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Medicaid and SCHIP Provisions in H.R. 5291 and S. 3165 (the 2000 Medicare "Refinement Bills")

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Jean Hearne
Elicia Herz
Specialists in Social Legislation
Evelyne Baumrucker
Analyst in Social Legislation
Domestic Social Policy Division

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Summary

On September 27, 2000, the House Commerce Committee ordered reported a bipartisan bill, the *Beneficiary Improvement and Protection Act of 2000* (H.R. 5291). On October 5, 2000 William V. Roth, Jr., the Chairman of the Senate Finance Committee, introduced the *Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000* (S. 3165). While both bills are largely comprised of Medicare provisions, they include a number of changes to the Medicaid and the State Children's Health Insurance Program (SCHIP).

Among the major changes included in the Medicaid provisions of both bills are changes to the disproportionate share hospital allotments for states, changes to reimbursement methods for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), and new options for states to cover certain legal immigrants who are pregnant women and children.

Major SCHIP provisions include extending the availability of unused funds from FY1998 and FY1999 and redistributing these unused funds among both states that spend and that do not spend their full original allotments, and giving states the option to cover certain legal immigrant children.

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Introduction

Medicaid is a joint federal-state entitlement program that pays for medical assistance primarily for low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children. Within broad federal guidelines, each state designs and administers its own program. Total program outlays in FY1999 were $180.9 billion. Federal outlays were $102.5 billion and state outlays were approximately $78.4 billion. The federal government shares in a state's Medicaid costs by means of a statutory formula designed to provide a higher federal matching rate to states with lower per capita incomes. In FY1999, federal matching rates ranged from 50% to 76% of a state's expenditures for Medicaid items and services. Overall, the federal government finances about 57% of all Medicaid costs.

The State Children's Health Insurance Program (SCHIP), enacted in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) is targeted at uninsured children who live in families with income below twice the federal poverty level and who would not otherwise be eligible for Medicaid. States may use SCHIP funds to provide coverage through health insurance that meets specific standards for benefits and cost-sharing (known as separate state programs), or through expansions of eligibility under Medicaid, or through a combination of both options. SCHIP entitles states with approved SCHIP plans to pre-determined, annual federal allotments based on a distribution formula set in law. Each state has flexibility to define the group of targeted, low-income children who are eligible for its SCHIP. Eligibility criteria may include, for example, geography, age, income and resources, residency, disability status, access to other health insurance, and duration of eligibility for SCHIP.

As of October 4, 2000, all 50 states, the District of Columbia and all five territories had approved SCHIP plans. Among these, 23 are Medicaid expansions, 15 are new or expanded separate state programs, and 18 will use both a Medicaid expansion and a separate state program.

The 105th Congress made important changes to the Medicaid program through the BBA 97.[1] That legislation included provisions to achieve net Medicaid savings of about $13 billion between FY1998 and FY2002, largely from reductions in

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[1] For a detailed description of the changes to Medicaid under BBA 97, see CRS Report 98-132, *Medicaid: 105th Congress*, by Melvina Ford and Richard Price.

supplemental payments to hospitals that serve a disproportionate share of Medicaid and low-income patients. BBA 97 also significantly increased the flexibility that states have to manage their Medicaid programs. In particular, it gave states the option of requiring most beneficiaries to enroll in managed care plans without seeking a federal waiver, and replaced federal reimbursement requirements imposed by the Boren amendments with a public notice process for setting payment rates for institutional services. The Act also required that the previously existing cost-based reimbursement system for Federally Qualified Health Centers and Rural Health Clinics be phased out over a 6-year period. Spending items in the Act included Medicaid coverage for additional children, and increased assistance for low-income individuals to pay Medicare Part B premiums.

BBA 97 also included the provisions establishing SCHIP under a new Title XXI of the Social Security Act. SCHIP represents the largest federal effort to provide health insurance coverage to uninsured, low-income children since the enactment of Medicaid in 1965. The program began in October 1997 with total federal funding of $39.7 billion for the period FY1998 through FY2007.

The 106th Congress revisited Medicaid and SCHIP in 1999. On November 29 of that year, the President signed the Consolidated Appropriations Act for FY2000 (P.L. 106-113). Included in that bill by reference was the *Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999* (BBRA 99), a bill largely comprised of Medicare provisions, but which also included a number of changes to the Medicaid and the State Children's Health Insurance Program (SCHIP).

In addition to technical amendments to BBA 97, BBRA 99 included provisions allowing for increased Medicaid disproportionate share payments to hospitals for certain states and the District of Columbia, and for extended access to a special $500 million fund to pay for Medicaid eligibility determinations resulting from welfare reform for a longer period of time than allowed under previous law. BBRA 99 also modified the schedule for phasing out cost-based reimbursement for Federally Qualified Health Centers and Rural Health Clinics that had been included in the BBA 97.

Changes to SCHIP in BBRA 99 included provisions to improve state-level data collection; to evaluate the SCHIP (and Medicaid) programs with respect to outreach and enrollment practices; and to create a clearinghouse to coordinate and consolidate federal databases and reports on children's health. In addition, BBRA 99 included a number of changes to the formula used to distribute federal SCHIP funds among the states, increased the amounts available for U.S. territories, and minor technical changes.[2]

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[2] For a detailed description of changes to Medicaid and SCHIP under BBRA 99, see CRS Report RL30400, *Medicaid and the State Children's Health Insurance Program (SCHIP): Provisions in the Consolidated Appropriations Act for FY2000,* by Jean Hearne and Elicia Herz.

Recent Legislative Activity

Committees with jurisdiction over Medicaid and SCHIP, the House Committee on Commerce and the Senate Committee on Finance, are considering legislation that would affect these programs. On September 27, 2000, the House Commerce Committee ordered reported a bipartisan bill, the *Beneficiary Improvement and Protection Act of 2000* (H.R. 5291). On October 5, 2000 William V. Roth Jr., the Senate Finance Committee Chairman, introduced the *Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000* (S. 3165). While both the House and Senate bills are largely comprised of Medicare provisions, they include a number of changes to Medicaid and SCHIP.

Several such provisions appear in both the House and Senate bills. Both would freeze Medicaid disproportionate share hospital (DSH) allotments, but for different fiscal years. H.R. 5291 contains other changes to DSH, including setting a higher rate of increase in such allotments for extremely low DSH states, making other adjustments specific to the District of Columbia and Tennessee, and clarifying that Medicaid beneficiaries enrolled in managed care arrangements must be included in calculations related to DSH payments. In addition, both bills include provisions to replace the current cost-based reimbursement arrangements for Federally Qualified Health Centers and Rural Health Clinics with a new Medicaid prospective payment system. Both bills also clarify states' authority to conduct presumptive eligibility determinations, as defined in Medicaid law, under separate (non-Medicaid) SCHIP programs. Both the House and Senate bills have nearly identical provisions regarding the availability and redistribution of unused FY1998 and FY1999 SCHIP allotments. Following specific formulas, these unspent funds are redistributed to both states that have and have not fully exhausted their original allotments within required time frames. Finally, both bills increase appropriated amounts for diabetes grants under SCHIP, but the amount of the increases differ.

Other Medicaid and SCHIP provisions in H.R. 5291 only include: (1) optional coverage of certain legal immigrants who are pregnant women and children, (2) addition of new entities to the list of those qualified to make presumptive eligibility determinations for low-income pregnant women and children, (3) a 1-year extension of transitional medical assistance (TMA) for low-income working families under Medicaid, simplification of TMA reporting and notification requirements, and making TMA optional for states meeting certain income eligibility requirements, (4) continuation of the current exemption from Medicaid health maintenance organization (HMO) reporting requirements for certain county-organized health systems, and (5) addition of the services of physician assistants to the list of optional Medicaid benefits.

Other Medicaid and SCHIP provisions in S. 3165 only include: (1) permanent extension of Medicaid payments for Medicare Part B premiums on behalf of qualified Medicare beneficiaries with income up to 135% of the federal poverty level (FPL), (2) streamlined approval of continued statewide 1115 Medicaid waivers, (3) adjustment to the federal medical assistance percentage (FMAP) for Alaska, and (4) authority to pay Medicaid expansion costs under SCHIP out of the SCHIP appropriation, and codification of the Administration's policy regarding the order of payments for specified benefit and administrative costs from state-specific SCHIP allotments.

The Congressional Budget Office has released a preliminary cost estimate for H.R. 5291. Changes to Medicaid in the *Beneficiary Health Improvement Act* as ordered reported on September 27, were estimated to increase federal outlays by $5.7 billion over the 5-year period 2001 to 2005 and $15.1 billion over 10 years (2001-2010). Provisions affecting SCHIP are estimated to increase federal outlays by $0.2 billion for 2001 through 2005 and $0.3 billion for 2001 through 2010. Cost estimates are not yet available for S. 3165.

The following side-by-side comparison provides a description of current law and a more detailed explanation of the proposed changes to Medicaid and SCHIP included in H.R. 5291 and in S. 3165.

Medicaid and SCHIP Provisions in H.R. 5291 and S. 3165 (the 2000 Medicare "Refinement Bills")

Medicaid

Disproportionate Share Hospital Payments

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Continuation of Medicaid DSH allotments	The federal share of Medicaid disproportionate share hospital (DSH) payments, payments for hospitals that treat a disproportionate share of uninsured and Medicaid enrollees, is capped at specified amounts for each state for FY1998 through FY2002. States' allotments for years after 2002 will be equal to its allotment for the previous year increased by the percentage change in the consumer price index for the previous year. Each state's DSH payments for FY2003 and beyond are limited to no more than 12% of spending for medical assistance for that year.	Freezes state-specific DSH allotments for FY2001 and FY2002 at the FY2000 levels. For FY2001 and beyond, each state's DSH allotment would be equal to its allotment for the previous year increased by the percentage change in the consumer price index for the previous year, subject to a ceiling equal to 12% of that state's total medical assistance payments in that year. Effective January 1, 2001.	Freezes Medicaid DSH payments for FY2001 at FY2000 levels. Effective October 1, 2000.

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Higher rate of increase in Medicaid DSH allotment for extremely low DSH states	No provision.	Creates a higher rate of increase in Medicaid DSH allotments for extremely low DSH states. For states where total FY1999 federal and state DSH spending is less than 1% of the state's total medical assistance expenditures for that fiscal year, the DSH allotment for FY2001 shall be increased to 1% of the state's total amount of expenditures under their plan for such assistance during that fiscal year. Effective January 1, 2001.	No provision.
Allotment for the District of Columbia	The DSH allotment for the District of Columbia is set at $32 million for FY2000 and FY2001 .	For the purpose of calculating the FY2001 allotment, the FY2000 DSH allotment for the District of Columbia is increased to $49 million. Effective January 1, 2001.	No provision.
Contingent allotment for Tennessee	Renewable waivers, authorized under section 1915(b), 1915(c), or section 1115 of Medicaid law, allow states to waive certain federal requirements in order to operate special programs or projects.	If Tennessee's statewide section 1115 Medicaid waiver program is revoked or terminated, Tennessee's FY2001 DSH allotment would be equal to $286,442,437. Effective January 1, 2001.	No provision.

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Assuring identification of Medicaid managed care patients	States are required to provide disproportionate share payments to those hospitals whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the State, and those with a low-income utilization rate above 25%. The Medicaid inpatient utilization rate includes the number of inpatient days attributable to Medicaid beneficiaries. The low-income utilization rate includes the total revenues paid on behalf of Medicaid beneficiaries.	Clarifies that Medicaid enrollees of managed care organizations and primary care case management organizations are to be included for the purposes of calculating the Medicaid inpatient utilization rate and the low-income utilization rate. The state must include in their MCO contracts information that allows the state to determine which hospital services are provided to Medicaid beneficiaries through managed care. Also requires states to include a sponsorship code for the managed care entity on the Medicaid beneficiary's identification card. Effective January 1, 2001.	No provision.

New Prospective Payment System for FQHCs and RHCs

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
New prospective payment system for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)	States are required to pay FQHCs and RHCs amounts that are at least a percentage of the facilities' reasonable costs for providing services - 100% of costs for services during FY1998 and FY1999; 95% for FY2000, FY2001 and FY2002; 90% for FY2003; 85% for FY2004. Cost-based reimbursement expires in 2005. In the case of a contract between an FQHC or RHC and a managed care organization (MCO), the MCO must pay the FQHC or RHC at least as much as it would pay any other provider for similar services. States are required to make supplemental payments to the FQHCs and RHCs, equal to the difference between the contracted amounts and the cost-based amounts.	Creates a prospective payment system for FQHCs and RHCs. Beginning in FY2001, FQHCs and RHCs would be paid per visit payments equal to 100% of reasonable costs incurred during 1999 and 2000 adjusted for any increase or decrease in the scope of services furnished. Per visit payments for entities first qualifying as FQHCs or RHCs after 2000 will begin in the first year that the center or clinic attains such qualification and would be 100% of the costs incurred during that year based on the rates established for similar centers or clinics. For subsequent years payment for all clinics would be equal to amounts for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index for primary care services, adjusted for any increase or decrease in the scope of services furnished.	Same as House bill.

Optional Coverage of Certain Legal Immigrants

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Optional coverage for certain sub-groups of qualified aliens	Non-qualified aliens are not eligible for federal medical assistance under Title XIX except in the case of medical emergency. States are required to cover certain categories of qualified aliens provided they meet the state's financial and other eligibility criteria. Other qualified aliens may become eligible for Medicaid at state option, subject to their state's financial and other criteria. Qualified aliens entering with sponsors after December 19, 1997 are subject to the "deeming rule", under which the sponsors' income and resources are deemed to be available to the immigrant in determining the immigrant's financial eligibility for benefits until the immigrant becomes a citizen or meets the 10-year work requirement.	Amends Title XIX to allow states the option of extending Medicaid coverage to certain subgroups of qualified aliens who have lawfully resided in the United States for 2 years. They include pregnant women (during pregnancy and for 60 days following birth) and children including optional targeted low-income children covered by Medicaid. For states that elect to provide medical assistance to a sub-category of aliens, action may not be brought under an affidavit of support against the sponsor of such an alien on the basis of the medical care received. Effective October 1, 2000.	No provision.

Presumptive Eligibility for Pregnant Women and Children

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Entities that qualify to determine presumptive eligibility for low-income pregnant women and children	Presumptive eligibility allows pregnant women and children in families with income that appears to be below a state's Medicaid income standards to enroll temporarily in Medicaid, until a final formal determination of eligibility is made. For children, entities qualified to make presumptive eligibility determinations include Medicaid providers, and agencies that determine eligibility for Head Start, subsidized child care, or the Special Supplemental Food Program for Women, Infants and Children (WIC). For pregnant women, qualified entities include Medicaid providers of outpatient hospital and clinic services receiving certain federal grants, providers of certain food and nutritional supplement services, state perinatal program providers, or providers of certain health services for Indians.	Adds several new entities to the list of those qualified to make Medicaid presumptive eligibility determinations for children and pregnant women. These include agencies that determine eligibility for Medicaid or the State Children's Health Insurance Program (SCHIP); certain elementary and secondary schools; state or tribal child support enforcement agencies; child care resource and referral agencies; certain organizations providing emergency food and shelter to the homeless; entities involved in enrollment under Medicaid, Temporary Assistance for Needy Families (TANF), SCHIP, or that determine eligibility for federally funded housing assistance; or any other entity deemed by a state, as approved by the Secretary of Health and Human Services (HHS). Effective October 1, 2000.	No provision.

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Application of presumptive eligibility provisions to State Children's Health Insurance Program (SCHIP)	There is no express provision for presumptive eligibility under separate (non-Medicaid) SCHIP programs. However, the Secretary of HHS permits states to develop, for separate (non-Medicaid) SCHIP programs, procedures that are similar to those permitted under Medicaid .	Clarifies states' authority to conduct presumptive eligibility, as defined in Medicaid law (and amended by the previous provision), under separate (non-Medicaid) SCHIP programs. Effective October 1, 2000.	Clarifies states' authority to conduct presumptive eligibility as defined in Medicaid law under separate (non-Medicaid) SCHIP programs. Effective October 1, 2000 and applies to SCHIP allotments for fiscal year 2001 forward.

Improving Welfare-To-Work Transition under Medicaid

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Extension and simplification options	In 1996, Temporary Assistance for Needy Families (TANF) replaced Aid to Families with Dependent Children (AFDC). Medicaid entitlement was retained for individuals who meet the requirements of the former AFDC program in effect on July 16, 1996, even if they do not qualify for TANF. For Medicaid purposes, states may modify their former AFDC income and resource standards within specified parameters. States are required to continue Medicaid coverage for a period of 6 to 12 months for individuals described above who meet specified prior enrollment requirements and who then lose Medicaid coverage because of employment or earnings rules applicable to this eligibility group. This transitional medical assistance (TMA) will sunset at the end of FY2001. States must adhere to certain beneficiary notification requirements for TMA. Families who qualify for the full 12 months of TMA must report gross earnings and employment-related child care costs for each of months 1 through 9.	Extends the sunset on TMA by one year to FY2002. Allows states to waive reporting requirements for families qualifying for up to 12 months of TMA (and the corresponding obligation of states to notify families of these reporting requirements). Makes TMA an option, rather than a requirement, for the subset of states that: (1) use income and resource methodologies that are less restrictive than those applicable under their former AFDC programs on July 16, 1996 for individuals who meet the other requirements for this group, and (2) cover, at a minimum, such individuals in families with gross income up to 185% FPL. States in this subset are further deemed to meet Medicaid state plan requirements specified in other sections of current law. Effective October 1, 2000.	No provision.

Medicaid County-Organized Health Systems

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Medicaid county-organized health systems	Health insuring organizations (HIOs) are county-sponsored health maintenance organizations. Up to three HIOs designated by the state of California are exempt from certain federal statutory requirements for Medicaid HMO contracts. The exemption only applies if the HIOs enroll no more than 10 percent of all Medicaid beneficiaries in California (not counting qualified Medicare beneficiaries.)	Allows the current exemption from Medicaid HMO contracting requirements to continue to apply as long as no more than 14% of all Medicaid beneficiaries in California are enrolled in those HIOs. Effective as if included in the Consolidated Omnibus Budget Reconciliation Act of 1985.	No provision.

Medicaid Recognition for Services of Physician Assistants

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Optional Medicaid coverage of physician assistants	Federal statute lists services that qualify as Medicaid benefits. Federal matching payments are available toward the cost of items on the list, if covered by State Medicaid programs. States are required to cover certain of those listed items and may choose to cover other items on the list.	Includes services provided by physician assistants as Medicaid recognized benefits as long as the services are provided under the supervision of a physician and are authorized under State law. The services of physician assistants would be an optional Medicaid benefit. Effective upon enactment.	No provision.

Extension of Payments for Certain Qualified Medicare Beneficiaries

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Extension of authorization for certain Medicare qualified individuals	Medicaid covers the costs of certain Medicare financial obligations for qualified Medicare beneficiaries (QMBs), specified low income Medicare beneficiaries (SLMBs) and two groups of "qualified individuals" referred to as QI-1s and QI-2s. QMBs are aged or disabled persons with incomes at or below the federal poverty line and assets below twice the SSI level. The eligibility pathways for QI-1 and QI-2 are authorized only between January of 1998 and December 2002 when QI-1 and QI-2. Federal amounts available for covering the costs of Medicaid benefits for QI-1s and QI-2s are capped for each of the fiscal years 1998-2002. States are allocated a portion of each year's allotment based on a formula that compares the number of individuals estimated to be in the two groups in each state relative to the national total of individuals in the two groups.	No provision.	The Committee's provision would remove the sunset date of December 2002, but only for QI-1 eligibility status. It also would create an allotment for FY2003 and beyond that is equal to the allotment for the previous fiscal year increased by the percentage increase in the medical care component of the Consumer Price Index for urban consumers. Effective as if included in BBA97.

Streamlined Approval of Continued State-Wide 1115 Medicaid Waivers

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Extension of waivers under Section 1115 of the Social Security Act	Under Section 1115 of the Social Security Act, states may obtain waivers of compliance with a broad range of Medicaid requirements to conduct experimental, pilot, or demonstration projects. Waivers are approved for a period of 5 years. States wishing to obtain approval for periods beyond 5 years may submit, during the 6-month period ending 1 year before the date the waiver would otherwise expire, a written request for an extension of up to 3 years.	No provision.	Creates a process for submitting requests for and receiving extensions of waiver projects that have already received an initial 3-year extension. Requires states to submit applications to extend those projects at least 120 days before the expiration date of the existing waiver. The Secretary would be required to notify the State if she intends to review the terms and conditions of the project and inform the State of proposed changes no later than 45 days after receipt. If the Secretary fails to provide such notification, the request is deemed approved. No more than 120 days after submission (or a later date if agreed to by the state), the request would be either approved subject to new terms and conditions or, in the absence of an agreement on those terms, new terms and conditions determined by the Secretary to be reasonably consistent with the overall objective of the waiver.

Alaska Federal Matching Rate

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Alaska FMAP	The federal share of the cost of Medicaid services is equal to the federal medical assistance percentage (FMAP) of those costs. It is determined annually according to a statutory formula designed to pay a higher federal matching percentage to states with lower per capita incomes relative to the national average. BBA 97 included a provision that set the FMAP for Alaska at 59.8% for FY1998 through FY2000.	No provision.	Changes the formula for calculating the FMAP for Alaska for fiscal years 2001 through 2005. The state percentage for Alaska would be calculated by using an adjusted per capita income instead of the per capita income generally used. The adjusted per capita income for Alaska would be calculated as the three year average per capita income for the state divided by 1.05. Applies to fiscal years 2001 through 2005.

State Children's Health Insurance Program

Continued Availability and Redistribution of Unused SCHIP Allotments

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Continued availability and redistribution of unused FY1998 and FY1999 SCHIP allotments	Funds for the SCHIP Program are authorized and appropriated for FY1998 through FY2007. From each year's appropriation, a state is allotted an amount as determined by a formula set in law. Federal funds not drawn down from a state's allotment by the end of each fiscal year continue to be available to that state for 2 additional fiscal years. Allotments not spent at the end of 3 years will be redistributed by the Secretary of Health and Human Services (HHS) to states that have fully spent their original allotments for that year. Redistributed funds not spent by the end of the fiscal year in which they are reallocated officially expire. All administrative expenses including outreach activities are subject to an overall limit of 10% of total program spending per fiscal year.	Establishes new methods for distributing unspent FY1998 and FY1999 allotments. States that use all their SCHIP allotments (for each of those years) would receive an amount equal to estimated spending in excess of their original exhausted allotment. Each territory that spends its original allotment would receive an amount that bears the same ratio to 1.05% of the total amount available for redistribution as the ratio of its original allotment to the total allotment for all territories. States that do *not* use all their SCHIP allotment would receive an amount equal to the total amount of unspent funds, less amounts distributed to states that fully exhausted their original allotments, multiplied by the ratio of a state's unspent original allotment to the total amount of unspent funds. Redistributed funds would remain available through the end of FY2002. States may use up to 10% of the retained FY1998 funds for outreach activities. Effective upon enactment.	Identical to the House reported bill with two exceptions. First, specifies that reallocated funds remain available through the end of FY2002 for both states that spend and those that do not spend all their original allotments within the specified timeframes. Second, the effective date of the Senate amendment is as if included in the enactment of BBA 97 (August 5, 1997).

Optional Coverage of Certain Legal Immigrants Under SCHIP

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Allows for state option of SCHIP coverage to certain subgroups of qualified aliens	For states that provide SCHIP coverage through a Medicaid expansion, legal immigrant children are subject to the same Medicaid restrictions as other legal immigrants. States that operate a separate state SCHIP program must cover those legal immigrant children who meet the Federal definition of qualified alien and who are otherwise eligible. These states may also cover battered immigrants. For qualified alien children entering with sponsors after December 19, 1997, SCHIP coverage is subject to the "deeming rule."	Adds a new provision that gives states the option of expanding health insurance coverage to permanent resident alien children who are otherwise eligible for SCHIP and who have been lawfully residing in the United States for 2 years. The coverage expansion would only be available to states that have expanded coverage to this category of children under their Medicaid state plan. Effective October 1, 2000.	No provision.

Authority to Pay for Medicaid Expansion SCHIP Costs From Title XXI Appropriation

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 200	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Authority to pay for Medicaid expansion SCHIP costs from Title XXI appropriation	States' allotments under SCHIP pay only the federal share of costs associated with separate (non-Medicaid) SCHIP programs. The federal share of costs associated with SCHIP Medicaid expansions are paid for under Medicaid. State SCHIP allotments are reduced by the amounts paid under Medicaid for SCHIP Medicaid expansion costs, and presumptive eligibility costs.	No provision.	Authorizes the payment of the costs of SCHIP Medicaid expansions from the SCHIP appropriation. As a conforming amendment, eliminates the requirement that state SCHIP allotments be reduced by amounts paid under Medicaid for SCHIP Medicaid expansion costs and presumptive eligibility costs. Also codifies proposed rules regarding the order of payments for benefits and administrative costs from state-specific SCHIP allotments. For fiscal years 1998 through 2000 only, authorizes the transfer of unexpended SCHIP appropriations to the Medicaid appropriation account for the purpose of reimbursing payments associated with SCHIP Medicaid expansion programs. Effective as if included in the enactment of the Balanced Budget Act of 1997 (August 5, 1997).

Other Provisions

Juvenile Diabetes Research Program

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Juvenile Diabetes Research	The Balanced Budget Act of 1997 amended Title III of the Public Health Service Act to create a grant program under which the Secretary could make grants to support prevention and treatment services of, and research relating to, type I diabetes in children. Congress committed $150 million, ($30 million each year over 5 years FY1998 through FY2002), for this program, with the funds being transferred from Title XXI of the Social Security Act (State Children's Health Insurance Program) for these grants. This commitment was in addition to the annual appropriations for NIH.	Extends the authority for grants to be made for Juvenile Diabetes Research and increases funding to $50 million each for FY2003 and FY2007. The funds will remain available until expended. The funds may not be derived or deducted from the State Children's Health Insurance Program.	Increases the appropriated funds available for diabetes grants, bringing the total to $100 million each for FY2001 and FY2002.

Indian Diabetes Grant Program

	Current Law	H.R. 5291 Beneficiary Improvement and Protection Act of 2000	S. 3165 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 2000
Indian Diabetes Grants	The Balanced Budget Act of 1997 amended Title III of the Public Health Service Act to create a grant program under which the Secretary could make grants to support prevention and treatment services of diabetes in Indians. These grants were to purchase services provided through one or more of the following entities: the Indian Health Service, a tribal Indian health program, and an urban Indian health program. Congress committed $150 million, ($30 million each year over 5 years FY1998 through FY2002), for this program, with the funds being transferred from Title XXI of the Social Security Act (State Children's Health Insurance Program) for these grants.	Extends the authority for grants to be made for diabetes prevention and treatment programs for Indians, and increases funding to $50 million each for FY2003 and FY2007. The funds will remain available until expended. The funds may not be derived or deducted from the State Children's Health Insurance Program.	Increases the appropriated funds available for diabetes prevention and treatment programs for Indians, bringing the total to $100 million each for FY2001 and FY2002.