John Ensign, Chairman
Pamela Thiessen, Staff Director

347 Russell Senate Office Building
Washington, DC 20510
202-224-2946
http://rpc.senate.gov

U.S. SENATE REPUBLICAN POLICY COMMITTEE

Legislative Notice

No. 3 January 26, 2009

S. 275, the Children's Health Insurance Program Reauthorization Act of 2009

Calendar No. 17

Reported from the Finance Committee on January 16, 2009 by a vote of 12-7; no written report.

Noteworthy

- This evening, the Senate will begin consideration of H.R. 2, the House-passed Children's Health Insurance Program reauthorization. It is anticipated that the Senate will strike the language of H.R. 2 and insert the language of S. 275 for purpose of amendment.
- S. 275, the Children's Health Insurance Program Reauthorization Act of 2009, will revise and expand the State Children's Health Insurance Program (SCHIP). SCHIP was created to provide health care to children whose families earned too much to qualify for Medicaid, but not enough to afford private health insurance.
- The program is currently funded through a continuing resolution which will expire on March 31, 2009. S. 275 is a 4 ½ year reauthorization and would provide funding through September 30, 2013.
- The legislation would increase SCHIP enrollment by 5.7 million and Medicaid enrollment by 800,000, for a total of 6.5 million newly enrolled individuals. When added to existing populations, CBO projects that 37.7 million would be covered by the programs.
- The revisions to H.R. 3963 (the previous SCHIP bill) include: overriding current law which provides a five-year waiting period in order for legal immigrant children and pregnant women to become eligible for SCHIP and Medicaid benefits; providing a loophole that could allow New York to receive the enhanced Federal Medical Assistance Percentage [E-FMAP] rate for covering children up to 400 percent Federal Poverty Level [FPL] ($88,000 a year for a family of four); making it easier for states to cover children above 300 percent FPL ($66,000 a year for a family of four) through their SCHIP programs; and deleting provisions designed to reduce "crowd-out" (the substitution of public coverage for private coverage).
- The legislation is paid for by increasing the federal excise tax on tobacco products. This will increase revenues by $31.8 billion over the authorization period and $71.4 billion over 10 years (2009-2019). The total change in revenues, which includes a provision changing the timing of corporate estimated tax payments and other interactions, is $33.9 billion over the authorization period and $74.8 billion over FYs 2009-2019.

Procedural History

This evening, the Senate will begin consideration of H.R. 2, the House-passed Children's Health Insurance Program reauthorization. It is anticipated that the Senate will strike the language of H.R. 2 and insert the language of S. 275 for purpose of amendment. S. 275 was reported from the Finance Committee on January 16, 2009 by a vote of 12-7.

H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009 (CHPRA), passed the House on January 14, 2009. (Vote No. 16, 289-139). The bill includes provisions from two earlier bills, H.R. 976 and H.R. 3963. Both previous SCHIP bills passed the House and Senate and were vetoed by President Bush. The veto override attempt failed in the House in both cases (Vote No. 982, Oct. 18, 2007; Vote No. 22, January 23, 2008).

Background

S. 275, the Children's Health Insurance Program Reauthorization Act of 2009, will revise and expand the State Children's Health Insurance Program (SCHIP). SCHIP was created to provide health care to children whose families earned too much to qualify for Medicaid, but not enough to afford private health insurance. The program is currently funded through a continuing resolution which will expire on March 31, 2009 (The Medicare, Medicaid, and SCHIP Extension Act of 2007, P.L. 110-173). S. 275 is a 4 ½ year reauthorization and would provide funding through September 30, 2013.

In FY 2008, federal SCHIP funding totaled $7.0 billion, and states are projected to spend $7.9 billion in FY 2009.[1] SCHIP covered 7.1 million children and 587,000 adults in FY 2007.[2]

The Congressional Research Service (CRS) reports that an estimated 62 percent of uninsured children are eligible for either SCHIP or Medicaid but not enrolled.[3] This breaks out to approximately 3.7 million who are eligible for Medicaid but not enrolled, and 1.7 million who are eligible but not enrolled in SCHIP.

The legislation would increase SCHIP enrollment by 5.7 million and Medicaid enrollment by 800,000, for a total of 6.5 million newly enrolled individuals. When added to existing populations, the Congressional Budget Office (CBO) projects that 37.7 million would be covered by the programs.[4] Crowd-out would remain high in expansion populations with 500,000

---

[1] Congressional Research Service, "H.R. 2: The Children's Health Insurance Program Reauthorization Act of 2009," January 14, 2009. R40130.

[2] Congressional Research Service, "H.R. 2: The Children's Health Insurance Program Reauthorization Act of 2009," January 14, 2009.

[3] Congressional Research Service, "H.R. 2: The Children's Health Insurance Program Reauthorization Act of 2009," January 14, 2009.

[4] Congressional Budget Office, "Preliminary Estimate of Changes in SCHIP and Medicaid Enrollment in Fiscal Year 2013 of Children Under the Children's Health Insurance Program Reauthorization Act of 2009."

uninsured receiving new coverage, but a corresponding 500,000 leaving their private coverage as a result of the new public subsidies. Overall, CBO estimates that of the individuals covered, 2.4 million (37 percent) would have had private coverage without the legislation, and 4.1 million (63 percent) would have been uninsured. S. 275 would enroll 2 million more children than H.R. 3963 (37.7 million vs. 35.7 million). This is largely a result of the larger baseline enrollment projections.

S. 275 makes changes to the previous SCHIP reauthorization bill, H.R. 3963. This legislative notice focuses on these changes. For a substantive review of the legislation and the proposed revisions to the SCHIP program, please see the RPC legislative notice for H.R. 976, released on September 26, 2008.[5]

The revisions to H.R. 3963 include: overriding current law which provides a five-year waiting period in order for legal immigrant children and pregnant women to become eligible for SCHIP and Medicaid benefits; providing a loophole that could allow New York to receive the enhanced Federal Medical Assistance Percentage (E-FMAP) rate for covering children up to 400 percent Federal Poverty Level (FPL) ($88,000 a year for a family of four);[6] making it easier for states to cover children above 300 percent FPL ($66,000 a year for a family of four) through their SCHIP programs; and deleting provisions designed to reduce "crowd-out" (the substitution of public coverage for private coverage).

Noteworthy Changes from H.R. 3963

Coverage of populations over 300 percent FPL: States would be allowed to expand their SCHIP programs to cover populations above 300 percent FPL, but at the FMAP rate instead of the enhanced E-FMAP rate. In addition, the provision includes a loophole that allows states with an approved state plan amendment, or a state law to submit a state plan amendment, asking to expand their programs above 300 percent FPL to receive the higher E-FMAP rate. This exception would apply to New York and New Jersey. New Jersey covers children up to 350 percent FPL, while New York plans to expand its program to cover children up to 400 percent FPL ($88,000 a year for a family of four).

Provisions to prevent crowd-out: S. 275 removes Section 116 from H.R. 3963, which required that all states submit a state plan amendment detailing how each state will implement best practices to limit crowd-out. It also required the Government Accountability Office to issue a report describing the best practices by states in addressing the issue of SCHIP crowd-out. Finally, it required the Secretary of HHS to ensure that states which include higher income populations in their SCHIP programs cover a target rate of low-income children.

Extension of Medicaid and SCHIP benefits to legal immigrant children and pregnant women: The five-year waiting period for most legal aliens to receive federal welfare benefits was

[5] Available at: http://rpc.senate.gov/_files/L31HR976SCHIP092607AC.pdf.

[6] The Department of Health and Human Services recently released updated numbers for the Federal Poverty Level, which shows the 2009 federal poverty guideline to be $22,050 for a family of four. The updated guidelines are available at: http://aspe.hhs.gov/POVERTY/09poverty.shtml.

established as part of the welfare reform law (P.L. 104-196) signed by President Clinton in 1996. The legislation restricted or banned legal immigrants from aid programs including cash welfare, disability, food stamps and Medicaid. These provisions also apply to SCHIP, which was enacted in 1997. The five-year ban was enacted out of concern that legal aliens had an incentive to benefit from public programs rather than finding employment and contributing to the economy. The ban does not apply to legal, or illegal, immigrants given emergency care, which they can still receive under the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, children born to legal (or illegal) immigrants are citizens and would remain eligible for SCHIP and Medicaid.

S. 275 contains a provision allowing states the option to elect, through a state plan amendment, to provide medical benefits to children (under age 19) and pregnant women who are lawfully residing in the country and otherwise eligible for assistance. Supporters say about 400,000 to 600,000 children would be added to the SCHIP and Medicaid programs if all states opted to cover children of legal immigrants and pregnant legal immigrants.[7] CBO estimates that covering these populations would cost $1.7 billion from FYs 2009-2014, and $3.9 billion over the FY 2009-2019 period. Census Bureau data shows that almost half of low-income legal immigrant children are now uninsured.[8]

Even though the federal government ended funding for these populations, 21 states plus the District of Columbia continue to use state-only funds to cover legal immigrants in Medicaid and/or SCHIP.[9] The Center for Budget and Policy Priorities notes that, "Most of the states that traditionally have high concentrations of immigrants, such as California, New York, New Jersey, Massachusetts, Texas and Illinois, are among the states that chose to continue substantial coverage for legal immigrant children and pregnant women who otherwise would be disqualified by the 'five-year bar.'"[10] For these 21 states that already have chosen this option, the new law would substitute new federal funds for state funds.

Current law requires sponsors of immigrants to provide an affidavit of support which is used to show that the sponsor has "adequate means of financial support and that they [the immigrant] are not likely to become a public charge."[11] The form represents a contract between the sponsor and the U.S. government showing that the sponsor will support the immigrant if it becomes necessary. Thus, the sponsor is legally responsible to reimburse the government if the immigrant accepts prohibited federal benefits during this period. Eliminating the five-year bar would largely nullify the value of the affidavit of support in states that choose to cover legal immigrants.

[7] Associated Press, "House to Take up Children's Insurance," January 14, 2009.
[8] Center for Budget and Policy Priorities, "Reducing Disparities in Health Coverage for Legal Immigrant Children and Pregnant Women," April 20, 2007. Available at: http://www.cbpp.org/4-20-07health2.pdf
[9] Center for Budget and Policy Priorities, "Reducing Disparities in Health Coverage for Legal Immigrant Children and Pregnant Women," April 20, 2007.
[10] Center for Budget and Policy Priorities, "Reducing Disparities in Health Coverage for Legal Immigrant Children and Pregnant Women," April 20, 2007.
[11] I-864 Affidavit of Support. Available at: http://www.uscis.gov/files/form/I-864.pdf.

Cost

The legislation is paid for by increasing the federal excise tax on tobacco products.[12] The federal excise tax on cigarettes will be increased by 61 cents (to $1 per pack) and largely proportionate increases will be imposed on other tobacco products. This will increase revenues by $31.8 billion over the authorization period and $71.4 billion over 10 years (FYs 2009-2019).[13] The total change in revenues, which includes a provision changing the timing of corporate estimated tax payments and other interactions, is $33.9 billion over the authorization period and $74.8 billion over FYs 2009-2019.

The legislation is compliant with the Senate's "Pay-Go" rules over a five-year window. However, the legislation reduces the allotment in the fifth year in order to comply with "Pay-Go" over a 10-year window. CBO estimates that if H.R. 2 (the House companion legislation) was changed to authorize the SCHIP program through 2019 and to provide sufficient funding over that period, the bill would increase deficits by $41.6 billion over the 2009-2019 period.[14]

CBO has yet to provide a long term analysis of the bill, however it is likely that a long-term spending point of order lies against S. 275 because the changes in direct spending and revenues under S. 275 would cause an increase in the on-budget deficit greater than $5 billion in at least one of the 10-year periods between 2018 and 2057. This point of order would be subject to a 60-vote threshold.

---

[12] The Senate bill does not contain the restrictions on physician-owned "specialty" hospitals contained in the House bill.

[13] Congressional Budget Office, Preliminary Estimate of Changes in SCHIP and Medicaid Enrollment in Fiscal Year 2013 of Children Under the Children's Health Insurance Program Reauthorization Act of 2009."

[14] Congressional Budget Office, Letter to Representative Paul Ryan, January 14, 2009. Available at: https://www.cbo.gov/ftpdocs/99xx/doc9964/hr2RyanLtr.pdf.