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S. 1893/H.R. 976: The Children's Health Insurance Program Reauthorization Act of 2007

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Summary

On July 19, 2007, the Senate Finance Committee marked up the Children's Health Insurance Program Reauthorization Act of 2007 (S. 1893/H.R. 976). The Senate struck the language in an unrelated House-passed tax measure (H.R. 976) and replaced it with the language contained in S. 1893, as approved by the Senate Finance Committee. A total of 92 amendments were offered, with 9 adopted. The bill passed the Senate on August 2, 2007. This report provides a brief summary of the bill as passed in the Senate.

The Senate bill contains eight titles, six dealing with SCHIP and Medicaid. Title I provides authorized appropriations to SCHIP through FY2012. It also changes how federal SCHIP funds are allotted to states, provides new incentive bonuses for increased program enrollment, adds a contingency fund to help in the event of a state facing a shortfall of federal SCHIP funds, and changes the coverage and matching rates for selected groups of eligibles. Title II contains provisions that seek to enhance the program's outreach and enrollment efforts. Title III alters the citizenship verification process for program eligibility and attempts to reduce administrative barriers associated with the enrollment process. Title IV provides for increased private health insurance premium assistance (i.e., program payment of a beneficiary's share of employer sponsored insurance). Title V focuses on the development and implementation of measures of pediatric quality of care. Title VI contains a number of miscellaneous provisions. Title VII contains revenue provisions. Title VIII provides for the bill's enactment date.

Recent Congressional Budget Office (CBO) estimates indicate that the bill would increase SCHIP outlays by $28.6 billion over the five-year period of FY2008-FY2012 period. Additional outlay increases would occur as a result of effects on Medicaid, for example (e.g., changes in citizenship documentation). In sum, CBO estimates total spending increases of $35.2 billion over the five-year window. The proposal also contains provisions that offset this direct spending increase with changes in the excise taxes associated with tobacco products.

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The provisions in the bill encompass more than simply adding authorized appropriations in the State Children's Health Insurance Program (SCHIP) for an additional five years. The bill provides for changes how federal SCHIP funds are allotted to states, phases out coverage of parents and childless adults in SCHIP programs, encourages enhanced outreach and enrollment efforts to increase the number of children covered by the program, alters the citizenship verification process, expands states' options to pay for a beneficiary's share of employer sponsored health insurance, and includes efforts to strengthen child health quality measures, as well as other provisions.

Based on recent Congressional Budget Office (CBO) estimates, the Senate bill would result in a net increase of $35.2 billion in federal spending between 2008 and 2012. The bill offsets this increase through an excise tax increase on tobacco products.

By FY2012, CBO estimates that average monthly program enrollment in SCHIP would increase by 4.5 million, compared to CBO's baseline projections of FY2012 enrollment of 3.3 million.[1] CBO estimates the provisions in the bill would also increase FY2012 average monthly enrollment in Medicaid by 2.2 million.[2] [3]

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[1] The 4.5 million increased enrollment includes 1.9 million individuals who would lose SCHIP coverage by FY2012 because of shortfalls under CBO's baseline projections. One might prefer not to consider these "new" enrollees. From that perspective, increased enrollment would be 2.6 million rather than 4.5 million. CBO also specifies the number of these estimated new enrollees who were previously uninsured and who had private coverage. Of the 2.6 million in FY2012, CBO estimates 1.5 million would be from the previously uninsured and 1.2 million would be from those who had private coverage. (The two numbers do not add to 2.6 million due to rounding.)

[2] Of the 2.2 million, CBO estimates that 1.7 million would be previously uninsured compared to 0.4 million who had private coverage. The percentage of new enrollees coming from private coverage is lower than in the SCHIP estimates in the previous footnote because Medicaid enrollees tend to be lower income and therefore less likely to have been enrolled

(continued...)

A Brief Description of the Current Program

The State Children's Health Insurance Program (SCHIP) is authorized under Title XXI of the Social Security Act. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels. As of July 2006, the upper income eligibility limit under SCHIP had reached 350% of the federal poverty level (FPL) in one state. States may enroll targeted low-income children in an SCHIP-financed expansion of Medicaid, create a new separate state SCHIP program, or devise a combination of both approaches. States choosing the Medicaid option must provide all mandatory benefits and all optional services covered under the state plan, and must follow the nominal Medicaid cost-sharing rules (with some exceptions). In general, separate state programs must follow certain coverage and benefit options outlined in SCHIP law. While some cost-sharing provisions vary by family income, the total annual aggregate cost-sharing (including premiums, copayments, and other similar charges) for a family may not exceed 5% of total income in a year. Preventive services are exempt from cost-sharing.

In the Balanced Budget Act of 1997, nearly $40 billion was appropriated for SCHIP for FY1998 to FY2007. Appropriations for FY2007 equaled about $5.7 billion.[4] Annual allotments among the states are determined by a formula that is based on a combination of the number of low-income children and low-income uninsured children in the state, and includes a cost factor that represents the average health service industry wages in the state compared to the national average. Like Medicaid, SCHIP is a federal-state matching program. While the Medicaid federal medical assistance percentage (FMAP) ranged from 50% to 75.89% in FY2007, the enhanced SCHIP FMAP ranged from 65% to 83.12% across states.

All states, the District of Columbia, and five territories have SCHIP programs. As of November 2006, 17 use Medicaid expansions, 18 use separate state programs, and 21 use a combination approach. Approximately 6.7 million children were enrolled in SCHIP during FY2006. In addition, 12 states reported enrolling about 700,000 adults in SCHIP through program waivers.

The remaining sections of this report provides summaries of major provisions in the bill.

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[2] (...continued)
in private coverage.

[3] "Cost estimate for the legislative language (ERN07632) provided by the Committee on Finance on July 26, 2007," Congressional Budget Office, available at [http://www.cbo.gov/ftpdocs/84xx/doc8489/BaucusSCHIP7-26-07.pdf].

[4] In addition to the original appropriation level of $5.04 billion this appropriation amount includes supplemental funding up to $650 million. In some years, there were unspent prior year funds that were available for a state's use. As a result relying on appropriation amounts alone may not accurately reflect total funds available in any given year.

Title I: Financing of SCHIP

SCHIP Allotments

For the 10-year period of FY1998 to FY2007, SCHIP was appropriated nearly $40 billion, plus later appropriations totaling less than $1 billion to address projected shortfalls in FY2006 and FY2007.[5] S. 1893/H.R. 976 calls for appropriations totaling $61.4 billion for purposes of allotments to the states and territories over the five-year period of FY2008 to FY2012.[6]

The annual SCHIP funds available to states — that is, the available national allotment — is the amount of the total appropriation remaining after amounts allotted to the territories. For FY2008, each territory's allotment is its highest annual federal SCHIP spending between FY1998 and FY2007, plus the annual adjustment for health care cost growth and national child population growth described below. For FY2009 through FY2012, each territory's allotment is the prior year's allotment, plus the annual adjustment for health care cost growth and national child population growth.

For FY2008, a state's allotment is calculated as 110% of the greatest of the following four amounts:

- the state's FY2007 federal SCHIP spending multiplied by the annual adjustment;[7]
- the state's FY2007 federal SCHIP allotment multiplied by the annual adjustment;
- for states that receive federal SCHIP funds in FY2007 because of their shortfalls, or states that were projected to be in shortfall based

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[5] Congress appropriated $283 million (Deficit Reduction Act of 2005 (DRA), P.L. 109-171) to address projected SCHIP shortfalls in FY2006 and up to $650 million (U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (UTRA), P.L. 110-28) to address projected SCHIP shortfalls in FY2007.

[6] As described above, the bill would provide authorized appropriations for five years. In FY2012, this funding would consist of a regular $3.5 billion appropriation (distributed in semiannual installments of $1.75 billion each) plus a one-time appropriation of $12.5 billion (allotted in the first half of FY2012). For years beyond FY2012, CBO is required to assume that national allotment funding continues at the last appropriated level prescribed by current law, which appears to be $3.5 billion under the bill. The SCHIP baseline under current law assumes an appropriation of $5.04 billion for years beyond FY2007. As a result of this difference, CBO's cost estimate for national allotments in the Senate bill shows *savings* in years beyond FY2012. For more information on budget baselines and scorekeeping, see CRS Report 98-560, *Baselines and Scorekeeping in the Federal Budget Process*, by Bill Heniff Jr.

[7] The annual adjustment for health care cost growth and child population growth is the product of (1) 1 plus the percentage increase (if any) in the projected per capita spending in National Health Expenditures for the year over the prior year, and (2) 1.01 plus the percentage change in the child population (under age 19) in each state as of July 1 of the fiscal year over the prior fiscal year's, based on the most timely and accurate published estimates from the Census Bureau.

on their November 2006 submission of projected expenditures, the state's FY2007 projected spending as of November 2006 (or as of May 2006, for a state whose May 2006 projection was $95 million to $96 million higher than its November 2006 projection, a provision that affects only North Carolina) multiplied by the annual adjustment; and

- the state's FY2008 federal SCHIP projected spending as of August 2007 and certified by the state to the Secretary not later than September 30, 2007.

For FY2009 to FY2011, a state's allotment is calculated as 110% of its projected spending for that year. For FY2012, the allotments are provided on a semiannual basis. The regular appropriation amount of $3.5 billion for FY2012 is provided in $1.75 billion installments during the fiscal year. The one-time appropriation of $12.5 billion for FY2012 is provided in the first half of the fiscal year. The semiannual allotments are also calculated as 110% of the projected spending for that year. However, if the available national allotment for FY2012 exceeds the amount to be allotted in the semiannual period, the remainder is allotted proportionally based on each state's share of the allotment calculated for FY2012.

For FY2008, if the state allotments as calculated exceed the available national allotment, the allotments are reduced proportionally. For FY2009 to FY2012, if the state allotments as calculated exceed the available national allotment, then the available national allotment is distributed among states using a different formula, primarily based on states' own projected SCHIP expenditures for that fiscal year.

Under current law, SCHIP allotments are available for three years. Allotments unspent after three years are available for reallocation. For example, the FY2004 allotment was available through the end of FY2006; any remaining balances at the end of FY2006 were redistributed to other states. Under the Senate bill, SCHIP allotments through FY2006 are available for three years, but SCHIP allotments made for FY2007 through FY2012 are available for two years. Allotments unspent after their period of availability are transferred to the CHIP Incentive Pool, described below.

The Congressional Budget Office (CBO) has estimated that these particular provisions would yield increased federal SCHIP outlays[8] over the five-year period of FY2008 to FY2012 of approximately $28 billion (plus nearly $5 billion over the period because of the Medicaid interaction of these particular provisions).

Redistribution of Unspent FY2005 Allotments in FY2008. Under the Senate bill (as under current law), any FY2005 allotment unspent funds at the end of FY2007 are to be redistributed to other states. Under the Senate bill, unspent FY2005 funds will go to states that met the third criteria in the base FY2008

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[8] That is, above CBO's baseline levels. SCHIP outlays under CBO's baseline over the five-year period are $27.4 billion. The baseline assumptions are that the FY2007 appropriation of $5.04 billion continues annually in perpetuity using the current-law financing structure.

allotment formula (i.e., states receiving federal SCHIP funds for their FY2007 shortfalls, states that were considered to be a shortfall state in FY2007 based on their November 2006 submission of projected expenditures, as well as North Carolina). For these states, the unspent FY2005 funds are redistributed in proportion to their FY2007 allotment.

Retention of Unspent FY2006 and FY2007 Allotments in FY2008. Under the Senate bill, a state's available balances of unspent FY2006 and FY2007 allotments in FY2008 cannot exceed 50% of its FY2008 allotment. Unspent funds in excess of that threshold are transferred to the CHIP Incentive Pool, described below.

Retention of Unspent Prior-Year Allotments after FY2008. Under the Senate bill, after FY2008, the unspent allotment from the preceding fiscal year is the only prior-year allotment potentially available to states. This is because in FY2009 onward the allotments are only available for two years. For spending in FY2009, a state can only retain unspent FY2008 balances that are not in excess of 20% of the FY2008 allotment. For spending in FY2010 through FY2012, a state can only retain unspent prior-year balances that are not in excess of 10% of that prior year's allotment. The excess funds are to be transferred to the CHIP Incentive Pool.

CHIP Incentive Pool

S. 1893/H.R. 976 would establish a CHIP Incentive Bonuses Pool in the U.S. Treasury. The Incentive Pool would receive deposits from an initial appropriation in FY2008 of $3 billion, along with transfers from six different potential sources (some of which were already mentioned), with currently available but not immediately required funds invested in interest-bearing U.S. securities that provide additional income into the Incentive Pool. The six additional sources for deposits are as follows:

- On December 31, 2007, the amount by which states' FY2006 and FY2007 allotments not expended by September 30, 2007, exceed 50% of the FY2008 allotment;
- From 2008 to 2012, any of the national SCHIP appropriation not allotted to the states;
- On October 1 of fiscal years 2009 to 2012, the amount by which the unspent funds from the prior year's allotment exceeds a particular percentage of that allotment. That percentage is 20% for FY2009, and 10% for FY2010, FY2011, and FY2012;
- Any original allotment amounts not expended by the end of their second year of availability (beginning with the FY2007 allotment);
- On October 1, 2009, any amounts set aside for transition off of SCHIP coverage for childless adults that are not expended by September 30, 2009; and
- On October 1 of FY2009 through FY2012, any amounts in the CHIP Contingency Fund in excess of the fund's aggregate cap, as well as any Contingency Fund payments provided to a state that are unspent at the end of the fiscal year following the one in which the funds were provided.

Funds from the Incentive Pool are payable in FY2008 to FY2012 to states that have increased their Medicaid enrollment among low-income children above a defined baseline for the state. A state eligible for a bonus shall receive in the last quarter of the fiscal year the following amount, depending on the "excess" of the state's enrollment above the baseline monthly average. For FY2010 onward, these dollar amounts are to be increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for the calendar year beginning on January 1 of the coverage period over that of the preceding coverage period.

Payments from the Incentive Pool shall be used for any purpose that the State determines is likely to reduce the percentage of low-income children in the State without health insurance.

Contingency Fund

S. 1893/H.R. 976 also establishes a CHIP Contingency Fund in the U.S. Treasury. The Contingency Fund receives deposits through a separate appropriation. For FY2009, the appropriation to the Fund is equal to 12.5% of the available national allotment for SCHIP. For FY2010 through FY2012, the appropriation is such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual payments do not exceed 12.5% of that fiscal year's available national allotment for SCHIP. Balances that are not immediately required for payments from the Fund are to be invested in U.S. securities that provide addition income to the Fund, as long as the annual payments do not cause the Fund to exceed 12.5% of the available national allotment for SCHIP. Amounts in excess of the 12.5% limit shall be deposited into the Incentive Pool. For purposes of the CHIP Contingency Fund, amounts set aside for block grant payments for transitional coverage of childless adults shall not count as part of the available national allotment.

Payments from the Fund are to be used only to eliminate any eligible state's shortfall (that is, the amount by which a state's available federal SCHIP allotments are not adequate to cover the state's federal SCHIP expenditures).

The Secretary shall separately compute the shortfalls attributable to children and pregnant women, to childless adults, and to parents of low-income children. No payment from the Contingency Fund shall be made for nonpregnant childless adults. Any payments for shortfalls attributable to parents shall be made from the Fund at the relevant matching rate.

Eligible states, which cannot be territories, for a month in FY2009 to FY2012 are those that meet any of the following criteria:

- The state's available federal SCHIP allotments are at least 95% but less than 100% of its projected federal SCHIP expenditures for the fiscal year (i.e., less than 5% shortfall in federal funds), without regard to any payments provided from the Incentive Pool; or
- The state's available federal SCHIP allotments are less than 95% of its projected federal SCHIP expenditures for the fiscal year (i.e., more than 5% shortfall in federal funds) and that such shortfall is

> attributable to one or more of the following: (1) One or more parishes or counties has been declared a major disaster and the President has determined individual and public assistance has been warranted from the federal government pursuant to the Stafford Act, or a public health emergency was declared by the Secretary pursuant to the Public Health Service Act; (2) the state unemployment rate is at least 5.5% during any consecutive 13 week period during the fiscal year and such rate is at least 120% of the state unemployment rate for the same period as averaged over the last three fiscal years; (3) the state experienced a recent event that resulted in an increase in the percentage of low-income children in the state without health insurance that was outside the control of the state and warrants granting the state access to the Fund, as determined by the Secretary.

The Secretary shall make monthly payments from the Fund to all states determined eligible for a month. If the sum of the payments from the Fund exceeds the amount available, the Secretary shall reduce each payment proportionally.

Funding for the Territories

Under current law, the territories receive 0.25% of the total appropriations in §2104(a). Later legislation added specific appropriations for the territories in FY1999 to FY2007. Combined with the 0.25% available through the original enacting legislation, the territories were allotted 1.05% of the total appropriations in §2104(a) from FY2000 to FY2007. From these set aside amounts, each territory receives an annual allotment according to the following statutorily set percentages: Puerto Rico, 91.6%; Guam, 3.5%; the Virgin Islands, 2.6%; American Samoa, 1.2%; and the Northern Mariana Islands, 1.1%.

S. 1893/H.R. 976 would calculate the allotments to the territories from the national SCHIP appropriation as follows. For FY2008, each territory's allotment is its highest annual federal SCHIP spending between FY1998 and FY2007, multiplied by the annual adjustment for health care cost growth and *national* child population growth. For FY2009 through FY2012, each territory's allotment is the prior year's allotment, multiplied by the annual adjustment for health care cost growth and national child population growth. For FY2012 only, 89% of such allocated amounts would be available for the period beginning on October 1, 2011 and ending on March 31, 2012, and 11% of such amounts would be allocated for the period beginning on April 1, 2012 and ending on September 30, 2012.

Beginning with FY2008, the Senate bill would allow Medicaid federal matching payments for territories that qualify for start up expenses associated with claims processing and citizenship documentation data systems in each of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to be subject to the 90% match rate. Similarly, territories that qualify for reimbursement for operational costs of such data systems would receive the 75% FMAP for such administrative costs. The Senate bill would allow such expenditures to be matched with federal funds without regard to the specified Medicaid spending caps.

Finally, the Senate bill would require the Government Accountability Office (GAO) to submit a report to Congress describing the Medicaid and SCHIP programs in the territories, and recommendations for improving Medicaid and SCHIP funding to the territories.

Qualifying States

Under current law, §2105(g) of the Social Security Act permits qualifying states to apply federal SCHIP funds toward the coverage of certain children already enrolled in regular Medicaid (that is, not SCHIP-funded expansions of Medicaid). Specifically, these federal SCHIP funds are used to pay the difference between SCHIP's enhanced FMAP and the Medicaid FMAP that the state is already receiving for these children. Funds under this provision may only be claimed for expenditures occurring after August 15, 2003.

Qualifying states are limited in the amount they can claim for this purpose to the lesser of the following two amounts:

- 20% of the state's original SCHIP allotment amounts (if available) from FY1998-FY2001 and FY2004-FY2007 (hence the terms "20% allowance" and "20% spending"); and
- the state's available balances of those allotments. If there is no balance, states may not claim Section 2105(g) spending.

The statutory definitions for qualifying states capture most of those that had expanded their upper-income eligibility levels for children in their Medicaid programs to 185% of the federal poverty level or higher prior to the enactment of SCHIP. Based on statutory definitions, 11 states were determined to be qualifying states: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin.

SCHIP spending under §2105(g) can be used by qualifying states only for Medicaid enrollees (excluding those covered by an SCHIP-funded expansion of Medicaid) who are under age 19 and whose family income exceeds 150% of poverty, to pay the difference between the SCHIP enhanced FMAP and the regular Medicaid FMAP.

Under the Senate bill, qualifying states under §2105(g) may also use available balances from their SCHIP allotments from FY2008 to FY2012 to pay the difference between the regular Medicaid FMAP and the SCHIP enhanced FMAP for Medicaid enrollees under age 19 (or age 20 or 21, if the state has so elected in its Medicaid plan) whose family income exceeds 133% of poverty.

Phaseout of Nonpregnant Childless Adults and Parents of SCHIP and Medicaid-Eligible Children

Under current law, Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to modify virtually all aspects of the Medicaid and SCHIP programs. Approved SCHIP Section 1115 waivers are deemed to be part of a state's

SCHIP state plan for purposes of federal reimbursement. Costs associated with waiver programs are subject to each state's enhanced-FMAP. Under SCHIP Section 1115 waivers, states must meet an "allotment neutrality test" where combined federal expenditures for the state's regular SCHIP program and for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment. This policy limits federal spending to the capped allotment levels.

With respect to SCHIP, the Clinton Administration issued a July 31, 2000, letter regarding treatment of adults. While this Administration was supportive of using the 1115 authority to expand SCHIP to parents of Medicaid or SCHIP-eligible children, as well as to certain pregnant women, it opposed coverage of childless adults. Under the Bush Administration, the Health Insurance Flexibility and Accountability (HIFA) Initiative was implemented using the 1115 waiver authority. The initiative was created to encourage states to increase the number of individuals with health insurance coverage (including childless adults, pregnant women, and parents of Medicaid and SCHIP children) within current program resources. The Deficit Reduction Act of 2005 prohibited the approval of new demonstration projects that allow federal SCHIP funds to be used to provide coverage to nonpregnant childless adults, but allowed for the continuation of such existing Medicaid or SCHIP waiver projects affecting federal SCHIP funds that were approved under the Section 1115 waiver authority before February 8, 2006.

Nonpregnant Childless Adults. S. 1893/H.R. 976 would prohibit the approval or renewal of Section 1115 demonstration waivers that allow federal SCHIP funds to be used to provide coverage to nonpregnant childless adults. The six states with CMS approval for such waivers would be permitted to use federal SCHIP funds to continue such coverage through FY2008.

In FY2009, these states would receive an amount (as part of a separate allotment) equal to the federal share of the State's projected FY2008 expenditures for providing coverage under the waiver to nonpregnant childless adults in FY2008 increased by the annual adjustment for per capita health care growth. The cost of coverage (provided during FY2009) to such individuals would be matched at the regular Medicaid FMAP rate up to the set-aside spending cap.

States with existing SCHIP waivers (in effect during FY2007) to extend coverage to nonpregnant childless adults would be permitted to submit a request to CMS for a Medicaid nonpregnant childless adult waiver. For such waivers the Senate bill would require such States to meet the following "budget neutrality" requirements. For FY2010, allowable waiver expenditures for nonpregnant childless adults would not be permitted to exceed the total amount of payments made to the State for FY2009, increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for calendar year 2010 over calendar year 2009). In the case of any succeeding fiscal year, allowable waiver expenditures for these populations would not be permitted to exceed each such State's set aside amount (described above) for the preceding fiscal year, increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for the calendar year that begins during the fiscal year involved over the prior calendar year.

SCHIP Parent Coverage Waivers. S. 1893/H.R. 976 would also prohibit the approval or renewal of Section 1115 demonstration waivers that allow federal SCHIP funds to be used to provide coverage to parent(s) of a targeted low-income child(ren) (hereafter referred to as existing SCHIP parent coverage waivers). The 11 states with CMS approval for such waivers would be permitted to use federal SCHIP funds to continue such coverage during FY2008 and FY2009.

States with existing SCHIP parent coverage waivers would be permitted to continue such assistance during each of fiscal years 2010, 2011, and 2012 subject to the following requirements: (1) the Secretary would be required to set aside an amount as part of a separate allotment equal to the federal share of 110% of the State's projected expenditures for providing waiver coverage to such individuals enrolled in the waiver in the applicable fiscal year, and (2) the Secretary would pay the State from the set aside amount (specified above) for each such fiscal year an amount equal to the applicable percentage for expenditures in the quarter to provide coverage as specified under the waiver to parent(s) of targeted low-income child(ren). In the case of FY2012 only, the set aside amount for such states would be computed separately for the period beginning on October 1 and ending on March 31, and the period beginning on April 1 and ending on September 30. Any increase or reduction in the amount of the semi annual allotments (described above) would be allocated on a pro rata basis to such set aside. In addition, the Senate bill would require that no such payments would be made for providing parent coverage to individuals whose family income exceeds the income eligibility threshold that was in place under the existing parent coverage waiver as of the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.

In FY2010 only, costs associated with such parent coverage would be subject to each such state's SCHIP enhanced FMAP for States that meet certain coverage benchmarks (related to performance in providing coverage to children) in FY2009, or each such state's Medicaid FMAP rate for all other states. The provision would prohibit federal matching payments for the payment of services beyond the set-aside spending cap.

For FY2011 or 2012, costs associated with such parent coverage would be subject to: (1) a state's REMAP percentage (i.e., a percentage which would be equal to the sum of (a) the state's FMAP percentage and (b) the number of percentage points equal to one-half of the difference between the state's FMAP rate and the state's enhanced FMAP rate) if the state meets certain coverage benchmarks (related to performance in providing coverage to children) for the preceding fiscal year, or (2) the state's regular Medicaid FMAP rate if the state failed to meet the specified coverage benchmarks for the preceding fiscal year. The provision would prohibit federal matching payments for the payment of services beyond the set-aside spending cap.

Finally, the Senate bill would require the Government Accountability Office to conduct a study to determine if the coverage of a parent, caretaker relative, or legal guardian of a targeted low-income child increases the enrollment of or quality of care for children, and if such parents, relatives, and legal guardians are more likely to

enroll their children in SCHIP or Medicaid. Results of the study (and recommended changes) would be reported to Congress two years after the date of enactment.

State Option to Cover Low-Income Pregnant Women under SCHIP through a State Plan Amendment

Under current SCHIP law, states can cover pregnant women ages 19 and older in one of two ways: (1) via a special waiver of program rules (through Section 1115 waiver authority), or (2) by providing coverage to unborn children as permitted through regulations. In the latter case, coverage includes prenatal and delivery services only.

S. 1893/H.R. 976 allows states to provide optional coverage under SCHIP to pregnant women when specific conditions are met, including for example (1) the upper income eligibility level for certain pregnant women under traditional Medicaid must be at least 185% FPL, (2) in determining eligibility for SCHIP, states must not apply any pre-existing condition or waiting period restrictions, and (3) the state must provide the same cost-sharing protections applicable to SCHIP children, and all cost-sharing incurred by pregnant women must be capped at 5% of annual family income. In addition, no cost-sharing would be allowed for pregnancy-related services. States choosing this new optional coverage may also temporarily enroll such women for up to two months until a formal determination of eligibility is made. The upper income limit for this new coverage group is the upper income standard applicable to SCHIP children in the state. Other eligibility restrictions for children under SCHIP also apply to this new group of pregnant women (i.e., must be uninsured, ineligible for state employee coverage, etc.).

Pregnancy-related assistance would include all services covered under SCHIP for children in a state as well as prenatal, delivery and postpartum care. Also children born to these pregnant women would be deemed eligible for Medicaid or SCHIP, as appropriate, and would be covered up to age 1.

Limitation on Matching Rate for States that Exceed 300 Percent of the Poverty Line

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The enhanced FMAP (E-FMAP) for SCHIP equals a state's Medicaid FMAP increased by the number of percentage points that is equal to 30% of the difference between a state's FMAP and 100%. For example, in states with an FMAP of 60%, the E-FMAP equals the FMAP increased by 12 percentage points (60% + [30% multiplied by 40 percentage points] = 72%). E-FMAPs can range from 65% to 85%.

In determining the amount of income that "counts" for eligibility purposes, there are two types of income disregards used by states. The first type is exclusions of particular dollar amounts or types of income (or certain expenses, such as child care

expenses). Nearly every state uses such disregards in SCHIP. These disregards often mirror the disregards in states' Medicaid programs. Although an individual's *gross* family income may be above the state's upper-income eligibility level for SCHIP, the person may qualify because his or her *net* family income (taking into account the state's disregards) falls below the upper-income threshold. The SCHIP statute provides flexibility for states to use such disregards. The second type of income disregard is when a state excludes an entire block of percent-of-poverty income. For example, New Jersey's SCHIP program covers children with *net* family income up to 200% of poverty. The state excludes all family income between 200% and 350% of poverty. As a result, children with *gross* family income up to 350% of poverty may be eligible for the state's SCHIP program.

Under the Senate bill, for child health assistance or health benefits coverage furnished in any fiscal year beginning with FY2008 to targeted low-income children whose effective family income would exceed 300% of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income, states would be reimbursed using the FMAP instead of the E-FMAP. An exception would be provided for states that, on the date of enactment, have an approved state plan amendment or waiver or have enacted a state law to submit a state plan amendment to cover targeted low-income children above 300% of the poverty line.

Title II: Outreach and Enrollment

Grants for Outreach and Enrollment

Under current law, title XXI specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance, which meets certain requirements. Apart from these benefit payments; SCHIP payments for four other specific health care activities can be made, including (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of SCHIP children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for other specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP benefits and other specific health care activities combined.

S. 1893/H.R. 976 would set aside $100 million (during the period of fiscal years 2008 through 2012) to establish a new grant program under SCHIP to finance outreach and enrollment efforts that increase participation of eligible children in both Medicaid and SCHIP. Such amounts would be in addition to amounts appropriated for SCHIP allotments to states, would remain available until expended, and would not be subject to current law restrictions on expenditures for outreach activities.

For such period, the Senate bill would require that 10% of the funding be dedicated to a national enrollment campaign, and10% would be set-side for grants for outreach to, and enrollment of, children who are Indians. The remaining grant funds would be distributed by the Secretary to specified entities (including states, local governments, community-based organizations, and federal health safety net

organizations) to conduct outreach campaigns that target geographic areas with high rates of eligible but not enrolled children who reside in rural areas, or racial and ethnic minorities and health disparity populations. Grant funds would also be targeted at proposals that address cultural and linguistic barriers to enrollment.

States that are awarded Outreach and Enrollment grants would be required to meet a maintenance of effort requirement with regard to the state share of funds spent on outreach and enrollment activities under the SCHIP state plan in the preceding fiscal year, and no state matching funds would be required for the state to receive an outreach and enrollment grant. Finally, the Senate bill would provide the greater of 75%, or the sum of the enhanced FMAP for the state plus five percentage points for translation and interpretation services under SCHIP by individuals for whom English is not their primary language.

Increased Outreach and Enrollment of Indians

S. 1893/H.R. 976 encourages states to take steps to enroll Indians residing in or near reservations in Medicaid and SCHIP. These steps may include outstationing of eligibility workers (at certain hospitals and Federally Qualified Health Centers); entering into agreements with Indian entities (i.e., the IHS, tribes, tribal organizations) to provide outreach; education regarding eligibility, benefits, and enrollment; and translation services. The Secretary would be required to facilitate cooperation between states and Indian entities in providing benefits to Indians under Medicaid and SCHIP.

Certain nonbenefit payments under SCHIP (e.g., for other child health assistance, health service initiatives, outreach, and program administration) cannot exceed 10% of the total amount of expenditures for benefits and these nonbenefit payments combined. The Senate bill would exclude from this 10% cap the expenditures for outreach to potentially eligible Indian children and families.

Demonstration Program to Permit States to Rely on Findings by an Express Lane Agency to Determine Components of a Child's Eligibility for Medicaid or SCHIP

Medicaid law and regulations contain requirements regarding determinations of eligibility and applications for assistance. In limited circumstances outside agencies are permitted to determine eligibility for Medicaid. For example, when a joint TANF-Medicaid application is used the state TANF agency may make the Medicaid eligibility determination. Medicaid applicants must attest to the accuracy of the information submitted on their applications, and sign application forms under penalty of perjury.

The Senate bill would create a three-year demonstration program that would allow up to ten states to use Express Lane eligibility determinations at Medicaid and SCHIP enrollment and renewal. The demonstration would authorize and appropriate $44 million for the period of FY2008 through FY2012 for systems upgrades and implementation. Of this amount, $5 million would be dedicated to an independent evaluation of the demonstration for the Congress.

The demonstration would allow states the option to rely on a finding made by an Express Lane Agency within the preceding 12 months to determine whether a child has met one or more of the eligibility requirements (e.g., income, assets, citizenship or other criteria) necessary to determine an individual's eligibility for Medicaid or SCHIP. The Senate bill does not relieve states of their obligation to determine eligibility for Medicaid, and would require the state to inform families that they may qualify for lower premium payments or more comprehensive health coverage under Medicaid if the family's income were directly evaluated by the state Medicaid agency.

Express Lane agencies would include public agencies determined by the State as capable of making eligibility determinations such as public agencies that determine eligibility under TANF, SCHIP, Medicaid, Food Stamps, Head Start, the School Lunch programs, the Child Nutrition programs, etc. Also included are state-specified governmental agencies that have fiscal liability or legal responsibility for the accuracy of eligibility determination findings, and public agencies that are subject to an interagency agreement limiting the disclosure and use of such information for eligibility determination purposes. The Senate bill would explicitly exclude programs run through title XX (Social Services Block Grants) of the Social Security Act, and private for-profit organizations as agencies that would qualify as an Express Lane agency.

Other key components of this provision in the Senate bill would drop the requirement for signatures under penalty of perjury, and permit signature requirements for a Medicaid application to be satisfied through an electronic signature. Error rates associated with incorrect eligibility determinations would also be monitored under the demonstrations.

Authorization of Certain Information Disclosure to Simplify Health Coverage Determinations

Under current law, each State must have an income and eligibility verification system under which (1) applicants for Medicaid and several other specified government programs must furnish their Social Security numbers to the state as a condition for eligibility, and (2) wage information from various specified government agencies is used to verify eligibility and to determine the amount of the available benefits. Subsequent to initial application, States must request information from other federal and state agencies, to verify applicants' income, resources, citizenship status, and validity of Social Security number, unearned income, unemployment information, etc.

S. 1893/H.R. 976 would authorize federal or State agencies or private entities with data sources that are directly relevant for the determination of eligibility under Medicaid to share such information with the Medicaid agency if: (1) there is no family objection to such disclosure, (2) the data would be used solely for the purpose of determining Medicaid eligibility, and (3) there is an interagency agreement in place to prevent the unauthorized use or disclosure of such information. Individuals involved in such unauthorized use would be subject to criminal penalty. In addition,

for the purposes of the Express Lane Demonstration states only, the provision would allow the Medicaid and SCHIP programs to receive such data from (1) the National New Hires Database, (2) the National Income Data collected by the Commissioner of Social Security, or (3) data about enrollment in insurance that may help to facilitate outreach and enrollment under Medicaid, SCHIP, and certain other programs.

Title III: Removal of Barriers to Enrollment

Verification of Declaration of Citizenship or Nationality for Purposes of Eligibility for Medicaid and SCHIP

Under current law, noncitizens who apply for full Medicaid benefits have been required since 1986 to present documentation that indicates a "satisfactory immigration status." Due to recent changes, citizens and nationals also must present documentation that proves citizenship and documents personal identity in order for states to receive federal Medicaid reimbursement for services provided to them. This citizenship documentation requirement was included in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and modified by the Tax Relief and Health Care Act of 2006 (P.L. 109-432). Before the DRA, states could accept self-declaration of citizenship for Medicaid, although some chose to require additional supporting evidence. The citizenship documentation requirement is outlined under Section 1903(x) of the Social Security Act and applies to Medicaid eligibility determinations and redeterminations made on or after July 1, 2006. The law specifies documents that are acceptable for this purpose and exempts certain groups from the requirement. It does not apply to SCHIP. However, since some states use the same enrollment procedures for all Medicaid and SCHIP applicants, it is possible that some SCHIP enrollees would be asked to present evidence of citizenship.

The Senate bill would provide a new option for meeting citizenship documentation requirements. As part of its Medicaid state plan and with respect to individuals declaring to be U.S. citizens or nationals for purposes of establishing Medicaid eligibility, a state would be required to provide that it satisfies existing Medicaid citizenship documentation rules under section 1903(x) of the Social Security Act or new rules under section 1902(dd). Under section 1902(dd), a state could meet its Medicaid state plan requirement for citizenship documentation by: (1) submitting the name and Social Security number (SSN) of an individual to the Commissioner of Social Security as part of a plan established under specified rules and (2) in the case of an individual whose name or SSN is invalid, notifying the individual, providing him or her with a period of 90 days to either present evidence of citizenship as defined in Section 1903(x) or cure the invalid determination with the Commissioner of Social Security, and disenrolling the individual within 30 days after the end of the 90-day period if evidence is not provided. States would receive 90% reimbursement for costs attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement name and SSN validation, and 75% for the operation of such systems.

The legislation would also clarify requirements under the existing Section 1903(x). It would add additional documentation options for federally-recognized Indian tribes; require states to provide citizens with the same reasonable opportunity to present evidence that is provided to noncitizens who must present evidence of satisfactory immigration status; provide a permanent exemption for children who are deemed eligible for Medicaid coverage by virtue of being born to a mother on Medicaid; clarify that deemed eligibility applies to children born to noncitizen women on emergency Medicaid; and require separate identification numbers for children born to these women.

In order to receive reimbursement for an individual who has, or is, declared to be a U.S. citizen or national for purposes of establishing SCHIP eligibility, a state would be required to meet the Medicaid state plan requirement for citizenship documentation described above. The 90% and 75% reimbursement for name and SSN validation would be available under SCHIP, and would not count towards a state's SCHIP administrative expenditures cap.

Except for clarifications made to the existing citizenship documentation requirement, which would be retroactive, the provision would be effective on October 1, 2008. States would be allowed to provide retroactive eligibility for certain individuals who had been determined ineligible under previous citizenship documentation rules.

Reducing Administrative Barriers to Enrollment

During the implementation of SCHIP states instituted a variety of enrollment facilitation and outreach strategies to bring eligible children into Medicaid and SCHIP. As a result, substantial progress was made at the state level to simplify the application and enrollment processes to find, enroll, and maintain eligibility among those eligible for the program.

The Senate bill would require the State plan to describe the procedures used to reduce the administrative barriers to the enrollment of children and pregnant women in Medicaid and SCHIP, and to ensure that such procedures are revised as often as the State determines is appropriate to reduce newly identified barriers to enrollment.

Title IV: Reducing Barriers to Providing Premium Assistance

Additional State Option for Providing Premium Assistance

Under Medicaid, state Medicaid programs may pay a Medicaid beneficiary's share of costs for group (employer-based) health coverage for any Medicaid enrollee for whom coverage is available, comprehensive, and cost-effective for the state. An individual's enrollment in an employer plan is considered cost effective if paying the premiums, deductibles, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the state's expected cost of directly providing

Medicaid-covered services. States were also to provide coverage for those Medicaid covered services that are not included in the private plans.

Under SCHIP, the Secretary has the authority to approve funding for the purchase of "family coverage" under an employer-sponsored health insurance plan if it is cost effective relative to the amount paid to cover only the targeted low-income children and does not substitute for coverage under group health plans that would otherwise be provided to the children. In addition, states using SCHIP funds for employer-based plan premiums must ensure that SCHIP minimum benefits are provided and SCHIP cost-sharing ceilings are met.

Because of these requirements, implementation of premium assistance programs under Medicaid and SCHIP are not widespread. In August 2001, the Bush Administration introduced the Health Insurance Flexibility and Accountability (HIFA) Initiative under the Section 1115 waiver authority. Under HIFA, states were to direct unspent SCHIP funds to extend coverage to uninsured populations with annual income less than 200% FPL and to use Medicaid and SCHIP funds to pay premium costs for waiver enrollees who have access to Employer Sponsored Insurance (ESI). This resulted in an increased emphasis on states' use of the Section 1115 waiver authority to offer premium assistance for employer-based health coverage in lieu of full Medicaid and/or SCHIP coverage. ESI programs approved under the Section 1115 waiver authority are not subject to the same current law constraints required under Medicaid's Health Insurance Premium Payment (HIPP) program or SCHIP's family coverage variance option (i.e., the comprehensiveness and cost-effectiveness tests).

The Senate bill would allow states to offer a premium assistance subsidy for qualified employer sponsored coverage to all targeted low-income children who are eligible for child health assistance and have access to such coverage, or to parents of targeted low-income children. Qualified employer sponsored coverage would be defined as a group health plan or health insurance coverage offered through an employer that (1) qualifies as credible health coverage as a group health plan under the Public Health Service Act, (2) for which the employer contributes at least 40% toward the cost of the premium, and (3) is nondiscriminatory in a manner similar to section 105(h)of the Internal Revenue Code but would not allow employers to exclude workers who had less than three years of service. Qualified employer-sponsored insurance explicitly excludes (1) benefits provided under a health flexible spending arrangement, (2) a high deductible health plan purchased in conjunction with a health savings account as defined in the Internal Revenue Code of 1986.

The Senate bill would establish a new cost effectiveness test for employer sponsored insurance (ESI) programs. A group health plan or health insurance coverage offered through an employer would be considered qualified employer sponsored coverage if the state establishes that (1) the cost of such coverage is less than the expenditures that the State would have made to enroll the child or the family (as applicable) in SCHIP, or (2) the State establishes that the aggregate amount of State expenditures for the purchase of all such coverage for targeted low-income children under SCHIP (including administrative expenses) does not exceed the aggregate amount of expenditures that the State would have made for providing coverage under the SCHIP state plan for all such children.

States would be required to provide supplemental coverage for each targeted low-income child enrolled in the ESI plan consisting of items or services that are not covered, or are only partially covered, and cost-sharing protections consistent with the requirements of SCHIP. States would be permitted to directly pay out-of-pocket expenditures for cost-sharing imposed under the qualified ESI coverage and collect all (or any) portion for cost-sharing imposed on the family. Parents would be permitted to disenroll their child(ren) from ESI coverage and enroll them in SCHIP coverage effective on the first day of any month for which the child is eligible for such coverage.

The Senate bill would also allow States to provide premium assistance subsidies for enrollment of targeted low-income children in coverage under a group health plan or health insurance coverage offered through an employer if it is determined that such coverage is actuarially equivalent to SCHIP benchmark benefits coverage, or SCHIP benchmark-equivalent coverage. Plans that meet the SCHIP benefit coverage requirements would not be required to provide supplemental coverage for benefits and cost-sharing protections as required under SCHIP. Such provisions would be applied to Medicaid-eligible children and to the parents of Medicaid-eligible children in the same manner as they are applied to SCHIP.

States would also be permitted to establish an employer-family premium assistance purchasing pool for employers with less than 250 employees who have at least one employee who is an SCHIP-eligible pregnant woman or at least one member of the family is an SCHIP-eligible child. Eligible families would have access to not less than 2 private health plans where the health benefits coverage is equivalent to the benefits coverage available through a SCHIP benchmark benefit package or SCHIP benchmark equivalent coverage benefits package.

Finally, the Senate bill would require the Government Accountability Office to submit a report to the appropriate committees of Congress on cost and coverage issues relating to any State premium assistance programs for which federal matching payments are made under Medicaid, SCHIP, or the Section 1115 waiver authority. Such report will be due to Congress no later than January 1, 2009.

Outreach, Education and Enrollment Assistance

SCHIP states plans are required to include a description of the procedures in place to provide outreach to children eligible for SCHIP child health assistance, or other public or private health programs to (1) inform these families of the availability of SCHIP coverage, and (2) to assist them in enrolling such children in SCHIP. In addition, states are required to provide a description of the state's efforts to ensure coordination between SCHIP and other public and private health coverage. There is a limit on federal spending for SCHIP administrative expenses, which include activities such as data collection and reporting, as well as outreach and education. For federal matching purposes, a 10% cap applies to state administrative expenses.

The provision would require states to include a description of the procedures in place to provide outreach, education, and enrollment assistance for families of children likely to be eligible for premium assistance subsidies under SCHIP or a waiver approved under Section 1115. For employers likely to provide qualified

employer-sponsored coverage, the state is required to include the specific resources the State intends to use to educate employers about the availability of premium assistance subsidies under the SCHIP state plan. Expenditures for such outreach activities would not be subject to the 10% limit on spending for administrative costs associated with the SCHIP program.

Special Enrollment Period Under Group Health Plans in Case of Termination of Medicaid or SCHIP Coverage or Eligibility for Assistance in Purchase of Employment-Based Coverage

Under the Internal Revenue Code, a group health plan is required to provide special enrollment opportunities to qualified individuals. Special enrollment refers to the opportunity given to qualified individuals to enroll in a health plan without having to wait until a late enrollment opportunity or open season. Such individuals must have lost eligibility for other group coverage, or lost employer contributions towards health coverage, or added a dependent due to marriage, birth, adoption, or placement for adoption. In addition, the individual must meet the health plan's substantive eligibility requirements, such as being a full-time worker or satisfying a waiting period. Health plans must give qualified individuals at least 30 days after the qualifying event (e.g., loss of eligibility) to make a request for special enrollment.

The same special enrollment opportunities apply to group health plans and health insurance issuers offering group health insurance under the Employee Retirement Income Security Act and the Public Health Service Act. The Employee Retirement Income Security Act specifies the persons who may bring civil action to enforce the provisions under this statute. Such persons include a plan participant or beneficiary, a fiduciary, the Secretary of Labor, and a State. Current law allows the Secretary to assess a maximum financial penalty against a plan administrator or employer for certain violations, including failure to meet the existing notice requirement.

The Senate bill includes changes to applicable federal laws that streamline coordination between public and private coverage including making Medicaid/CHIP eligibility and loss of eligibility a "qualifying event" for the purposes of eligibility for employer-sponsored coverage; requiring employers to share information about their benefit packages with states so states can evaluate the need to provide "wraparound" coverage; and requiring employers to notify families of their potential eligibility for premium assistance.

Title V: Strengthening Quality of Care and Health Outcomes of Children

Child Health Quality Improvement Activities for Children Enrolled in Medicaid or SCHIP

The Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) are both actively involved in funding and

implementing an array of quality improvement initiatives, though only AHRQ has engaged in activities specific to children. The Senate bill includes a number of provisions that would direct the Secretary of HHS to develop (1) child health quality measures for children enrolled in Medicaid and SCHIP and (2) a standardized format for reporting information, and procedures that encourage states to voluntarily report on the quality of pediatric care under these programs. In addition, the Secretary would be required to disseminate information to states regarding best practices with respect to measuring and reporting such data. Reports to Congress on these activities and recommendations for new actions to improve quality of care and reporting by states would also be required. A total of $45 million would be appropriated for the provisions of this section, of which specific amounts would be earmarked for selected activities identified below. (The childhood obesity demonstration described below would have its own separate appropriation.)

The Secretary would be required to award grants and contracts for (1) the development, testing and validation of new, emerging, and innovative evidence-based measures for children's health services, (2) the development of consensus on evidence-based measures, (3) dissemination of such measures to public and private purchasers of health care for children, and (4) updating of such measures as necessary.

Each state would be required to report annually to the Secretary on a variety of measures, including for example, (1) duration and stability of insurance coverage for children, (2) quality of care with respect to preventive services, acute care, and care provided for chronic conditions, (3) health care safety, and (4) elimination of racial, ethnic and socioeconomic disparities in health care.

In addition, the Secretary would be required to award not more than 10 grants to states and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care provided under Medicaid and SCHIP. Only one such demonstration project could be conducted in a state and such demonstrations must be evenly distributed between states with large urban areas and large rural areas. Multi-state grants are permitted. A total of $20 million would appropriated for this activity.

The Secretary would also be required to conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity through grants to eligible entities (e.g., city, county, Indian tribe, education agency, federally qualified health center, local health department, health care provider, community based organization). The model would (1) identify behavioral risk factors for obesity among children, (2) identify preventive and screening services for children at risk, (3) provide ongoing support for targeted populations and promote appropriate use of such services, and (4) improve health outcomes, quality of life and appropriate use of services available under Medicaid and SCHIP. Entities receiving grant awards would be required to use the funds to (1) carry out community-based activities and age-appropriate school-based activities to reduce childhood obesity, (2) implement educational, counseling, promotional and training activities through local health care delivery systems, and (3) provide training and supervision for community health workers engaged in such education efforts. This demonstration would be authorized at $25 million over five years ($5 million per year for FY2008 through

FY2012). The Secretary would be required to submit a report to Congress describing the effectiveness and cost-effectiveness of project activities, beneficiary satisfaction, and other information as the Secretary deems appropriate.

The Senate bill would also require the Secretary to establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled in Medicaid or SCHIP. Such a record would be required to conform to applicable state laws, allow for interoperable exchanges that conform with federal and state privacy and security requirements, structured in a manner that is accessible and understandable to parents and caregivers, and is compatible with other standards developed for electronic health records. A total of $5 million is appropriated for this activity.

The Institute of Medicine would be required to study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and care for chronic illness. Up to $1 million is appropriated for this activity.

Finally, the federal share of the costs incurred by states for the development or modification of existing claims processing and retrieval systems as is necessary for the efficient collection and reporting on child health measures would be based on the matching rate used under Medicaid.

Improved Information Regarding Access to Coverage Under SCHIP

The Senate bill adds several reporting requirements to states' annual SCHIP reports that are submitted to the Secretary of HHS. Examples of these new requirements include (1) data on eligibility criteria, enrollment and continuity of coverage, (2) use of self-declaration of income for applications and renewals, and presumptive eligibility, (3) data on denials of eligibility and redeterminations of eligibility, (4) data regarding access to primary and specialty care, networks of care and care coordination, and (5) if the state provides premium assistance for employer-sponsored health insurance coverage, data regarding the extent to which such coverage is available to SCHIP children, the range of monthly premiums amounts provided, the number of children/families receiving such assistance on a monthly basis, the income level of the children/families involved, the benefits and cost-sharing protections provided to such children/families under SCHIP, the strategies implemented to reduce administrative barriers to such coverage, and the effects of such premium assistance on preventing substitution of SCHIP coverage for employer-sponsored health insurance coverage.

The Senate bill also requires GAO to conduct a study on access to primary and specialty services under Medicaid and SCHIP. GAO must report its findings to Congress, including recommendations for federal and state legislation and administrative changes needed to address existing barriers to children's access to care under these programs.

Application of Certain Managed Care Quality Safeguards to CHIP

A number of sections of the Social Security Act apply to states under title XXI (SCHIP) in the same manner as they apply to a state under title XIX (Medicaid). These include section 1902(a)(4)(C) (relating to conflict of interest standards); paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment); section 1903(w) (relating to limitations on provider taxes and donations); and section 1920A (relating to presumptive eligibility for children). The Senate bill would add subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care) to the list of title XIX provisions that apply under title XXI.

Title VI: Miscellaneous Provisions

Technical Corrections Regarding Current State Authority Under Medicaid

With respect to expenditures for Medicaid for fiscal years 2007 and 2008 only, a state may elect (1) to cover optional, poverty-related children and, may apply less restrictive income methodologies to such individuals, for which the regular Medicaid matching rate, rather than the enhanced matching rate under SCHIP, would apply to determine the federal share of such expenditures, or (2) to receive the regular Medicaid matching rate, rather than the enhanced SCHIP matching rate, for SCHIP children under an expansion of the state's Medicaid program. This provision will be repealed as of October 1, 2008 (i.e., the beginning of FY2009). States electing these options would be "held harmless" for related expenditures in FY2007 and FY2008, once this repeal takes effect.

Payment Error Rate Measurement (PERM)

Federal agencies are required to annually review programs that are susceptible to significant erroneous payments, and to estimate the amount of improper payments, to report those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous payments.

A new regulation regarding the Payment Error Rate Measurement (PERM) for Medicaid and SCHIP was effective on October 1, 2006. With respect to these two programs, the subset of states selected for review in a given year must conduct reviews of a statistically valid random sample of beneficiary claims to determine if improper payments were made based on errors in the state agency's eligibility determinations. States must have a CMS-approved sampling plan. In addition to reporting error rates, states must also submit a corrective action plan based on the error rate analysis, and must return overpayments of federal funds.

The Senate bill would apply a federal matching rate of 90% to expenditures related to administration of PERM requirements applicable to SCHIP. The provision

would also exclude from the 10% cap on SCHIP administrative costs all expenditures related to the administration of PERM requirements applicable to SCHIP.

The Secretary must not calculate or publish national or state-specific error rates based on PERM for SCHIP until six months after the date on which a final PERM rule is in effect for all states. Calculations of national- or state-specific error rates after such a final rule is in effect for all states may only be inclusive of errors, as defined in this rule or in guidance issued after the effective date that includes detailed instructions for the specific methodology for error determinations.

The final PERM rule would be required to include (1) clearly defined criteria for errors for both states and providers, (2) a clearly defined process for appealing error determinations by review contractors, and (3) clearly defined responsibilities and deadlines for states in implementing any corrective action plans.

Special provisions would apply to states for which the PERM requirements were first in effect under interim final rules for FY2007 or FY2008 and their application depends on when the final PERM rule is in effect for all states.

The Senate bill would also require the Secretary to review the Medicaid Eligibility Quality Control (MEQC) requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing redundancies. For purposes of determining the erroneous excess payments ratio applicable to the state under MEQC, a state may elect to substitute data resulting from the application of PERM after the final PERM rule is in effect for all states, for the data used for the MEQC requirements.

The Secretary would also be required to establish state-specific sample sizes for application of the PERM requirements to SCHIP for FY2009 forward. In establishing such sample sizes, the Secretary must minimize the administrative cost burden on states under Medicaid and SCHIP, and must maintain state flexibility to manage these programs.

Elimination of Counting Medicaid Presumptive Eligibility Costs Against Title XXI Allotment

The Senate bill would strike the language in existing SCHIP statute that sets the federal share of costs incurred during periods of presumptive eligibility for children (i.e, up to two months of coverage while a final determination of eligibility is made) at the Medicaid matching rate, and also would strike the language that allows payment out of SCHIP allotments for Medicaid benefits received by Medicaid children during periods of presumptive eligibility.

Deficit Reduction Act Technical Correction

Benchmark Benefits. Under SCHIP, states may provide coverage under the Medicaid programs, create a new separate SCHIP program, or both. Under separate SCHIP programs, states may elect any of three benefit options: (1) a benchmark plan, (2) a benchmark-equivalent plan, or (3) any other plan that the Secretary deems

would provide appropriate coverage for the target population. Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under FEHBP, (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state.

Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and outpatient hospital services, physician services, lab/X-ray, and well-child care including immunizations), and must include 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services).

Under the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit under Medicaid, most children under age 21 receive comprehensive basic screening services (i.e., well-child visits including age-appropriate immunizations) as well as dental, vision, and hearing services. In addition, EPSDT guarantees access to all federally coverable services necessary to treat a problem or condition among eligible individuals.

The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage that is nearly identical to plans available under SCHIP. For any child under age 19 in one of the major mandatory and optional eligibility groups in Medicaid, wrap-around benefits to the DRA benchmark and benchmark-equivalent coverage includes EPSDT. In traditional Medicaid, EPSDT is available to most individuals under age 21.

The Senate bill would require that EPSDT be covered for any individual under age 21 who is eligible for Medicaid through the state Medicaid plan under one of the major mandatory and optional coverage groups and is enrolled in benchmark or benchmark-equivalent plans authorized under DRA. The provision would also give states flexibility in providing coverage of EPSDT services through the issuer of benchmark or benchmark-equivalent coverage or otherwise.

In addition, the Secretary would be required to publish in the *Federal Register* and on the internet website of CMS, a list of the provisions in Title XIX that the Secretary has determined do not apply in order to enable a state to carry out a state plan amendment to provide benchmark or benchmark-equivalent coverage under Medicaid. In such publications, the Secretary must also provide the reason for each such determination. The effective date would be the same as the original DRA provisions (i.e., March 31, 2006).

Elimination of Confusing Program References

The Senate bill would repeal the section in P.L. 106-113 that directed the Secretary of HHS or any other federal officer or employee, with respect to references to the program under Title XXI, in any publication or official communication to use the term “SCHIP” instead of “CHIP” and to use the term “State children’s health insurance program” instead of “children’s health insurance program.”

Thus, for official publication and communication purposes, S. 1893/H.R. 976 would reinstate "CHIP" and "children's health insurance program," as appropriate, when referencing Title XXI.

Mental Health Parity in SCHIP Plans

In 1996, Congress passed the Mental Health Parity Act (MHPA) that established new federal standards for mental health coverage offered by group health plans, most of which are employment-based. Under provisions included in the 1997 Balanced Budget Act (P.L. 105-33), Medicaid managed care plans and SCHIP programs must comply with the requirements of MHPA.

Medicaid expansions under SCHIP follow Medicaid rules. Thus, when such expansions provide for enrollment in Medicaid managed care plans, the MHPA applies. Separate state programs under SCHIP follow SCHIP rules that have broader application than the Medicaid rules. In separate state SCHIP programs, to the extent that a health insurance issuer offers group health insurance coverage, which can include, but is not limited to managed care, the MHPA applies.

Under MHPA, Medicaid and SCHIP plans may define what constitutes mental health benefits (if any). The MHPA prohibits group plans from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than those applicable to medical and surgical coverage. Full parity is not required, that is, group plans may still impose more restrictive treatment limits (e.g., with respect to total number of outpatient visits or inpatient days) or cost-sharing requirements on mental health coverage compared to their medical and surgical services.

The Senate bill would ensure that the financial requirements and treatment limitations applicable to mental health or substance abuse benefits (when such benefits are covered) are no more restrictive than the financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered under the state SCHIP plan. State SCHIP plans that include coverage of EPSDT services (as defined in Medicaid statute) would be deemed to satisfy this mental health parity requirement.

Dental Health Grants

The Senate bill would include authority for new dental health grants for programs and activities designed to improve the availability of dental services and strengthen dental coverage for children under SCHIP. Among several requirements to be awarded such a grant, states would describe quality and outcomes performance measures to be used to evaluate the effectiveness of grant activities, and must assure that they will cooperate with the collection and reporting of data to the Secretary of HHS. Grantees would be required to maintain state funding of dental services under SCHIP at the level of expenditures in the fiscal year preceding the first fiscal year for which the new grant is awarded. In addition, such states would not be required to provide any state matching funds for the new dental grant program. The Secretary would be required to submit to Congress an annual report on state activities and performances assessments under the new dental grant program. For the period

FY2008 through FY2012, $200 million would be appropriated for this grant program, to remain available until expended.

The provision would also require the Secretary of HHS to work with states and dental providers to include on the *Insure Kids Now* website and hotline a current and accurate list of all dentists and other dental providers in each state that provide such services to Medicaid and SCHIP children, and must update this listing at least on a quarterly basis. The Secretary would also be required to work with states to include a description of covered dental services for children under both programs (including under applicable waivers) for each state, and must post this information on the *Insure Kids Now* website.

The provision requires GAO to conduct a study on children's access to oral health care, including preventive and restorative services under Medicaid and SCHIP, including (1) the extent to which providers are willing to treat Medicaid and SCHIP children, (2) information on such children's access to networks of care, and (3) geographic availability of dental services for such children. A report on this study would be due to Congress not later than two years after the date of enactment of this Act. This report must include recommendations for such federal and state legislative and administrative changes necessary to address barriers to access to dental care that may exist under Medicaid and SCHIP. Also, the provision would add an assessment of the quality of dental care provided to Medicaid and SCHIP children to the Secretary's annual reports to Congress under the new child health quality improvement activities authorized in the Senate-passed bill.

Payment for Services Provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Under current Medicaid law, FQHCs and RHCs are paid based on a prospective payment system. Beginning in FY2001, per visit payments were based on 100% of average costs during 1999 and 2000 adjusted for changes in the scope of services furnished. (Special rules applied to entities first established after 2000). For subsequent years, the per visit payment for all FQHCs and RHCs equals the amounts for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index applicable to primary care services, and adjusted for any changes in the scope of services furnished during that fiscal year. In managed care contracts, states are required to make supplemental payments to the facility equal to the difference between the contracted amount and the cost-based amounts.

Under the Senate bill, states that operate separate and/or combination SCHIP programs would be required to reimburse FQHCs and RHCs based on the Medicaid prospective payment system. This provision would apply to services provided on or after October 1, 2008.

For FY2008, $5 million would be appropriated (to remain available until expended) to states with separate SCHIP programs for expenditures related to transitioning to a prospective payment system for FQHCs/RHCs under SCHIP. Finally, the Secretary would be required to report to Congress on the effects (if any)

of the new prospective payment system on access to benefits, provider payment rates or scope of benefits.

Sense of Senate Regarding Access to Affordable and Meaningful Health Insurance Coverage

The Senate bill would include findings regarding the uninsured and health care cost growth and a sense of the Senate that recognizes the necessity to improve affordability and access to health insurance for all Americans, acknowledges the value of building upon the existing private health insurance market, and affirms its intent to enact legislation this year that facilitates pooling mechanisms (including pooling across state lines) and provides assistance to small businesses and individuals (including financial assistance and tax incentives) for the purchase of private insurance coverage.

Demonstration Projects Relating to Diabetes Prevention

The Senate bill would create a new demonstration project to fund up to 10 states over three years for voluntary incentive programs to promote children's receipt of screenings and improvements in healthy eating and physical activity to reduce the incidence of type 2 diabetes. Activities may include reductions in cost-sharing or premiums when children receive regular screening and reach certain benchmarks in healthy eating and physical activity. States receiving grants under this demonstration would also be permitted to provide (1) financial bonuses for partnerships with entities (e.g., schools) that increase education and other activities to reduce the incidence of type 2 diabetes, and (2) incentives to providers serving Medicaid and SCHIP children to perform screening and counseling regarding healthy eating and exercise. The Secretary of HHS would be required to provide a report to Congress on the results of this demonstration and the degree to which funded activities improve health outcomes related to type 2 diabetes among children in participating states. The provision would authorize to be appropriated a total of $15 million during FY2008 through FY2012 to fund this demonstration. (The provision for a child health quality improvement project described above includes a childhood obesity demonstration that would also include activities designed to improve healthy eating and physical activity among children.)

Outreach Regarding Health Insurance Options Available to Children

The Senate bill would establish a task force, consisting of the Administrator of the Small Business Administration (SBA) and the Secretaries of HHS, Labor, and the Treasury, to conduct a nationwide campaign of education and outreach for small businesses regarding the availability of coverage for children through private insurance, Medicaid, and SCHIP. The campaign would include information regarding options to make insurance more affordable, including federal and state tax deductions and credits and the federal tax exclusion available under employer-sponsored cafeteria plans; it would also include efforts to educate small businesses about the value of health insurance coverage for children, assistance available through public programs, and the availability of the hotline operated as part of the

Insure Kids Now program at HHS. The task force would be allowed to use any business partner of the SBA, enter into a memorandum of understanding with a chamber of commerce and a partnership with any appropriate small business or health advocacy group, and designate outreach programs at HHS regional offices to work with SBA district offices. It would require the SBA website to prominently display links to state eligibility and enrollment requirements for Medicaid and SCHIP, and would require a report to Congress every two years.

Support for Injured Service Members and Military Family Job Protection

The Senate bill would amend the Family and Medical Leave Act of 1993 to allow up to six months of leave for a family member of a military servicemember who has a combat-related injury or illness, and would prohibit employers from denying certain family members retention, promotion, or any benefit of employment on the basis of their absence from employment for a period of not more than 52 workweeks.

Title VIII: Effective Date

Effective Date

The effective date of this bill (unless otherwise provided) would be October 1, 2007, whether or not final regulations to carry out provisions in the bill have been promulgated by that date. In the case of both current state SCHIP and Medicaid plans, if the Secretary of HHS determines that a state must pass new state legislation to implement the requirements of this bill, the state's existing SCHIP and/or Medicaid plans, if applicable, would not be considered to be out of compliance solely on the basis of its failure to meet such requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of this bill. In the case of a state that has a two-year legislative session, each year of such session must be considered to be a separate regular session of the state legislature.

Appendix

On July 30, 2007, CRS produced a Congressional Distribution memorandum that showed projected FY2008 federal SCHIP allotments as well as projected federal SCHIP spending and balances based on S. 1893/H.R. 976. This appendix contains the descriptions and projections included in that memorandum. These estimates are based on states' own projections of federal SCHIP spending submitted in May 2007. States will submit updated projections in August 2007, upon which the allotments under The Senate bill would be partly based. Thus, the actual amounts will vary from those shown here.

Currently Projected FY2008 SCHIP Allotments Based on S. 1893/H.R. 976

For FY2008, the Senate bill appropriates $9.125 billion to SCHIP. The states' and territories' SCHIP allotment from these funds are determined through a new SCHIP formula.

Both the territories' and the states' allotments in FY2008 rely at least partially on FY2007 amounts (for example, FY2007 federal SCHIP spending or allotments). An "annual adjustment" is calculated to raise the FY2007 amounts to FY2008 levels. This annual adjustment for health care cost growth and child population growth is the product of (a) 1 plus the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for 2008 over 2007, and (b) 1.01 plus the percentage change in the child population in each state (except for the territories, for which the national amount is used) as of July 1, 2008, over 2007, based on the most timely and accurate published estimates from the Census Bureau.

For FY2008, a *state's* allotment is calculated as 110% of the greatest of the following four amounts (with the currently projected amount for each shown in Columns B through E of **Table 1**): (1) the state's FY2007 federal SCHIP *spending* multiplied by the annual adjustment; (2) the state's FY2007 federal SCHIP *allotment* multiplied by the annual adjustment; (3) among states that were determined in FY2007 to have exhausted their own federal SCHIP allotments (shortfall states for FY2007),[9] the state's FY2007 projected spending as of November 2006 (or as of May 2006, for a state whose May 2006 projection was $95 million to $96 million higher than its November 2006 projection[10]) multiplied by the annual adjustment; and (4) the state's FY2008 federal SCHIP projected spending as of August 2007 and certified by the state to the Secretary not later than September 30, 2007.

For FY2008, each *territory's* allotment is its highest annual federal SCHIP spending between FY1998 and FY2007, multiplied by the annual adjustment for health care cost growth and *national* child population growth.

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[9] For FY2007 shortfall states, S. 1893/H.R. 976 includes not only states that receive funds for their FY2007 shortfalls but also includes states that were projected to face shortfalls based on their November 2006 projections.

[10] This provision affects only North Carolina.

The last column in **Table 1** shows the currently projected federal FY2008 SCHIP allotments under the Senate bill. These were calculated by using projected FY2007 and FY2008 federal SCHIP spending submitted by the states to the Centers for Medicare and Medicaid Services (CMS) in May 2007 (or earlier, if The Senate bill so specifies). *Actual* FY2008 allotments under The Senate bill would be based in part on projections that will be provided later (e.g., states' August 2007 submission to CMS). Those later projections may reflect other policy changes from the Senate bill (e.g., increased spending eligible for qualifying states under Section 2105(g) of the Social Security Act, per the provision in Section 111 of the bill that permits such spending from all available allotments, removes the 20% cap, and permits such spending on behalf of children enrolled in Medicaid with income as low as 133% of poverty). In addition, states' later projections may differ, for example, because of more recent information on the states' payments for services on behalf of SCHIP enrollees or due to expansions of SCHIP coverage recently enacted by states and approved by CMS that were not reflected in the May 2007 submission. As a result, the actual allotments will vary from those currently projected.

As shown in the last column of **Table 1**, the available information from states, the Census Bureau and CMS leads to projected FY2008 federal SCHIP allotments totaling approximately $8.8 billion.[11] Thus, the amount appropriated for SCHIP in FY2008 under S. 1893/H.R. 976 ($9.125 billion) is sufficient to cover the allotment levels projected here, based on the assumptions described.[12]

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[11] The Congressional Budget Office (CBO) has projected federal SCHIP *outlays* at $7.8 billion in FY2008 under the Chairman's Mark. That *actual spending* as projected by CBO is less than the amounts *made available* to the states and the territories through the allotments in FY2008 is due to the structure of the allotment formula (e.g., 110% of the greatest of the numbers described earlier).

[12] If the $9.125 billion were insufficient (e.g., if states' August 2007 submission of projected expenditures were markedly higher than the May submission), the states' allotments would be calculated differently, as described in the Chairman's Mark. Because the current projections show the appropriation amount as sufficient, those calculations are not used in this memorandum.

Table 1. Projected FY2008 Allotments Under S. 1893/H.R. 976

A	B	C	D	E	F = max (B,C,D,E)	G = F * 1.1
State	FY2007 spending (based on May 2007 submission), times annual adjustment	FY2007 allotment, times annual adjustment	For FY2007 shortfall states, FY2007 spending projected in Nov. 2006 (May 2006 for North Carolina), times annual adjustment	States' own FY2008 projected spending (based on May 2007 submission)	Greatest of preceding four columns	Projected FY2008 Allotments
Alabama	$102,543,621	$79,385,118		$112,547,000	$112,547,000	**$123,801,700**
Alaska	$19,035,973	$12,368,170	$32,356,759	$19,563,000	$32,356,759	**$35,592,434**
Arizona	$123,368,971	$139,702,163		$124,283,000	$139,702,163	**$153,672,379**
Arkansas	$74,927,494	$53,046,638		$116,498,000	$116,498,000	**$128,147,800**
California	$1,250,888,096	$849,024,249		$1,225,533,000	$1,250,888,096	**$1,375,976,905**
Colorado	$69,056,420	$77,149,089		$74,967,000	$77,149,089	**$84,863,998**
Connecticut	$25,329,463	$42,534,497		$27,478,000	$42,534,497	**$46,787,947**
Delaware	$9,464,736	$11,890,117		$8,998,000	$11,890,117	**$13,079,129**
DC	$7,945,976	$12,526,710		$9,662,000	$12,526,710	**$13,779,381**
Florida	$280,551,023	$320,787,525		$259,735,000	$320,787,525	**$352,866,278**
Georgia	$369,454,737	$179,896,477	$338,525,943	$363,219,000	$369,454,737	**$406,400,210**
Hawaii	$20,349,632	$16,522,926		$19,548,000	$20,349,632	**$22,384,595**
Idaho	$30,545,421	$26,328,561		$31,109,000	$31,109,000	**$34,219,900**
Illinois	$480,662,508	$224,466,443	$619,021,008	$464,118,000	$619,021,008	**$680,923,108**
Indiana	$74,504,936	$100,248,007		$73,494,000	$100,248,007	**$110,272,807**
Iowa	$59,567,269	$38,744,526	$60,685,873	$74,919,000	$74,919,000	**$82,410,900**
Kansas	$49,354,411	$39,122,217		$51,424,000	$51,424,000	**$56,566,400**
Kentucky	$84,487,145	$75,152,134		$83,030,000	$84,487,145	**$92,935,859**
Louisiana	$121,139,155	$95,785,914		$127,910,000	$127,910,000	**$140,701,000**
Maine	$28,134,698	$16,114,480	$26,594,613	$24,950,000	$28,134,698	**$30,948,168**
Maryland	$153,274,461	$72,005,573	$162,504,093	$171,692,000	$171,692,000	**$188,861,200**
Massachusetts	$240,980,739	$78,238,000	$229,467,211	$277,071,000	$277,071,000	**$304,778,100**
Michigan	$191,167,164	$159,471,818		$185,856,000	$191,167,164	**$210,283,880**
Minnesota	$72,079,233	$52,199,914	$84,488,840	$87,663,000	$87,663,000	**$96,429,300**
Mississippi	$128,745,612	$64,655,562	$128,937,993	$116,760,000	$128,937,993	**$141,831,793**
Missouri	$98,632,388	$77,268,799	$105,745,496	$124,635,000	$124,635,000	**$137,098,500**
Montana	$19,960,484	$16,822,372		$25,300,000	$25,300,000	**$27,830,000**
Nebraska	$35,383,414	$23,484,759	$36,130,067	$34,436,000	$36,130,067	**$39,743,073**
Nevada	$33,838,542	$57,110,438		$38,880,000	$57,110,438	**$62,821,482**
New Hampshire	$10,638,773	$11,531,160		$9,555,000	$11,531,160	**$12,684,276**
New Jersey	$311,365,170	$112,599,417	$306,612,083	$339,413,000	$339,413,000	**$373,354,300**
New Mexico	$50,399,192	$55,587,150		$106,762,000	$106,762,000	**$117,438,200**
New York	$362,516,020	$362,555,014		$415,218,000	$415,218,000	**$456,739,800**
North Carolina	$182,789,103	$147,528,974	$287,546,280	$197,532,000	$287,546,280	**$316,300,908**
North Dakota	$12,231,669	$8,209,828		$7,669,000	$12,231,669	**$13,454,836**
Ohio	$203,293,608	$168,530,759		$212,201,000	$212,201,000	**$233,421,100**
Oklahoma	$107,526,561	$76,032,897		$117,301,000	$117,301,000	**$129,031,100**
Oregon	$76,036,331	$61,079,480		$97,903,000	$97,903,000	**$107,693,300**
Pennsylvania	$209,569,821	$184,820,673		$236,319,000	$236,319,000	**$259,950,900**
Rhode Island	$79,156,889	$14,931,170	$75,083,187	$75,209,000	$79,156,889	**$87,072,577**
South Carolina	$44,561,856	$75,734,488		$46,699,000	$75,734,488	**$83,307,937**
South Dakota	$14,566,535	$11,077,958		$14,289,000	$14,566,535	**$16,023,189**
Tennessee	$27,482,040	$104,927,830		$29,076,000	$104,927,830	**$115,420,613**
Texas	$421,821,784	$606,594,053		$643,088,000	$643,088,000	**$707,396,800**

A	B	C	D	E	F = max (B,C,D,E)	G = F * 1.1
State	FY2007 spending (based on May 2007 submission), times annual adjustment	FY2007 allotment, times annual adjustment	For FY2007 shortfall states, FY2007 spending projected in Nov. 2006 (May 2006 for North Carolina), times annual adjustment	States' own FY2008 projected spending (based on May 2007 submission)	Greatest of preceding four columns	Projected FY2008 Allotments
Utah	$48,993,385	$43,905,964		$57,584,000	$57,584,000	**$63,342,400**
Vermont	$3,827,120	$6,097,673		$3,899,000	$6,097,673	**$6,707,440**
Virginia	$118,582,042	$101,427,991		$116,818,000	$118,582,042	**$130,440,246**
Washington	$29,355,818	$85,632,275		$28,885,000	$85,632,275	**$94,195,503**
West Virginia	$37,562,134	$29,374,315		$39,991,000	$39,991,000	**$43,990,100**
Wisconsin	$103,087,713	$74,399,113	$105,959,371	$104,333,000	$105,959,371	**$116,555,308**
Wyoming	$8,242,851	$7,407,856		$9,069,000	$9,069,000	**$9,975,900**
Puerto Rico						**$68,981,082**
Guam						**$3,870,364**
Virgin Islands	N/A	N/A	N/A	N/A	N/A	**$2,294,398**
Amer. Samoa						**$1,889,994**
CNMI						**$1,792,913**
Total	**$6,718,980,137**	**$5,362,039,232**	**$2,599,658,816**	**$7,264,091,000**	**$7,900,459,055**	**$8,769,333,711**

Source: Congressional Research Service (CRS) analysis of S. 1893/H.R. 976 using data from states' May 2007 (and earlier) submissions of projected expenditures to the Centers for Medicare and Medicaid Services (CMS), U.S. Health and Human Services' National Health Expenditure projections [http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf], and U.S. Census Bureau projections of child population growth by state [http://www.census.gov/population/projections/DownldFile3.xls]

Note: Actual allotments may vary depending on more recent projections (for example, states' submission for August 2007). The assumptions used are described in the body of this memorandum.

Currently Projected Federal SCHIP Funds Available in FY2008 Based on S. 1893/H.R. 976

Besides the FY2008 allotments, states in FY2008 may also have balances from redistributed FY2005 allotments and from states' own unspent FY2006 and FY2007 allotments, based on S. 1893/H.R. 976. The projections of these available balances are based on the descriptions below. The current projections of the impact of these policies is shown in **Table 2**, with total available federal SCHIP funds shown in the penultimate column, compared to the states' own projected spending levels for FY2008 (as provided in the May 2007 submission). These projections do not take into account federal funds that might be available from other possible sources provided in the legislation (for example, from the Incentive Pool or the Contingency Fund, described in Sections 105 and 108 respectively in legislation).

Redistribution of Unspent FY2005 Allotments. Under the Senate bill (as under current law), any FY2005 allotment funds unspent funds at the end of FY2007 are to be redistributed to other states. Under the Senate bill, unspent FY2005 funds will go to states that met the third criteria in the base FY2008 allotment formula — that is, states that (1) receive federal SCHIP funds in FY2007 for a shortfall, (2) had May 2006 projections of federal SCHIP expenditures that were $95 million to $96 million higher than its November 2006 projection, or (3) were projected to be a shortfall state in FY2007 based on states' November 2006 projection. For these states, the unspent FY2005 funds are redistributed in proportion to their FY2007 allotment.

Current projections are that approximately $93 million in unspent FY2005 funds would be available for redistribution at the end of FY2007 and would be redistributed among the 15 states shown in column C of **Table 2**.

Retention of Unspent FY2006 and FY2007 Allotments. Under the Senate bill, a state's available balances of unspent FY2006 and FY2007 allotments in FY2008 cannot exceed 50% of its FY2008 allotment. **Table 2** shows the current projections of the FY2006 and FY2007 allotments that would be forgone and that would be retained under the policy.

Table 2 shows the currently projected federal SCHIP funds available in FY2008 under the Senate bill, including the FY2008 allotment, compared to states' own projected FY2008 federal SCHIP spending as submitted in May 2007. Based on these estimates, no shortfalls are currently projected to occur in FY2008; states' available federal SCHIP funds under The Senate bill exceed their currently projected spending for FY2008.

Table 2. Projected Federal SCHIP Funds Available in FY2008 Under S. 1893/H.R. 976

A	B	C	D	E = 50% * B	F = positive(D-E)	G = D - F	H = B + C + G	I
State	Projected FY2008 allotments (from Table 1)	Redistribution of unspent FY2005 allotments	Unspent FY06 and FY07 allotments	Threshold for unspent FY2006-2007 allotments: 50% of FY08 allotment	FY06 and FY07 allotments forgone	FY06 and FY07 retained	Projected federal SCHIP funds available in FY2008	States' own FY08 projected spending (based on May 07 submission)
Alabama	$123,801,700	$0	$45,070,111	$61,900,850	$0	$45,070,111	$168,871,811	$112,547,000
Alaska	$35,592,434	$972,806	$0	$17,796,217	$0	$0	$36,565,240	$19,563,000
Arizona	$153,672,379	$0	$37,856,464	$76,836,190	$0	$37,856,464	$191,528,843	$124,283,000
Arkansas	$128,147,800	$0	$55,629,689	$64,073,900	$0	$55,629,689	$183,777,489	$116,498,000
California	$1,375,976,905	$0	$111,733,586	$687,988,453	$0	$111,733,586	$1,487,710,491	$1,225,533,000
Colorado	$84,863,998	$0	$101,567,030	$42,431,999	$59,135,031	$42,431,999	$127,295,996	$74,967,000
Connecticut	$46,787,947	$0	$74,425,669	$23,393,974	$51,031,695	$23,393,974	$70,181,921	$27,478,000
Delaware	$13,079,129	$0	$17,764,133	$6,539,564	$11,224,569	$6,539,564	$19,618,693	$8,998,000
DC	$13,779,381	$0	$20,169,651	$6,889,690	$13,279,961	$6,889,690	$20,669,071	$9,662,000
Florida	$352,866,278	$0	$455,876,804	$176,433,139	$279,443,665	$176,433,139	$529,299,416	$259,735,000
Georgia	$406,400,210	$13,989,522	$0	$203,200,105	$0	$0	$420,389,732	$363,219,000
Hawaii	$22,384,595	$0	$13,821,482	$11,192,298	$2,629,184	$11,192,298	$33,576,893	$19,548,000
Idaho	$34,219,900	$0	$35,913,159	$17,109,950	$18,803,209	$17,109,950	$51,329,850	$31,109,000
Illinois	$680,923,108	$17,691,372	$0	$340,461,554	$0	$0	$698,614,481	$464,118,000
Indiana	$110,272,807	$0	$137,880,908	$55,136,404	$82,744,504	$55,136,404	$165,409,211	$73,494,000
Iowa	$82,410,900	$3,055,553	$0	$41,205,450	$0	$0	$85,466,453	$74,919,000
Kansas	$56,566,400	$0	$18,455,292	$28,283,200	$0	$18,455,292	$75,021,692	$51,424,000
Kentucky	$92,935,859	$0	$65,259,358	$46,467,929	$18,791,429	$46,467,929	$139,403,788	$83,030,000
Louisiana	$140,701,000	$0	$43,530,239	$70,350,500	$0	$43,530,239	$184,231,239	$127,910,000
Maine	$30,948,168	$1,279,569	$0	$15,474,084	$0	$0	$32,227,737	$24,950,000
Maryland	$188,861,200	$5,647,354	$0	$94,430,600	$0	$0	$194,508,554	$171,692,000
Massachusetts	$304,778,100	$6,184,939	$0	$152,389,050	$0	$0	$310,963,039	$277,071,000
Michigan	$210,283,880	$0	$36,206,053	$105,141,940	$0	$36,206,053	$246,489,933	$185,856,000
Minnesota	$96,429,300	$3,099,973	$0	$48,214,650	$0	$0	$100,529,273	$87,663,000
Mississippi	$141,831,793	$5,102,000	$0	$70,915,896	$0	$0	$146,933,792	$116,760,000
Missouri	$137,098,500	$6,084,184	$3,302,416	$68,549,250	$0	$3,302,416	$146,485,100	$124,635,000
Montana	$27,830,000	$0	$13,575,788	$13,915,000	$0	$13,575,788	$41,405,788	$25,300,000
Nebraska	$39,743,073	$1,846,293	$615,136	$19,871,537	$0	$615,136	$42,204,503	$34,436,000
Nevada	$62,821,482	$0	$89,882,161	$31,410,741	$58,471,420	$31,410,741	$94,232,223	$38,880,000
New Hampshire	$12,684,276	$0	$15,930,630	$6,342,138	$9,588,492	$6,342,138	$19,026,414	$9,555,000
New Jersey	$373,354,300	$8,872,894	$0	$186,677,150	$0	$0	$382,227,194	$339,413,000
New Mexico	$117,438,200	$0	$77,269,074	$58,719,100	$18,549,974	$58,719,100	$176,157,300	$106,762,000

A	B	C	D	E = 50% * B	F = positive(D-E)	G = D - F	H = B + C + G	I
State	Projected FY2008 allotments (from Table 1)	Redistribution of unspent FY2005 allotments	Unspent FY06 and FY07 allotments	Threshold for unspent FY2006-2007 allotments: 50% of FY08 allotment	FY06 and FY07 allotments forgone	FY06 and FY07 retained	Projected federal SCHIP funds available in FY2008	States' own FY08 projected spending (based on May 07 submission)
New York	$456,739,800	$0	$430,558,011	$228,369,900	$202,188,111	$228,369,900	$685,109,700	$415,218,000
North Carolina	$316,300,908	$11,479,884	$13,731,005	$158,150,454	$0	$13,731,005	$341,511,797	$197,532,000
North Dakota	$13,454,836	$0	$865,167	$6,727,418	$0	$865,167	$14,320,003	$7,669,000
Ohio	$233,421,100	$0	$58,740,292	$116,710,550	$0	$58,740,292	$292,161,392	$212,201,000
Oklahoma	$129,031,100	$0	$29,990,434	$64,515,550	$0	$29,990,434	$159,021,534	$117,301,000
Oregon	$107,693,300	$0	$59,858,202	$53,846,650	$6,011,552	$53,846,650	$161,539,950	$97,903,000
Pennsylvania	$259,950,900	$0	$142,351,938	$129,975,450	$12,376,488	$129,975,450	$389,926,350	$236,319,000
Rhode Island	$87,072,577	$1,179,297	$0	$43,536,289	$0	$0	$88,251,875	$75,209,000
South Carolina	$83,307,937	$0	$112,321,749	$41,653,969	$70,667,780	$41,653,969	$124,961,906	$46,699,000
South Dakota	$16,023,189	$0	$2,030,484	$8,011,594	$0	$2,030,484	$18,053,673	$14,289,000
Tennessee	$115,420,613	$0	$177,866,480	$57,710,306	$120,156,174	$57,710,306	$173,130,919	$29,076,000
Texas	$707,396,800	$0	$1,012,721,814	$353,698,400	$659,023,414	$353,698,400	$1,061,095,200	$643,088,000
Utah	$63,342,400	$0	$34,061,025	$31,671,200	$2,389,825	$31,671,200	$95,013,600	$57,584,000
Vermont	$6,707,440	$0	$9,803,065	$3,353,720	$6,449,345	$3,353,720	$10,061,160	$3,899,000
Virginia	$130,440,246	$0	$66,114,475	$65,220,123	$894,352	$65,220,123	$195,660,370	$116,818,000
Washington	$94,195,503	$0	$144,588,787	$47,097,751	$97,491,036	$47,097,751	$141,293,254	$28,885,000
West Virginia	$43,990,100	$0	$23,532,242	$21,995,050	$1,537,192	$21,995,050	$65,985,150	$39,991,000
Wisconsin	$116,555,308	$5,866,829	$0	$58,277,654	$0	$0	$122,422,137	$104,333,000
Wyoming	$9,975,900	$0	$9,804,923	$4,987,950	$4,816,973	$4,987,950	$14,963,850	$9,069,000
Total	**$8,769,333,711**	**$93,352,469**	**$3,800,674,924**	**$4,345,252,480**	**$1,807,695,373**	**$1,992,979,551**	**$10,776,836,981**	**$7,264,091,000**

Source: Congressional Research Service (CRS) analysis of S. 1893/H.R. 976 using data from states' May 2007 (and earlier) submissions of projected expenditures to the Centers for Medicare and Medicaid Services (CMS), U.S. Health and Human Services' National Health Expenditure projections [http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf], and U.S. Census Bureau projections of child population growth by state [http://www.census.gov/population/projections/DownldFile3.xls].

Note: Does not include funds that may be available to states through the Incentive Pool or the Contingency Fund, as described in S. 1893/H.R. 976. Actual amounts may vary depending on more recent projections (for example, states' submission for August 2007).

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