eligible for public coverage.

Third, the extension did not address the August 2007 Directive, which, along with subsequent CMS rulings on state attempts to expand both Medicaid and SCHIP coverage for children, make it unlikely that many large-scale expansions of public programs will be launched this year to cover children with incomes above 250 or even above 200 percent of the FPL.³⁴ The directive requires, among other things, that states achieve participation rates of 95 percent among low-income children to receive federal matching funds to cover children with family incomes above 250 percent of the FPL.

Unless Congress reverses the August Directive or the courts overturn it, approximately 17 states will likely need to scale back their current programs by August 16, 2008.³⁵ To date, no means-tested public benefit program has enrolled 95 percent of eligible, low-income households on a national level,

which makes it very unlikely that many, if any, states will be able to clear this threshold.³⁶ At this point, CMS has not indicated which data sets and methodology will be used to calculate participation rates, how consistent the approach will be across states, whether and what type of adjustment will be made to account for the possible underreporting of Medicaid, how eligibility will be defined—that is, whether private coverage will be included or excluded, how immigration status will be taken into account, etc.—and whether confidence intervals will be used to determine whether states have attained the target.³⁷ Recent CPS tabulations of state-specific coverage rates among low-income children, which will tend to be higher than the corresponding participation rates

because they include private coverage in both the numerator and the denominator, suggest that no state has yet achieved a coverage rate of 95 percent or, conversely, an uninsured rate of less than five percent among low-income children.³⁸ While 10 states and the District of Columbia have estimated coverage rates above 90 percent for low-income children, 15 states have estimated coverage rates that are below 80 percent (Table 2).³⁹

Even if states are able to demonstrate a 95 percent participation rate (for example, by making substantial adjustments to coverage estimates from the CPS), the August Directive also holds states accountable for declines in employer-sponsored insurance, and it requires the use of a mandatory 12-

TABLE 2: Coverage Rates Among Low-Income Children by State, 2006

Rhode Island Iowa Vermont Washington	90 to 95% Michigan Wisconsin Ohio Tennessee	Maine West Virginia District of Columbia
Wyoming Indiana Kansas New York Connecticut	85 to 89% South Carolina Pennsylvania Hawaii Kentucky Arkansas	Alabama South Dakota Missouri Massachusetts New Hampshire
Alaska Idaho Illinois North Carolina	80 to 84% Oklahoma Delaware Nebraska	Virginia North Dakota Minnesota
California Maryland Oregon	75 to 79% Georgia Utah Louisiana	Arizona New Mexico
Montana New Jersey Mississippi	65 to 74% Colorado Nevada	Florida Texas

Source: Urban Institute, 2007. Estimated coverage rates rounded to the nearest whole number from the 2007 ASEC supplement to the Current Population Survey; standard errors available upon request. Figures do not adjust for possible underreporting of Medicaid/SCHIP on the CPS. Low-Income defined as family incomes less than 200% FPL.

month waiting period and new cost sharing requirements for children above 250 percent of the FPL.⁴⁰ Therefore, all things considered, it will be difficult, if not impossible, for states to comply with the August 17, 2007 Directive.

Thus, while the CMS Directive could cause some states to make greater efforts to cover low-income children, states will more likely scale back eligibility thresholds for children. In fact, as of December 2008, a number of states contemplating expansions have failed to go forward with their plans (Indiana), have been advised by CMS that their plan will likely be denied (Ohio), or ultimately proposed a smaller-scale expansion (Louisiana and Oklahoma).⁴¹ More generally, how many states will launch new outreach and enrollment initiatives that require CMS approval is unclear since CMS has indicated that proposed changes to a state's Medicaid or SCHIP plan could trigger a CMS audit of the state's entire plan. On the other hand, political support for enrolling children into health coverage remains strong in some states. Indeed, both New York and Wisconsin are proposing coverage expansions from 250 percent of the FPL to 400 and 300 percent of the FPL, respectively, with state funds.⁴²

Therefore, instead of seeing the increase in children's coverage projected under both five-year SCHIP reauthorization bills that were passed by Congress but vetoed by the president, the number of uninsured children will likely increase, at least in the short run. With the economic downturn, employer-sponsored coverage will continue to erode in 2008.⁴³ Thus, the underlying factors that led to a 1 million increase in the number of uninsured children between 2004 and 2006 will continue to exert upward pressure on the number of uninsured children in 2008.

In early February 2008, the president introduced his budget proposal which has an additional \$19.7 billion in allotments over five years for SCHIP above baseline levels between 2009 and

2013, about \$15 billion more than he had proposed for SCHIP in 2007. His proposal also includes \$50 million in funding for new outreach grants in 2009 and \$100 million in each of the following four years.⁴⁴ The president's budget does not include any other policy changes aimed at increasing enrollment in Medicaid or SCHIP nor did it include investments aimed at improving pediatric quality of care or health status. According to the Congressional Research Service, under the president's proposal, SCHIP funds would be targeted at children and pregnant women with family incomes under 200 percent of the FPL, no new children would be enrolled in SCHIP if their gross family incomes were above 250 percent of the FPL, and states covering children with incomes above 200 percent but below 250 percent of the FPL would be penalized with lower matching rates for not meeting the conditions set down in the August 2007 CMS Directive.⁴⁵

How the CBO will score the president's budget proposal is unclear, but based on last year's experience, it will likely be scored at substantially less than the proposed \$19.7 billion. While the proposed funding is about \$15 billion more than what the president proposed last year, projected outlays for SCHIP under the president's proposal would still be more than \$15 billion less than what was included in the SCHIP Reauthorization Act of 2007, with a widening gap in spending between the two proposals over time.⁴⁶ As a consequence, in 2012, the president's proposal would cover at least 1.8 million fewer children under SCHIP and 1.7 million fewer children under Medicaid relative to the number that would have been covered under the SCHIP Reauthorization Act of 2007.⁴⁷ The coverage gap between the two approaches is likely to be even greater than this because the president's proposal does not include any new policy options that would make enrolling and retaining children easier and because it includes no enrollment incentives or bonus payments. The

president's budget would therefore put children's coverage on a lower enrollment trajectory relative to the SCHIP Reauthorization Act, which means that it would likely produce smaller reductions in uninsurance among children, particularly among the poor and near-poor children eligible for Medicaid but not yet enrolled.⁴⁸

Given the short-run nature of the SCHIP extension, SCHIP reauthorization will be debated again, if not in 2008, then in early 2009. At this point, it is not clear whether any SCHIP legislation will be introduced that corresponds to the president's budget proposal or whether the August Directive will be addressed through legislation. To the extent that SCHIP reauthorization is put off until late 2008 or early 2009, the result of the November 2008 presidential election will likely shape the subsequent debate about SCHIP and its outcome, since the Republican and Democratic candidates espouse very different visions for health care reform. The major Democratic presidential hopefuls support broad expansions of public programs such as SCHIP in combination with other policy changes aimed at substantially reducing the number of uninsured Americans, while the presumptive Republican nominee is proposing narrower private-sector solutions that would reduce the number of uninsured to a much smaller extent.⁴⁹ While support for broad health care reform would likely be much higher under a Democratic administration, Congress will still need to address SCHIP in early 2009, either through another short-term extension or through a five-year reauthorization bill, before legislation aimed at broader reform could feasibly be introduced. In any case, Congress will revisit the issues debated as part of the 2007 SCHIP reauthorization attempt but may do so in the context of a broader effort to reform the health care system.

Notes

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- ² De Sa, J, E. Rollins, and R. Stewart. "Revised estimate of cost of maintaining SCHIP programs in 2008." Congressional Budget Office Memorandum. 14 Dec 2007.
- ³ The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) established the State Children's Health Insurance Program under Title XXI of the Social Security Act.
- ⁴ Peterson, C and E Herz. "Estimates of SCHIP Child Enrollees Up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees." Congressional Research Service. Report to Congress. 13 Mar 2007.
- ⁵ Georgetown Center for Children and Families. "Children's Health Coverage: States Moving Forward." May 2007. Updated 20 Jul 2007.
- ⁶ Kaye, N and L. Flowers. "How States Have Expanded Medicaid and SCHIP Eligibility." National Academy of State Health Policy. Jan 2002.
- ⁷ Georgetown Center for Children and Families. "Children's Health Coverage: States Moving Forward." 2007.
- ⁸ US Census Bureau. "Household Income Rises, Poverty Rate Declines, Number of Uninsured Up." News Release. 28 Aug 2007. http://www.census.gov/Press-Release/www/releases/archives/income_wealth/010583.html
- ⁹ Kenney, G. et al., "The Experiences of SCHIP Enrollees and Disenrollees in Ten States: Findings from the Congressionally Mandated SCHIP Evaluation, Final Report." Urban Institute and Mathematica Policy Research. Princeton, NJ, October 2005. http://www.urban.org/UploadedPDF/1001117_schip_experiences.pdf
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- ¹¹ Kenney, G and J Yee. "SCHIP At A Crossroads: Experiences to Date and Challenges Ahead." *Health Affairs*. March/April 2007; 26(2): 356-369.
- ¹² Cohen, R, and M. Martinez. "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-June 2007." National Center for Health Statistics. Released Dec 2007. <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200712.pdf>
- ¹³ Dick A, Brach C, Allison RA, et al. "SCHIP's Impact In Three States: How Do The Most Vulnerable Children Fare?" *Health Affairs*, September/October 2004; 23(5): 63-75; Kenney, G. "The Impacts of SCHIP on Children Who Enroll: Findings from Ten States." 2007. *Health Services Research* 42, no. 4: 1520-1543; Davidoff, A, G Kenney, and L Dubay. July 2005. "Effects of the State Children's Health Insurance Program Expansions on Children with Chronic Health Conditions." *Pediatrics* 116(1): e34-e42; D. Bermudez and L. Baker, "The Relationship between SCHIP Enrollment and Hospitalizations for Ambulatory Care Sensitive Conditions in California," *Journal of Health Care for the Poor and Underserved* 16, no. 1 (2005): 96-110, http://muse.jhu.edu/demo/journal_of_health_care_for_the_poor_and_underserved/v016/16.1bermudez.pdf; Szilagyi PG, Dick A, Klein J, Shone LP, Zwanziger J, Bajorska A, Yoos HL. "Improved asthma care after enrollment in the State Children's Health Insurance Program (SCHIP) in New York." *Pediatrics* 117:486-496, Feb 2006. <http://www.pediatrics.org/cgi/content/full/117/2/486>.
- ¹⁴ Kenney G and J Yee. "SCHIP At A Crossroads." 2007.
- ¹⁵ Simpson, L., et al. "Reauthorizing SCHIP: Opportunities for Promoting Effective Health Coverage and High-Quality Care for Children and Adolescents." *The Commonwealth Fund* 65, 9 Aug 2007; Hudson J and Selden T. "Children's Eligibility and Coverage: Recent Trends And A Look Ahead." *Health Affairs*. Web Exclusive. 16 August 2007. w618-w629; Lambrew, J. "The State Children's Health Insurance Program: Past, Present, and Future." *The Commonwealth Fund*. (Vol. 49) 9 Feb 2007; Kenney G and J Yee. "SCHIP At A Crossroads." 2007; Cuttler L and Kenney G. "State Children's Health Insurance Program and Pediatrics." *Archives of Pediatric Adolescent Medicine*. Vol. 161 (No. 7). July 2007.
- ¹⁶ Rep. Biggert. "SCHIP should be for children, not adults." Letter to the Editor. *The Chicago Tribune*. 11 Oct 2007.; Owcharenko, N. "The Revised SCHIP Bill: Still Bad Health Policy." *The Heritage Foundation*. Web Memo #1680. 29 Oct 2007.
- ¹⁷ Republicans in Congress introduced several alternate SCHIP reauthorization bills. Two bills in particular would have provided a five-year, \$6.5 billion reauthorization of the program: H.R. 3176, introduced in the House by Rep. Barton (R-TX-6) in July and S. 2193/H.R. 3888, introduced in the Senate by Sen. Martinez (R-FL) and in the House by Rep. Musgrave (R-CO-4) in October. The Barton bill would have required states to set forth plans to cover 90 percent of eligible children in their state, prohibited the use of federal funds to cover children in families earning more than 250 percent of the FPL, and required states to reach the 90 percent coverage benchmark before expanding eligibility above 200 percent of the FPL. The bill also applied citizen documentation rules outlined in the Deficit Reduction Act of 2005 to SCHIP applicants, capped eligibility to families with net assets of less than \$500,000, limited the use of income disregards in determining eligibility, and loosened requirements that states verify minimum benefits packages and cost-sharing limits on employer-sponsored family insurance plans before using premium assistance programs to cover children in these plans. The Martinez bill was very similar to the Barton bill, with the exception that it set aside funds for grants to increase outreach and enrollment of eligible children and created a tax credit for families who purchase qualified health insurance plans for their dependent child. Neither bill has left committee.
- ¹⁸ Congressional Budget Office. "Fact Sheet for CBO's March 2007 Baseline." 23 Feb 2007. This assumes that additional federal allocations are targeted at states with funding shortfalls.
- ¹⁹ CBO Estimates of Medicaid and SCHIP Proposals in the President's Budget for Fiscal Year 2008. 6 Mar 2007. https://www.cbo.gov/ftpdocs/88xx/doc8823/m Medicaid_schip_pres.pdf
- ²⁰ Mann, C and M. Odeh. "Moving Backward: New Federally Imposed Limits On States' Ability to Cover Children." Georgetown Center for Children and Families. 30 Aug 2007.
- ²¹ It also relied on the funding mechanism proposed in the original Senate bill. The House bill had proposed a smaller tobacco tax increase and had included savings from Medicare Advantage plans (and other Medicare policy changes) that were not included in the conference bill.
- ²² 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.
- ²³ 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." 24 Oct 2007.
- ²⁴ Kenney G, A Cook and J Pelletier. "SCHIP Reauthorization: How Will Low-Income Kids Benefit Under House and Senate Bills?" *The Urban Institute*. September 2007.
- ²⁵ 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." 24 Oct 2007. Crowd out is defined as the share of additional enrollment in public programs projected under the bill that is assumed to be attributable to reductions in private coverage.
- ²⁶ The previous conference bill had also provided bonus payments for increased enrollment in SCHIP but not for premium assistance.
- ²⁷ The previous conference bill had allowed states to expand coverage to higher-income children (above 300 percent of the FPL) and receive the lower, Medicaid match rate to cover these children, provided they adopted a state plan to address crowd-out and achieved a target rate of coverage of children with incomes under 200 percent of the FPL by 10/1/2010. Failure to adopt these two measures would make the state ineligible to receive any federal funds to cover higher-income children.
- ²⁸ President's Radio Address. 6 Oct 2007. <http://www.whitehouse.gov/news/releases/2007/10/20071006.html>; Rosenbaum, S. "The Proxy War: SCHIP and the Government's Role in Health Care Reform." *New England Journal of Medicine*. 358(9). February 28, 2008.
- ²⁹ The Senate vote breakdown on this bill was as follows: Democrats voted 45-0, Independents voted 2-0, and Republicans voted 17-30.

- ³⁰ Peterson, C. "FY 2008 Federal SCHIP Financing."
- ³¹ De Sa, J, E. Rollins, and R. Stewart. "Revised estimate of cost of maintaining SCHIP programs in 2008."
- ³² Peterson, C. "FY 2008 Federal SCHIP Financing."
- ³³ Some legislators have proposed increasing federal matching rates under Medicaid though it is not clear that action will be taken in 2008. McNichol, E. and I. Lav. "13 States Face Total Budget Shortfall of at Least \$23 Billion; 11 Others Expect Budget Problems." Center on Budget and Policy Priorities. 18 Dec 2007; Update: "21 States Face Total Budget Shortfall of at Least \$37 Billion in 2009; Seven Others Expect Budget Problems." 10 Mar 2008.
- ³⁴ Pear, R. "U.S. Curtailing Bids to Expand Medicaid Rolls." *The New York Times*. 4 Jan 2008; Mann, C., and M. Odeh. "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive to Impose New Limits on States' Ability to Cover Uninsured Children." Georgetown Center for Children and Families. Dec 2007.
- ³⁵ Smith, D. Letter to Rep. Barton. Centers for Medicare and Medicaid Services. 22 Jan 2008.
- ³⁶ Dorn, S. "Eligible but Not Enrolled: How SCHIP Reauthorization Can Help." *The Urban Institute*. Sep. 2007.
- ³⁷ See Kenney, G. "Medicaid and SCHIP Participation Rates: Implications for the New CMS Directive." *The Urban Institute. Health Policy Online*. No. 16. Sep 2007; and Smith, D. "Covering Uninsured Kids: Missed Opportunities for Moving Forward." Testimony Before The House Energy and Commerce Subcommittee on Health. January 28, 2009.
- ³⁸ For example, if 40 percent of low-income children have public coverage, 20 percent are uninsured and 40 percent have private coverage and all low-income children are eligible for public coverage, the participation rate would be 66 percent (40 percent divided by 60 percent—the share with public coverage divided by the sum of the share with public coverage and the uninsured share) whereas the coverage rate would be 80 percent.
- ³⁹ Urban Institute tabulations of the 2007 ASEC Supplement to the Current Population Survey that do not adjust for the possible misreporting of Medicaid/SCHIP coverage or model eligibility.
- ⁴⁰ Mann, C and M. Odeh. "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive"
- ⁴¹ Mann, C and M. Odeh. "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive"
- ⁴² Crowley, C. "Hotline, lower costs for care." *Albany Times Union*. 30 Jan 2008.; Bolton, G. "State moves on health insurance for children." *Milwaukee Journal Sentinel*. 7 Nov 2007. New York currently covers children up to 250 percent FPL. Wisconsin currently covers children up to 200 percent FPL, but plans to fund children between 200 and 250 percent FPL with a combination of state and federal funds, pending approval by CMS.
- ⁴³ Holahan, J. and A. Cook. "The US Economy and Changes in Health Insurance Coverage, 2000-2006." *Health Affairs*. Web Exclusive. 20 Feb 2008: w135-w144.
- ⁴⁴ President's FY 2009 Budget Fact Sheet on the Department of Health and Human Services. <http://www.whitehouse.gov/omb/budget/fy2009/pdf/budget/hhs.pdf>
- ⁴⁵ Binder, C. et al. "Medicaid and the State Children's Health Insurance Program (SCHIP): FY2009 Budget Issues." Congressional Research Service. Report for Congress. Updated 13 Feb 2008.
- ⁴⁶ Funding levels in the president's budget from Historical Table 11.3 of the FY 2009 Budget. Funding levels for The SCHIP Reauthorization Act (H.R. 3963) from CBO's October 24 cost estimates of the bill.
- ⁴⁷ Enrollment projections for the president's budget from The Office of the Actuary (4 Feb 2008) are reported as enrollees in SCHIP in terms of person-years. While only limited information is available on the impact of the President's budget, it does not appear that it will have positive effects on Medicaid enrollment for children. This will be revised once CBO has scored the President's budget proposal. Enrollment projections for H.R. 3963, The SCHIP Reauthorization Act, from The Congressional Budget Office "Estimate of changes in SCHIP and Medicaid enrollment," (24 Oct 2007) are average monthly enrollment levels in 2012. The CBO figures include adults, who account for less than 10 percent of SCHIP enrollment.
- ⁴⁸ Only limited information is available on the President's proposal so it is not possible to rigorously assess its impact on the number of uninsured children.
- ⁴⁹ Among the three presidential hopefuls, Senators Clinton and Obama voted for and Senator McCain voted against The Children's Health Insurance Program Reauthorization Act of 2007 on August 2, 2007. In subsequent votes on the two conference bills, Senators McCain and Obama were not present, and Senator Clinton voted for the first conference bill on September 27 and was not present for the vote on the second conference bill on November 1. Details on each of the candidates' plans may be found on their campaign Web sites:
- Hillary Clinton
<http://www.hillaryclinton.com/feature/healthcare/replan/>
- Barack Obama
<http://www.barackobama.com/issues/healthcare/>
- John McCain
<http://www.johnmccain.com/Informing/Issues/19ba2f1c-c03f-4ac2-8cd5-cf2edb527cf.htm>

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