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Medicaid, SCHIP, and Health Insurance: FY2008 Budget Issues

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Medicaid, SCHIP, and Health Insurance: FY2008 Budget Issues

Summary

Each year, the President is required to submit a comprehensive federal budget proposal to Congress no later than the first Monday in February. The House and Senate Budget Committees then develop their respective budget resolutions. Differences between the houses are supposed to be resolved by April 15, but this deadline is rarely met. Although it is not binding, the resolution provides a framework for subsequent legislative action.

The President's FY2008 budget contains a number of proposals that would affect Medicaid and the State Children's Health Insurance Program (SCHIP). While certain proposals would require legislative action, others would be implemented administratively (e.g., via regulatory changes, issuance of program guidance, or other possible methods). The President's budget also contains a number of proposals that would affect health insurance.

On May 17, 2007, the House and Senate adopted a conference agreement on the budget resolution (H.Rept. 110-153 accompanying S.Con.Res. 21). The FY2008 budget resolution provides a reserve fund of up to $50 billion for SCHIP legislation that is deficit-neutral in the Senate and deficit/surplus-neutral in the House, a variety of other deficit-neutral reserve funds, up to $383 million for health care fraud and abuse control, and two "sense of the Congress" provisions regarding health care cost growth and affordable health coverage.

To date, a number of Medicaid and SCHIP issues have seen legislative action in the 110th Congress. P.L. 110-28, P.L. 110-48, P.L. 110-90, and P.L. 110-173 included provisions to address SCHIP funding, delay implementation of certain Medicaid administrative proposals, require (and subsequently delay) the use of tamper-resistant pads for Medicaid prescriptions, provide a Medicaid Pharmacy Plus waiver extension, temporarily extend Medicaid transitional medical assistance and the QI-1 program, apply an asset verification pilot to Medicaid for five years, and extend Medicaid disproportionate share hospital payments for Tennessee and Hawaii.

On the issue of SCHIP reauthorization, numerous bills have been introduced, including the Senate-passed S. 1893/H.R. 976 and the House-passed H.R. 3162. A bicameral agreement on SCHIP reauthorization was passed as an amendment to H.R. 976 and then vetoed by President Bush on October 3. A modified version of the agreement was passed as H.R. 3963 and then vetoed on December 12. In lieu of reauthorization, continuing resolutions (P.L. 110-92, P.L. 110-116, P.L. 110-137, P.L. 110-149) contained temporary FY2008 appropriations for SCHIP allotments through December 31, 2007. P.L. 110-173 provides appropriations through March 31, 2009.

This report will be updated to reflect relevant activity until the President's FY2009 budget is released.

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Introduction

Each year, the President is required to submit a comprehensive federal budget proposal to Congress no later than the first Monday in February. Once it is submitted, the Congressional Budget Office (CBO) analyzes the proposal using its own economic assumptions and estimation techniques. The House and Senate Budget Committees then develop their respective budget resolutions after reviewing the President's budget, the views of other committees, and information from CBO. Differences between the houses are supposed to be resolved by April 15, but this deadline is rarely met. Although it is not binding, the resolution provides a framework for subsequent legislative action.

This report provides information on Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance issues. It will be updated to reflect relevant activity until the President's FY2009 budget is released. Congressional Research Service (CRS) staff contact information by topic area is provided in **Tables 3** and **4** at the end of the report.

Medicaid and SCHIP in the President's FY2008 Budget

The President's FY2008 budget contains a number of proposals that would affect Medicaid and SCHIP. Some are program expansions, and others are designed to reduce federal spending. For each of the proposals, this report provides:

- background;
- a description of the proposal based on available information;[1]
- a description of recent action (if any); and
- a list of relevant CRS reports.

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[1] Sources include Department of Health and Human Services (HHS), *Fiscal Year 2008 Budget in Brief*, available at [http://www.hhs.gov/budget/docbudget.htm]; Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2008*, available at [http://www.whitehouse.gov/omb/budget/fy2008/]; and HHS, Centers for Medicare and Medicaid Services, *Fiscal Year 2008 Justification of Estimates for Appropriations Committees*, available at [http://www.hhs.gov/budget/pdf/FY2008CMSCJ.pdf].

The proposals generally are presented in the order in which they appear in the Department of Health and Human Services' (HHS) *Fiscal Year 2008 Budget in Brief*. The description of each proposal includes HHS and CBO estimates of its cost or savings in FY2008 and over the FY2008-FY2012 period. These estimates are summarized in **Table 1**.

As described below, proposals that have seen recent legislative or administrative action include:

- Medicaid: Require Tamper-Resistant Prescription Pads;
- Medicaid: Expand Asset Verification System;
- Medicaid: Transitional Medical Assistance;
- Medicaid: Extend Qualified Individual Program;
- Medicaid: Revise Payments for Government Providers;
- Medicaid: School-Based Services;
- Medicaid: Eliminate Medicaid Graduate Medical Education;
- Medicaid: Clarify Rehabilitation Services;
- Medicaid: Clarify Provider Tax Policy; and
- SCHIP: Reauthorization.

Legislative Versus Administrative Proposals

As shown in **Table 1**, some of the President's proposals would require legislative action, while others would be implemented administratively (e.g., via regulatory changes, issuance of program guidance, etc.).

In their analyses of the President's budget, both CBO and executive branch agencies such as HHS and the Office of Management and Budget (OMB) provide baseline (current law) estimates of Medicaid and SCHIP spending along with estimated costs and savings of proposed changes. However, CBO and the executive branch differ in their treatment of legislative and administrative proposals.

In executive branch documents describing the President's budget, implementation of proposed administrative changes is assumed in estimates of baseline Medicaid and SCHIP spending,[2] and estimates for legislative proposals are presented separately. In general, CBO assesses the likelihood that a particular administrative action will take place before adjusting its baseline,[3] and only provides separate estimates for legislative proposals. For this reason and others, CBO and executive branch estimates of Medicaid and SCHIP spending will differ.

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[2] For a description of adjustments made to arrive at baseline Medicaid expenditures, see HHS, *Fiscal Year 2008 Justification of Estimates for Appropriations Committees*, pp. 125-131.

[3] CBO, letter to the Honorable John M. Spratt Jr., May 2, 2007, available at [http://www.cbo.gov/ftpdocs/80xx/doc8060/05-02-LetterOnRegs.pdf].

Table 1. Cost (Savings) of Medicaid and SCHIP Proposals in the President's FY2008 Budget

Proposal	Outlays in millions			
	HHS estimate		CBO estimate	
	FY2008	FY2008-FY2012	FY2008	FY2008-FY2012
Medicaid				
Legislative proposals	($1,942)	($13,016)	($2,273)	($19,600)
Streamline administrative match rates	(945)	(5,315)	(1,160)	(8,380)
Implement cost allocation	(280)	(1,770)	(280)	(1,770)
Require state reporting and link performance to reimbursement	0	(330)	0	(350)
Reimburse targeted case management at 50%	(200)	(1,160)	(225)	(1,370)
Rationalize pharmacy reimbursement	(160)	(1,200)	(325)	(2,225)
Allow optional managed formulary	(160)	(870)	(10)	(175)
Require tamper-resistant prescription pads	(35)	(210)	(15)	(150)
Replace best price with budget-neutral rebate	0	0	0	0
Expand asset verification demonstration	(65)	(640)	(50)	(460)
Enhance third party liability	(10)	(85)	(40)	(235)
Define home equity limit at $500,000	(70)	(430)	(70)	(415)
Extend Section 1915(b) waiver period	0	0	—	—
Modify HIPAA	0	0	—	—
Extend TMA (Medicaid impact)	460	665	470	965
Extend Qualified Individual program (net Medicaid impact)	0	0	76	0
Other legislative proposals with an impact on Medicaid				
Refugee extension exemption	33	99	5	12
Funding for disability reviews	—	—	(48)	(1,502)
SCHIP reauthorization (Medicaid impact)	(510)	(1,770)	(601)	(3,545)
Administrative proposals	(1,515)	(12,715)	—	—
Revise payments for government providers	(530)	(5,000)	—	—
School-based services — eliminate administration and transportation	(615)	(3,645)	—	—
Eliminate graduate medical education	(140)	(1,780)	—	—
Clarify rehabilitation services	(230)	(2,290)	—	—
Issue guidance defining 1915(b)(3) services	0	0	—	—
Third party liability — eliminate pay and chase for pharmacy	0	0	—	—
Clarify provider tax policy	0	0	—	—
Codify disproportionate share hospital provisions in regulation	0	0	—	—
SCHIP				
Legislative proposals	1,220	5,930	933	5,457
SCHIP reauthorization (SCHIP impact)	1,220	5,930	939	5,463
Other legislative proposals with an impact on SCHIP				
Extend TMA (SCHIP impact)	—	—	(6)	(6)
Total Medicaid and SCHIP	(2,237)	(19,801)	(1,340)	(14,143)
Health Care Fraud and Abuse Control account (Medicaid and SCHIP financial management)	10.1	10.1	—	—

Source: Department of Health and Human Services, *Fiscal Year 2008 Budget in Brief*, available at [http://www.hhs.gov/budget/docbudget.htm], and Congressional Budget Office, *CBO Estimates of Medicaid and SCHIP Proposals in the President's Budget for Fiscal Year 2008*, available at [http://cbo.gov/budget/factsheets/2007b/medicaid_schip_pres.pdf].

Note: Numbers in parentheses represent savings. Estimates for proposals that do not show a dollar figure were not provided in the documents cited above. In executive branch documents describing the President's budget, implementation of proposed administrative changes is assumed in estimates of baseline Medicaid and SCHIP spending, and estimates for legislative proposals are presented separately. In general, CBO only adjusts its baseline estimates to account for administrative changes as they are implemented — rather than as they are proposed — and only provides separate estimates for legislative proposals.

Medicaid: Streamline Administrative Match Rates

Background. The federal government pays a share of every state's spending on Medicaid services and program administration. For Medicaid services, this share is called the federal medical assistance percentage (FMAP). The FMAP is based on a formula that provides higher reimbursement to states with lower per capita incomes (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal match. Functions with a 75% federal match include:

- compensation or training of skilled professional medical personnel (and their direct support staff) of the state Medicaid or other public agency;
- preadmission screening and resident review for individuals with mental illness or mental retardation who are admitted to a nursing facility;
- survey and certification of nursing facilities;
- operation of an approved Medicaid Management Information System (MMIS) for claims and information processing;
- performance of medical and utilization review activities or external independent review of managed care activities; and
- operation of a state Medicaid fraud control unit (MFCU).

In the case of MMISs and MFCUs, the federal match is 90% for startup expenses. There is a 100% match for the implementation and operation of immigration status verification systems. Section 1903(a)(7) of the Social Security Act specifies that a 50% match will be provided for remaining expenditures that are found necessary by the Secretary of HHS for the proper and efficient administration of the state Medicaid program.

Proposal. The President's budget seeks legislation to align all administrative reimbursement rates in Medicaid at 50%. HHS estimates that the proposal would save $945 million in FY2008, and $5.315 billion over the FY2008-FY2012 period. CBO estimates that the proposal would save $1.160 billion in FY2008, and $8.380 billion over the FY2008-FY2012 period.

Reports. See CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*, by April Grady.

Medicaid: Implement Cost Allocation

Background. Because of the overlap in eligible populations, states often undertake administrative activities that benefit more than one program. Under the former Aid to Families with Dependent Children (AFDC) cash welfare program, AFDC and Medicaid program eligibility were linked, and many AFDC families also qualified for food stamps. As a result, states often collected necessary information for all three programs during a single eligibility interview or performed other shared administrative tasks and charged the full amount of the cost to AFDC as a matter of convenience. Since the federal government reimbursed states for 50% of administrative expenditures for all three programs, total federal spending was not affected by the way in which states allocated the programs' common administrative costs.

When Congress replaced AFDC with the Temporary Assistance for Needy Families (TANF) block grant program in 1996, the 50% federal match for expenditures related to cash welfare assistance ended and the automatic link between cash welfare and Medicaid eligibility was severed. Later, HHS clarified that states are required to allocate common administrative costs for TANF, Medicaid, and food stamps based on the relative benefits derived by each program. A remaining issue of controversy stems from the fact that TANF block grants are calculated in part on the basis of pre-1996 federal welfare spending, including any amounts received by states as reimbursement for common administrative costs. As a result, TANF block grants are higher in many states than they would be if common administrative costs attributable to Medicaid and food stamps were excluded from block grant calculations. To compensate, Congress has permanently reduced federal reimbursement for food stamp administrative costs in most states by a flat dollar amount that reflects the administrative costs attributable to food stamps that are included in each state's TANF block grant (the annual reductions total nearly $200 million). Congress has not reduced federal reimbursement for Medicaid administrative costs in a similar manner.

Proposal. The President's budget seeks legislation to recoup Medicaid administrative costs assumed in states' TANF block grants. HHS and CBO both estimate that the proposal would save $280 million in FY2008, and $1.770 billion over the FY2008-FY2012 period.

Reports. See CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*, by April Grady.

Medicaid: Require State Reporting and Link Performance to Reimbursement

Background. The Budget Act of 1997 mandated performance monitoring as a tool for ensuring the delivery of quality services in Medicaid and SCHIP. Among several initiatives, the Centers for Medicare and Medicaid Services (CMS) formed the Performance Measurement Partnership Project (PMPP) to select a common set of measures that can be used by Medicaid and SCHIP programs on a voluntary basis to assess the quality of care.

Proposal. The President's budget proposal would seek legislation to require states to monitor and report on Medicaid performance measures aimed at improving quality of care, program integrity, and efficiency, and would link performance to federal Medicaid grant awards. Reporting would begin in FY2008 with a three-year phase-in for each of the measures. Beginning in 2011, states that fail to meet targeted thresholds for each performance measure would be subject to an FMAP or Medicaid grant award reduction, depending on the performance measure. These reductions would remain in effect until the state meets the designated thresholds for specific performance measures. Budget documents further indicate that performance measures currently being considered include increasing estate recovery collection rates and reducing the prevalence of daily physical restraints in nursing homes. For this proposal, HHS estimates no cost impact in FY2008, and a savings of $330 million over the FY2008-FY2012 period. CBO estimates no cost impact in FY2008, and a savings of $350 million over the FY2008-FY2012 period.

Reports. Currently, no other CRS reports address this topic.

Medicaid: Reimburse Targeted Case Management at 50 Percent Rate

Background. Under current law, case management is an optional benefit under the Medicaid state plan that assists Medicaid beneficiaries in gaining access to needed medical, social, educational and other services. The term "targeted case management" refers to situations in which these services are not provided statewide to all Medicaid beneficiaries but rather are provided only to specific classes of individuals (e.g., those with AIDS, tuberculosis, chronic physical or mental illness, developmental disabilities, or children in foster care) or to persons who reside in a specific area. The federal government matches payments for such services using the federal medical assistance percentage (FMAP), which is the rate applicable to Medicaid benefits. FMAPs can range from 50% to 83% (statutory upper boundary) depending on the state. In FY2008, 13 states will have an FMAP equal to 50%.

Case management can also be claimed as an administrative activity rather than as a Medicaid benefit. When claimed as an administrative service, the federal government matches case management at the 50% rate applicable to most administrative services.

Proposal. The President's budget seeks legislation that would set the federal reimbursement rate for all case management activities at 50% to ensure that such services are reimbursed in a cost effective and efficient manner. The Administration maintains that case management activities are inherently the same, regardless of how federal matching funds are claimed, and that the availability of different matching rates has resulted in states choosing to submit claims for case management that will yield the highest reimbursement rate. For example, states may claim case management services as a benefit rather than as an administrative activity when the FMAP for the state is higher than the standard 50% match rate for administrative activities. HHS estimates that the proposal would save $200 million in FY2008, and $1.160 billion over the FY2008-FY2012 period. CBO estimates that the proposal

would save $225 million in FY2008 and $1.370 billion over the FY2008-FY2012 period.

Reports. For general information on Medicaid administrative costs, see CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*, by April Grady.

Medicaid: Rationalize Pharmacy Reimbursement

Background. Under current law, state Medicaid programs set the prices paid to pharmacies for Medicaid outpatient drugs. Federal reimbursements for those drugs, however, are limited to a federal upper limit (FUL). The FUL that applies to drugs available from multiple sources (generic drugs, for the most part) is calculated by CMS to be equal to 250% of the average manufacturer's price (AMP, the average price paid by wholesalers to manufacturers) as reported to CMS by the manufacturers.

Proposal. The President's budget seeks legislation that would build on changes made by the Deficit Reduction Act of 2005 (DRA) to achieve additional savings in the Medicaid program. The proposal would reduce the FULs on multiple source drugs from 250% of the AMP to 150% of the AMP of the lowest priced drug in the group. HHS estimates that the proposal would save $160 million in FY2008, and $1.200 billion over the FY2008-FY2012 period. CBO estimates that the proposal would save $325 million in FY2008 and $2.225 billion over the FY2008-FY2012 period.

Reports. For more information on the Medicaid provisions of DRA 2005, see CRS Report RL33131, *Budget Reconciliation FY2006: Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP) Provisions*, by Evelyne P. Baumrucker, et al. and CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*, by Karen Tritz et al. Additional background information on Medicaid prescription drugs can be found in CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

Medicaid: Allow Optional Managed Formulary

Background. Federal statute allows state Medicaid programs to establish formularies, or lists of preferred pharmaceuticals to be made available to Medicaid beneficiaries. When health care insurers or providers cover only those drugs on the list and deny payment for others, the list is referred to as a "closed formulary." Medicaid formularies are seldom as restrictive as the closed formularies found in the private market for insurance because of two requirements: (1) states are required to provide any non-formulary drug (with the exception of drugs in specific categories, described below) that is specifically requested and approved through a prior authorization process, and (2) states are required to cover all drugs offered by manufacturers entering into rebate agreements with the Secretary of HHS.

States, on the other hand, are permitted to exclude certain categories of drug products from Medicaid coverage. These include drugs used: (a) to treat anorexia, weight loss or weight gain; (b) to promote fertility; (c) for cosmetic purposes or hair growth; (d) for the relief of coughs and colds; (e) for smoking cessation; and (f) prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations); (g) non-prescription drugs; (h) barbiturates; (i) benzodiazepines; and (j) drugs requiring tests or monitoring that can only be provided by the drug manufacturer. Formularies may also exclude a drug for which there is no significant therapeutic advantage over other drugs that are included in the formularies as long as there is a written explanation of the reason for its exclusion and the explanation is available to the public. As of January 1, 2006, federal law also prohibits federal Medicaid funds from being used to pay for drugs for the treatment of sexual or erectile dysfunction.

Proposal. The President's budget seeks legislation to allow states to use private sector management techniques to leverage greater discounts through negotiations with drug manufacturers. The "managed formulary" is described as a list of prescription drug products that are not covered under the program. HHS estimates that the proposal would save $160 million in FY2008, and $870 million over the FY2008-FY2012 period. CBO estimates that the proposal would save $10 million in FY2008 and $175 million over the FY2008-FY2012 period.

Reports. For a general background on Medicaid prescription drug benefits, formularies, and other cost control mechanisms used in administering those benefits, see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

Medicaid: Require Tamper-Resistant Prescription Pads

Background. There are currently no federal Medicaid laws or rules regarding the use of prescription pads. Thirteen states, however, utilize tamper-resistant pads.

Proposal. The President's budget proposed to require all states where providers use hand-written prescription pads to use "tamper-resistant" pads. HHS estimates that the proposal would save $35 million in FY2008, and $210 million over the FY2008-FY2012 period. CBO estimates that the proposal would save $15 million in FY2008, and $150 million over the FY2008-FY2012 period.

Recent Action. A war supplemental appropriations bill that was vetoed on May 1, 2007 (H.R. 1591), included a provision that would have required the use of tamper-resistant pads for Medicaid prescriptions. A subsequent war supplemental enacted on May 25 (P.L. 110-28) included the same provision, which will apply to prescriptions executed after September 30, 2007. Legislation to delay implementation of the new requirement for six months (P.L. 110-90) was enacted at the end of September.

Reports. For a general background on Medicaid prescription drug benefits, formularies, and other cost control mechanisms used in administering those benefits,

see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

Medicaid: Replace Best Price with Budget Neutral Rebate

Background. Under Medicaid, drug manufacturers that wish to have their drugs available for Medicaid enrollees are required to enter into rebate agreements with the Secretary of HHS, on behalf of the states. Under the agreements, pharmaceutical manufacturers must provide state Medicaid programs with rebates on drugs paid on behalf of Medicaid beneficiaries. The formulas used to compute the rebates are intended to ensure that Medicaid pays the lowest price that the manufacturers offer for the drugs. Rebate calculations depend on the type of drug. For single source and innovator multiple source drugs, basic rebate amounts are determined by comparing the average manufacturer price (AMP) for a drug (the average price paid by wholesalers) to the "best price," which is the lowest price offered by the manufacturer in the same period to any wholesaler, retailer, nonprofit, or public entity. The basic rebate is the greater of 15.1% of the AMP or the difference between the AMP and the best price. Additional rebates are required if the weighted average prices for all of a given manufacturer's single source and innovator multiple source drugs rise faster than inflation. For non-innovator multiple source drugs, basic rebates are equal to 11% of the AMP.

Proposal. The President's budget seeks legislation to eliminate the "best price" from the rebate formula for single source and innovator multiple source drugs, changing the best price-based formula to a flat rebate. This change is intended to be made in a budget neutral manner. HHS explanatory materials describe the proposal as a way to simplify drug rebate calculations and as a way to allow private purchasers to negotiate lower prices without affecting Medicaid drug costs. HHS and CBO both estimate that the proposal would have no cost impact in FY2008 or over the FY2008-FY2012 period.

Reports. For a general background on Medicaid prescription drug coverage and pricing including a description of drug rebates, see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

Medicaid: Expand Asset Verification System

Background. The Social Security Administration is piloting a financial account verification system (in field offices located in New York and New Jersey) that uses an electronic asset verification system to help confirm that individuals who apply for Supplemental Security Income (SSI) benefits are eligible. The process permits automated paperless transmission of asset verification requests between SSA field offices and financial institutions. Part of this pilot involved a comprehensive study to measure the value of such a system for SSI applicants as well as recipients already on the payment rolls. This study identified a small percentage (about 5 percent) of applicants and recipients who were overpaid based on this financial account verification system.

Proposal. The President's budget seeks legislation to expand the SSA pilot to CMS programs whose eligibility criteria include limitations on financial resources. CMS would work with states to establish Medicaid pilots in the same locations as SSA. HHS estimates that the proposal would save $65 million in FY2008, and $640 million over the FY2008-FY2012 period. CBO estimates that the proposal would save $50 million in FY2008 and $460 million over the FY2008-FY2012 period.

Recent Action. H.R. 3162, the SCHIP reauthorization bill passed by the House on August 1, would implement a similar proposal. Legislation (P.L. 110-90) to apply the SSA pilot to Medicaid beginning on October 1, 2007, and ending on September 30, 2012, was enacted at the end of September. Two SCHIP bills vetoed by President Bush (H.R. 976 and H.R. 3963) would have applied the pilot beginning on October 1, 2012.

Reports. For information on the provisions in SCHIP reauthorization legislation, see CRS Report RL34129, *Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R. 976*, by Evelyne Baumrucker et al.

Medicaid: Enhance Third Party Liability

Background. Third party liability (TPL) refers to the legal obligation of third parties — individuals, entities, or programs — to pay all or part of the expenditures for medical assistance furnished under Medicaid. In general, federal law requires Medicaid to be the payer of last resort, meaning that all other available third parties must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual.

States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state Medicaid plan. If a state has determined that probable liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third-party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase").

States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay-and-chase method. However, there are two statutory exceptions to this rule. In the case of prenatal and preventive pediatric care, states are required to use pay and chase. In the case of a Medicaid beneficiary whose parent provides medical support (e.g., health insurance coverage via an employer) as part of a child support order being enforced by the state, the state must use pay and chase if a provider has not been paid under the medical support arrangement within 30 days.

In some cases, a Medicaid beneficiary may be required to reimburse the state for Medicaid expenses paid on his or her behalf. To facilitate such reimbursement, the state may place a lien on the Medicaid beneficiary's property. With certain exceptions, federal law generally prohibits states from imposing Medicaid liens on

the property of living beneficiaries. In contrast, federal law permits Medicaid liens on the estates of deceased beneficiaries in a wider variety of situations.

Proposal. The President's budget seeks legislation to allow states to avoid costs for prenatal and preventive pediatric claims where a third party is responsible; collect for medical child support where a health insurance is derived from a non-custodial parent's obligation to provide coverage; and recover Medicaid expenditures from beneficiary liability settlements. HHS estimates that the proposal would save $10 million in FY2008 and $85 million over the FY2008-FY2012 period. CBO estimates that the proposal would save $40 million in FY2008 and $235 million over the FY2008-FY2012 period.

Reports. Currently, no other CRS reports address this topic.

Medicaid: Define Home Equity Limit at $500,000

Background. The Deficit Reduction Act of 2005 amended the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than $500,000. Under the law, the state may elect without regard to Medicaid's requirements concerning statewideness and comparability, to substitute an amount that exceeds $500,000 but does not exceed $750,000. These dollar amounts are increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest $1,000. The Secretary establishes a process for waiving this provision in the case of a demonstrated hardship. Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the Section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility.

Proposal. The President's budget seeks legislation that would limit the allowable home equity amount to $500,000 for all states by eliminating the state option to increase the equity limit to a number between $500,000 and $750,000. HHS estimates that the proposal would save $70 million in FY2008, and $430 million over the FY2008-FY2012 period. CBO estimates that the proposal would save $70 million in FY2008, and $415 million over the FY2008-FY2012 period.

Reports. For more information about home equity and Medicaid eligibility, see CRS Report RL33593, *Medicaid Coverage for Long-Term Care: Eligibility, Asset Transfers, and Estate Recovery*, by Julie Stone.

Medicaid: Extend Section 1915(b) Waiver Period

Background. Section 1915(b) of the Social Security Act gives the Secretary of HHS the authority to waive certain Medicaid program requirements (including statewideness, comparability of services, and freedom of choice of provider)[4] to

[4] "Freedom of choice" refers to a requirement that Medicaid beneficiaries have the freedom (continued...)

allow states to establish mandatory managed care programs that restrict the providers from whom a beneficiary may obtain covered services, or that create a "carve out" delivery system for specialty care as long as such programs do not negatively impact beneficiary access and quality of care of services. Prior to passage of the Balanced Budget Act of 1997 (BBA 97), a state had to obtain a Section 1115 or a Section 1915(b) ("freedom-of-choice") waiver from the Secretary of HHS if it wanted to require Medicaid recipients to enroll in a managed care program.[5]

Section 1915(b) waiver programs are generally approved for a two-year period and must be cost effective (cannot cost more than what the Medicaid program would have cost without the waiver). They may not be used to expand eligibility to individuals not otherwise eligible under the approved Medicaid state plan, but cost savings achieved under the waivers may used to provide additional services (i.e., those not typically provided under the state plan) to Medicaid beneficiaries.

Proposal. The President's budget seeks legislation to extend the renewal period for 1915(b) "freedom of choice" waivers from two years to three years. HHS estimates that the proposal would have no cost impact in FY2008 or over the FY2008-FY2012 period. CBO did not provide an estimate for the proposal.

Reports. For more information on Medicaid managed care, see CRS Report RL33711, *Medicaid Managed Care: An Overview and Key Issues for Congress* by Elicia J. Herz.

Medicaid: Modify the Health Insurance Portability and Accountability Act (HIPAA)

Background. The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established a number of rules for employer-based health insurance plans to improve access to and portability of plans for people enrolled or enrolling into those plans. One of those provisions requires employer-based health plans to allow for new enrollment into the plan during periods outside of the typical annual open enrollment period for certain special reasons. Examples of those reasons include when an eligible employee (or their dependent) exhausts COBRA continuation coverage, or when an employee gains a new dependent through birth or adoption. Another HIPAA provision limits the ability of private health insurance plans to exclude coverage for pre-existing conditions during what are known as "pre-existing condition exclusion periods." The allowable length of such pre-existing condition exclusion periods depends on the amount of time the new enrollee had

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[4] (...continued)
to choose their medical care providers. "Comparability" refers to a requirement that services be comparable in amount, duration, and scope for all persons in each eligibility group. "Statewideness" refers to the requirement that states provide services on a state-wide basis, rather than in only a portion of the state.

[5] BBA 97 granted states the flexibility to require enrollment of most Medicaid recipients into mandatory Medicaid managed care without a waiver so long as they offered beneficiaries a choice between at least two managed care organizations or two primary care case managers.

been covered by prior "creditable" health insurance coverage.[6] A beneficiary can prove they have had prior creditable coverage by providing certificates issued by insurers at the end of each year. Because HIPAA was created in law before SCHIP was established, SCHIP was not included on the list of types of health insurance that can be considered as prior creditable coverage.

Proposal. The President's budget seeks several legislative changes relating to HIPAA. The first would define a determination of Medicaid or SCHIP eligibility as a qualifying event allowing for a special enrollment period into employer-based health insurance plans. This provision is intended to improve Medicaid and SCHIP programs' ability to coordinate coverage with private employer-offered coverage. The second proposal would require SCHIP programs to issue certificates of creditable coverage. This provision is intended to improve the reach of HIPAA's portability provisions by recognizing SCHIP coverage as prior creditable coverage. Both of these interpretations have previously been promulgated in a final regulation implementing HIPAA's portability for group health plan provisions.[7] HHS estimates that the proposal would have no cost impact in FY2008 or over the FY2008-FY2012 period. CBO did not provide an estimate for the proposal.

Reports. For general information on HIPAA, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda Chaikind, Jean Hearne, Bob Lyke, and C. Stephen Redhead.

Medicaid: Transitional Medical Assistance

Background. States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation of benefits is known as transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections. It also permanently requires four months of TMA for families who lose Medicaid eligibility due to an increase in earned income or hours of employment.

However, Congress expanded work-related TMA benefits in 1988, requiring states to provide at least six, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard (such disregards allow families to qualify for Medicaid at higher income levels for a set period of time). Congress has acted on numerous occasions to extend these expanded TMA requirements (which are

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[6] Not all prior health insurance coverage is considered to be creditable. For a discussion of creditable coverage, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda R. Chaikind, Jean Hearne, Bob Lyke, and C. Stephen Redhead.

[7] 69 *Federal Register* 78720, *Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA* Titles I and IV, December 30, 2004.

outlined in Section 1925 of the Social Security Act) beyond their original sunset date of September 30, 1998. They are currently set to expire on June 30, 2007.

Proposal. The President's budget seeks legislation to extend expanded TMA requirements through September 30, 2008. HHS estimates that the President's proposal would cost Medicaid $35 million in FY2007, $460 million in FY2008, and $665 million over the FY2008-FY2012 period (the budgetary effects extend beyond FY2008 because families are still entitled to up to 12 months of TMA if they qualify on or before the expiration date). CBO estimates that the proposal would have no cost impact on Medicaid in FY2007 and that it would cost Medicaid $470 million in FY2008 and $965 million over the FY2008-FY2012 period; it also estimates that the proposal would have no cost impact on SCHIP in FY2007, and that it would cost SCHIP $6 million in FY2008 and $6 million over the FY2008-FY2012 period.

Recent Action. Legislation was enacted to extend TMA through September 30, 2007 (P.L. 110-48), December 31, 2007 (P.L. 110-90), and June 30, 2008 (P.L. 110-173). Although a provision to modify and extend TMA for four years was included in an SCHIP reauthorization bill passed by the House (H.R. 3162), it was not included in either of the SCHIP bills vetoed by President Bush (H.R. 976 and H.R. 3963). The FY2008 budget resolution also included a deficit-neutral reserve fund for extending TMA (see discussion at the end of this report).

Reports. See CRS Report RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by April Grady. For information on the provision in SCHIP reauthorization legislation, see CRS Report RL34129, *Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R. 976*, by Evelyne Baumrucker et al.

Medicaid: Extend Qualified Individual Program

Background. Congress requires state Medicaid programs to cover the Medicare Part B premiums for a certain group of low-income Medicare beneficiaries. The Qualifying Individual (QI-1) program includes individuals who would otherwise be Qualified Medicare Beneficiaries (QMBs) but whose income is between 120% and 135% of the federal poverty level. The Balanced Budget Act of 1997 established this group of eligibles for a temporary period between January 1998 and December 2002. Congress has extended eligibility for this group several times since its expiration. The most recent extension was authorized under the QI, TMA, and Abstinence Programs Extension and Hurricane Katrina Unemployment Relief Act of 2005 (P.L. 109-91), which extended the QI-1 program from September 2005 through September 2007. Without changes to current law, eligibility for this group would expire in September 2007.

Proposal. The President's budget seeks legislation to extend premium assistance for QI-1s through September 30, 2008. HHS estimates that the net cost to Medicaid would be zero in FY2008 and over the FY2008-FY2012 period (amounts paid by Medicaid for the Medicare Part B premium costs of QI-1s are offset by a reimbursement from Medicare Part B). CBO estimates that the proposal would cost Medicaid $76 million in FY2008, and that the net cost to Medicaid would be zero over the FY2008-FY2012 period.

Recent Action. Legislation was enacted to extend the QI-1 program through December 31, 2007 (P.L. 110-90), and June 30, 2008 (P.L. 110-173).

Reports. For more information about the QI-1 program, see CRS Report RL32977, *Dual Eligibles: A Review of Medicaid's Role in Providing Services and Assistance*, by Karen Tritz.

Medicaid: Refugee Exemption Extension

Background. Under current law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date, are not eligible for Supplemental Security Income (SSI) benefits — and thus, SSI-related Medicaid — until they have resided in the country for five years or have obtained citizenship. Refugees and asylees are currently exempted from this ban for the first seven years they reside in the United States.

Proposal. The President's budget seeks legislation to extend the exemption for refugees and asylees from seven years to eight years, allowing additional time for individuals to complete the citizenship process without penalty. HHS estimates that the proposal would cost $33 million in FY2008, and $99 million over the FY2008-FY2012 period. CBO estimates that the proposal would cost $5 million in FY2008, and $12 million over the FY2008-FY2012 period.

Reports. For general background information, see CRS Report RL31269, *Refugee Admissions and Resettlement Policy*, by Andorra Bruno; CRS Report RL31630, *Federal Funding for Unauthorized Aliens' Emergency Medical Expenses*, by Alison M. Siskin; and CRS Report RL33809, *Noncitizen Eligibility for Federal Public Assistance: Policy Overview and Trends*, Ruth Ellen Wasem.

Medicaid: Revise Payments for Government Providers

Background. Aggregate Medicaid payments to specific groups of institutional providers (e.g., hospitals and nursing facilities) cannot exceed a reasonable estimate of what would have been paid under Medicare payment principles. This is called the Medicaid upper payment limit (UPL) rule. In many states, Medicare payment rates for hospital and nursing home care are higher than corresponding Medicaid payment rates. The UPL based on Medicare payment principles has enabled some states to draw down additional federal dollars that exceed what they would have received based on Medicaid payment rates. These additional funds are paid to government providers which are sometimes required by states to transfer all or a portion of the extra payments received (i.e., some or all of the difference between the Medicare and Medicaid payment rates) back to the state through an intergovernmental transfer (IGT). Instead of financing more or improved Medicaid services, in some cases states have used the additional federal dollars for non-health services, or to make up part of the state share of Medicaid costs to draw down another round of federal dollars.

During 2000-2002, Congress and the Clinton and Bush Administrations revised UPL rules by changing permissible accounting methods used to claim federal

matching payments. These changes significantly reduced the excess federal dollars states received under approved UPL plans that involved IGTs. However, these reforms did not eliminate all such excess payments because no changes were made to the Medicaid UPL standard which remains tied to the Medicare payment rate, nor to federal statute or regulations governing IGTs. Administration officials have taken additional steps to curb what they have identified as improper state financing mechanisms, especially certain intergovernmental transfers. In late 2003, CMS began requesting detailed information regarding the sources of the state share of Medicaid costs from states applying for Medicaid waivers and submitting Medicaid state plan amendments. In some cases, these proposals were modified to minimize the use of improper IGTs (i.e., IGTs that use "recycling mechanisms" under which payments to providers are returned to the state, artificially inflating the federal matching rate).

Proposal. The President's budget would, through administrative action: (1) clarify that only units of government are able to contribute to the financing of the non-federal share of Medicaid costs, (2) establish minimum requirements for documenting cost when using a certified public expenditure as part of the non-federal share, (3) cap payments to government providers to no more than the cost of providing services to Medicaid beneficiaries, rather than to Medicare payment principles, (4) establish a new regulatory provision requiring that providers receive and retain the total computable amount of their Medicaid payments, and (5) make corresponding and conforming changes to SCHIP. On January 18, 2007, the Administration published a proposed rule detailing these actions.

HHS estimates that the President's proposal would save $530 million in FY2008, and $5.000 billion over the FY2008-FY2012 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Recent Action. On May 29, 2007, CMS published a final rule on payments for government providers that addresses IGTs and other issues (a related proposed rule on outpatient hospital services was published on September 28). A war supplemental appropriations bill that was vetoed on May 1, 2007 (H.R. 1591), included a provision that would have delayed implementation for one year. A subsequent war supplemental enacted on May 25 (P.L. 110-28) included the same provision. The FY2008 budget resolution also includes a deficit-neutral reserve fund for delayed implementation (see discussion at the end of this report).

Reports. See CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Elicia J. Herz, and CRS Congressional Distribution Memorandum, *Proposed Medicaid Regulation to Establish a Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership*, by Jean Hearne (available upon request).

Medicaid: School-Based Services — Eliminate Administration and Transportation

Background. Medicaid pays for covered medical services provided to Medicaid-eligible children with Individualized Family Service Plans (IFSP) and Individualized Education Plans (IEP), pursuant to the Individuals with Disabilities Education Act (IDEA). In the President's FY2007 budget proposal, the Administration noted that Medicaid claims for services in the school setting were prone to abuse and overpayment, especially with respect to administrative and transportation services. Over the past few years, several GAO and HHS OIG studies have reached similar conclusions.[8]

For transportation services, examples of inappropriate Medicaid billing include (1) no verification that transportation was in fact provided, (2) a Medicaid-covered school health service other than transportation was not provided on the day that transportation was billed, and (3) child/family plans did not include a recommendation for transportation services, or there was no IEP or IFSP.

School districts may perform administrative functions for Medicaid purposes, including for example, outreach, eligibility intake, information and referrals, health service coordination and monitoring, and interagency coordination. Examples of inappropriate Medicaid billing include (1) payments based on inaccurate time studies used to allocate the cost of these administrative activities across funding sources including Medicaid, (2) expenditures for school employees who do not perform Medicaid administrative activities, (3) expenditures for operating costs such as nursing supplies, non-Medicaid outreach supplies, and education-related expenditures, (4) expenditures for personnel funded by other federal programs, and (5) payments for personnel who render only direct medical services.

Proposal. The President's FY2008 budget would, through administrative action, phase out Medicaid reimbursement for certain school-based IDEA-related transportation and school administrative claiming. The Administration says that appropriate medical services and transportation to and from these services under IDEA would continue to be reimbursed as under current law.

HHS estimates that the President's proposal would save $615 million in FY2008 ($167 million attributable to transportation cost savings and $448 million attributable to state and local administration savings), and $3.645 billion over the FY2008-FY2012 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

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[8] For example, see HHS, Office of Inspector General (OIG), *Review of Medicaid Transportation Claims Made by the New York City Department of Education*, A-02-03-01023, September 2005; HHS, OIG, *Audit of LaPorte Consortium's Administrative Costs Claimed for Medicaid School-Based Services*, A-06-02-00051, January 2006; and Government Accountability Office, *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight*, GAO/HES/OSI-00-69, April 2000.

Recent Action. On September 7, 2007, CMS published a proposed rule regarding Medicaid payments for school-based administration and transportation, which was issued as a final rule on December 21, 2007. P.L. 110-173 will delay the effective date of the final rule, shifting it from February 26, 2008, to June 30, 2008. In addition, a House-passed SCHIP reauthorization bill (H.R. 3162) and two SCHIP bills vetoed by President Bush (H.R. 976 and H.R. 3963) would have prohibited the Secretary of HHS from taking any action to restrict Medicaid coverage or payments for school-based activities for a set period of time. The FY2008 budget resolution also includes a deficit-neutral reserve fund for delayed implementation of the President's proposal (see discussion at the end of this report).

Reports. See CRS Report RS22397, *Medicaid and Schools*, by Elicia J. Herz, and CRS Report RL31722, *Individuals with Disabilities Education Act (IDEA) and Medicaid*, by Richard N. Apling and Elicia J. Herz.

Medicaid: Eliminate Medicaid Graduate Medical Education

Background. Medicare reimburses teaching hospitals for graduate medical education (GME) training through an indirect medical education (IME) adjustment within its hospital prospective payment system (PPS) and with direct graduate medical education (DGME) payments made outside of PPS. IME payments are designed to cover the higher patient costs associated with the training function (such as additional laboratory tests ordered by residents). DGME payments cover the costs of salaries and fringe benefits paid to medical residents, interns and teaching faculty. While Medicare has a statutory requirement to support GME, Medicaid does not. Nonetheless, most states make GME payments, primarily designed to cover DGME costs, through the Medicaid fee-for-service delivery system. Many states also make IME payments to teaching hospitals as well. On average, GME payments comprise about 8 to 9 percent of total Medicaid inpatient hospital expenditures.

Proposal. The Administration maintains that paying for GME is outside Medicaid's primary purpose, which is to provide medical care to low-income populations, and that current law does not explicitly authorize such payments. Through administrative action, the Administration proposes to eliminate funding for GME under Medicaid.

HHS estimates that the President's proposal would save $140 million in FY2008, and $1.780 billion over the FY2008-FY2012 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Recent Action. On May 23, 2007, CMS published a proposed rule to clarify that GME is not federally reimbursable under Medicaid. A war supplemental appropriations bill that was vetoed on May 1, 2007 (H.R. 1591), included a provision that would have delayed implementation of this proposal for one year. A subsequent war supplemental enacted on May 25 (P.L. 110-28) included the same provision. The FY2008 budget resolution also includes a deficit-neutral reserve fund for delayed implementation (see discussion at the end of this report).

Reports. Currently, no other CRS reports address this topic.

Medicaid: Clarify Rehabilitation Services

Background. Since the inception of Medicaid in 1965, states have been authorized to cover "other diagnostic, screening, preventive, or *rehabilitative* services" as an optional Medicaid service. In subsequent legislation (OBRA 90, P.L. 101-508), Congress clarified the benefit as "including any medical or remedial service (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." The rehabilitation benefit allows states to cover a broad range of services to individuals with various types of conditions and disabilities. Under the rehabilitation benefit, states often cover ongoing mental health and/or substance abuse services, early intervention services for children with disabilities, rehabilitation for individuals with physical disabilities, school-based rehabilitation, and services for children in foster care and juvenile justice programs.

Both the Government Accountability Office (GAO) and the HHS Office of the Inspector General (OIG) have reported that the Medicaid rehabilitation benefit has been used by some states to bill Medicaid for activities that are not allowable as rehabilitation services, and/or to pay rehabilitation providers using methods that did not meet the statutory requirement for being "efficient and economical."[9][10] Further, CMS financial management officials reported to GAO that they believed that states "were inappropriately filing claims for services that were the responsibility of other state programs."[11]

Proposal. The President's budget seeks to clarify, through regulation, which services may be claimed as Medicaid rehabilitation services. HHS estimates the President's proposal would save $230 million in FY2008, and $2.290 billion over the FY2008-FY2012 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Recent Action. On August 13, 2007, CMS published a proposed rule on rehabilitation services under Medicaid. P.L. 110-173 prohibits the Secretary of HHS from taking any action to restrict Medicaid coverage or payments for rehabilitation services for one year. In addition, a House-passed SCHIP reauthorization bill (H.R. 3162) and two SCHIP bills vetoed by President Bush (H.R. 976 and H.R. 3963) would have prohibited the Secretary of HHS from taking such action for a set period of time. The FY2008 budget resolution also includes a deficit-neutral reserve fund

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[9] K. Allen, *States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight*, Government Accountability Office, Testimony Before the U.S. Senate, Committee on Finance, GAO-05-836T, June 28, 2005. (Hereafter cited as "GAO Testimony, June 2005.")

[10] HHS, Office of Inspector General, *Audit of Medicaid Claims for Iowa Rehabilitation Treatment Services Family-Centered Program*, A-07-02-03023, July 2004.

[11] GAO Testimony, June 2005.

for delayed implementation of the President's proposal (see discussion at the end of this report).

Reports. For information on the provisions in SCHIP reauthorization legislation, see CRS Report RL34129, *Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R. 976*, by Evelyne Baumrucker et al., and CRS Report RS22746, *SCHIP: Differences Between H.R. 3963 and H.R. 976*, by Evelyne Baumrucker et al.

Medicaid: Issue Guidance Defining 1915(b)(3) Services

Background. See the "Extend Section 1915(b) Waiver Period" proposal described earlier.

Proposal. The President's budget would, through administrative action, clarify which additional services may be provided under Section 1915(b)(3) out of cost savings achieved under Section 1915(b) waiver programs. HHS estimates that the proposal would have no cost impact in FY2008 or over the FY2008-FY2012 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Reports. For more information on Medicaid managed care, see CRS Report RL33711, *Medicaid Managed Care: An Overview and Key Issues for Congress* by Elicia J. Herz.

Medicaid: Third Party Liability — Eliminate Pay and Chase for Pharmacy

Background. As described earlier (under the "enhance third party liability" proposal), if a state has determined that probable third party liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase"). States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay and chase method.

Proposal. The President's budget would, through administrative action, require states to use cost avoidance and eliminate the pay and chase waiver option for pharmacy claims. HHS estimates that the proposal would have no cost impact in FY2008 or over the FY2008-FY2012 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Reports. Currently, no other CRS reports address this topic.

Medicaid: Clarify Provider Tax Policy

Background. Under federal law and regulations, a state's ability to use provider-specific taxes to fund its state share of Medicaid expenditures is limited. If states establish provider-specific taxes, the taxes must be broad based in that they apply to all providers within a class, they cannot exceed 25% of the state (or non-federal) share of Medicaid expenditures and the state cannot provide a guarantee to the providers that the taxes will be returned to them. However, if the taxes returned to a provider are less than 6% of the provider's revenues (a ceiling created in regulation by HHS), the prohibition on guaranteeing the return of tax funds is not violated. As a result, a state could impose a provider tax of 6% of revenues, return those revenues to the provider in the form of a Medicaid "payment," and receive a federal match for those amounts. In effect, the state has temporarily borrowed funds from the provider for the purpose of inflating federal matching funds. In 2006, Congress included a provision in the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) preventing the Secretary of HHS from taking action to reduce this percentage. The law fixed the provider tax ceiling in statute at 6%, except for the period January 1, 2008-September 31, 2011, during which the rate is fixed at 5.5%.

Proposal. The President's budget seeks to revise existing rules to more explicitly state the policies and procedures CMS uses when evaluating states' provider taxes. HHS estimates that the proposal would have no cost impact in FY2008 or over the FY2008-FY2012 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Recent Action. On March 23, 2007, CMS published a proposed rule on health-care-related taxes to reflect the TRHCA change and clarify existing provisions.

Reports. For background information on provider taxes, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

Medicaid: Clarify DSH Provisions in Regulation

Background. States and the District of Columbia are required to recognize, in establishing hospital payment rates, the situation of hospitals that serve a disproportionate number of Medicaid beneficiaries and other low-income patients with special needs. Under broad federal guidelines, each state determines which hospitals receive disproportionate share hospital (DSH) payments and the payment amounts to be made to each qualifying hospital. The federal government shares in the cost of state DSH payments at the same federal matching percentage as for most other Medicaid services. Total federal reimbursement for each state's DSH payments are capped at a statewide ceiling, referred to as the state's DSH allotment, and DSH payments to each hospital are capped at a hospital-specific ceiling.

Proposal. The President's budget seeks to clarify, through regulation, provisions related to the allowable uses of DSH funds. HHS estimates that the proposal would have no cost impact in FY2008 or over the FY2008-FY2012 period.

CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Reports. For background information on Medicaid DSH payments, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

SCHIP: Reauthorization

Background. The Balanced Budget Act of 1997 established SCHIP. 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. States may choose among three benefit options when designing their SCHIP programs. They may enroll targeted low-income children in Medicaid, create a separate state program, or devise a combination of both approaches. All states, the District of Columbia, and five territories have SCHIP programs. Nearly $40 billion has been appropriated for SCHIP for FY1998-FY2007. The authorized appropriation for FY2007 is $5.04 billion. 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.

States that set up an SCHIP program are entitled to federal reimbursement, up to a cap, for a percentage of the incurred costs of covering enrolled individuals. This percentage, which varies by state, is called the enhanced federal medical assistance percentage (FMAP). It is based on the FMAP used for the Medicaid program but is higher in SCHIP than in Medicaid. In other words, the federal government contributes more toward the coverage of individuals in SCHIP (65% to 83% in FY2008) than it does for those covered under Medicaid (50% to 76% in FY2008).[12]

States have three years to spend each annual allotment (e.g., states have until the end of FY2007 to spend their FY2005 allotments). At the end of the applicable three-year period, unspent funds are reallocated among states based on year-specific rules. In the early years of the SCHIP, both states that did and did not fully exhaust their original allotments received unspent funds. For more recent years, only those states that fully exhaust their original allotments receive unspent funds. Some states have experienced shortfalls in SCHIP funds, meaning at the end of a given fiscal year, they have spent all federal SCHIP funds available to them at that point in time, including original allotments and reallocations of unspent funds from other states.

Although no SCHIP appropriations are currently slated for FY2008 forward, both OMB and CBO assume that the program continues at the FY2007 appropriation level of $5.04 billion.

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[12] Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2006 Through September 30, 2007," 70 *Federal Register* 71856, November 30, 2005, and 71 *Federal Register* 28041, May 15, 2006.

Proposal. Federal SCHIP funds would pay the enhanced FMAP only for enrolled children or pregnant adults with family income at or below 200% of poverty. States would receive the regular FMAP for all other enrollees (that is, non-pregnant adults and children with family income above 200% of poverty). The President's budget also proposes prohibiting any further expansion of coverage to parents or, in states already covering them, childless adults. SCHIP eligibility could not be expanded to new groups of non-pregnant adults.[13]

For FY2008, the President's budget calls for no more additional SCHIP appropriations above the $5.04 billion assumed in the baseline. However, the President's budget would reduce the period of availability of original allotments from three years to a single year. This means that as of the end of FY2007, any remaining balances of states' FY2006 and FY2007 federal SCHIP funds would be available for redistribution (in addition to the redistribution of unspent FY2005 funds slated under current law). CRS currently projects that reducing the period of availability of these original allotments would make nearly $4 billion of federal SCHIP funds available for potential redistribution in FY2008. Depending on how the funds are targeted, this could be enough to cover the FY2008 projected shortfalls (less any applicable reduction in shortfalls from the reduction in the FMAP discussed above).

Although no additional SCHIP appropriations are called for in FY2008 (because of the availability of redistribution funds, as described above), $4.813 billion in additional allotment funds would be appropriated over the FY2009-FY2012 period.

HHS estimates that the proposal would have no impact on SCHIP outlays in FY2007 and that it would increase SCHIP outlays by $1.220 billion in FY2008 and by $5.930 billion over the FY2008-FY2012 period; it also estimates that the proposal would have no impact on Medicaid outlays in FY2007 and that it would reduce Medicaid outlays by $510 million in FY2008 and by $1.770 billion over the FY2008-FY2012 period. CBO estimates that the proposal would increase SCHIP outlays by $735 million in FY2007, by $939 million in FY2008, and by $5.463 billion over the FY2008-FY2012 period; it also estimates that the proposal would reduce Medicaid outlays by $287 million in FY2007, by $601 million in FY2008, and by $3.545 billion over the FY2008-FY2012 period.

Recent Action. A war supplemental appropriations bill (H.R. 1591) that was vetoed on May 1, 2007, included funding to cover projected FY2007 shortfalls. A subsequent war supplemental (P.L. 110-28) enacted on May 25 included the same shortfall funding. In lieu of SCHIP reauthorization (see discussion at the end of this report), continuing resolutions (P.L. 110-92, P.L. 110-116, P.L. 110-137, P.L. 110-149) contained temporary FY2008 appropriations for SCHIP allotments through December 31, 2007. P.L. 110-173 provides appropriations through March 31, 2009.

Reports. See CRS Report RS22739, *FY2008 SCHIP Allotments and Projected Shortfalls*, by Chris L. Peterson, and CRS Report RL30473, *State Children's Health*

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[13] Some of the details of this description are based on a briefing by OMB officials on February 5, 2007.

Insurance Program (SCHIP): A Brief Overview, by Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker.

Health Care Fraud and Abuse Control Account

Background. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control (HCFAC) account within the federal Hospital Insurance (HI, also known as Medicare Part A) trust fund. The HCFAC account funds the Medicare Integrity Program within CMS, certain health care fraud and abuse activities within the Federal Bureau of Investigation, and HCFAC program activities carried out by HHS agencies and the Department of Justice. Annual mandatory minimum and maximum HCFAC appropriations are specified in statute.

Proposal. The President's budget seeks legislation to increase HCFAC funding with a discretionary appropriation. While the proposal would not directly affect Medicaid or SCHIP spending, it would fund Medicaid and SCHIP financial management activities and supplement HCFAC funding overall. HHS estimates that the Medicaid and SCHIP financial management portion of the proposal (which provides funding in FY2008 only) would cost $10.1 million in FY2008 and over the FY2008-FY2012 period. CBO did not provide an estimate for the proposal.

Reports. For information on discretionary HHS funding levels, see CRS Report RL34076, *Labor, Health and Human Services, and Education: FY2008 Appropriations*, by Pamela W. Smith.

Health Insurance in the President's FY2008 Budget

The President's FY2008 budget contains a number of proposals that would affect health insurance. For each of the proposals, this report provides:

- background information;
- a description of the proposal based on available information;[14] and
- a list of relevant CRS reports.

The description of each proposal includes Administration and JCT estimates of its cost or savings in FY2008 and over the FY2008-FY2017 period. These estimates are summarized in **Table 2**.

Although bills that would implement proposals similar to those in the President's budget have not been acted on in the 110th Congress to date, the FY2008 budget resolution (see discussion at the end of this report) and the SCHIP reauthorization bill passed by the Senate on August 2 (see CRS Report RL34107, *S.*

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[14] Sources include HHS, *Fiscal Year 2008 Budget in Brief*; OMB, *Budget of the United States Government, Fiscal Year 2008*; and Department of the Treasury, G*eneral Explanations of the Administration's Fiscal Year 2008 Revenue Proposals*, available at [http://www.treas.gov/offices/tax-policy/library/bluebk07.pdf].

1893/H.R. 976: The Children's Health Insurance Program Reauthorization Act of 2007, by Evelyne Baumrucker et al.) do contain some provisions related to private health insurance and affordable coverage.

Table 2. Revenue and Outlay Effects of Health Insurance Proposals in the President's FY2008 Budget

Proposal	Millions of dollars			
	Administration estimate		JCT estimate	
	FY2008-FY2012	FY2008-FY2017	FY2008-FY2012	FY2008-FY2017
Net revenue effect — provide a flat $15,000 deduction for family coverage ($7,500 for individual coverage)	—	—	($22,757)	$333,635
Revenue effect	($121,201)	$5,150	—	—
Outlay effect	$14,280	$37,886	$30,800	$77,000
Net revenue effect — expand and make HSAs more flexible	—	—	($389)	($1,451)
Revenue effect	($3,669)	($10,366)	—	—
Outlay effect	—	—	—	—
Net revenue effect — improve the Health Coverage Tax Credit	—	—	($116)	($265)
Revenue effect	($18)	($51)	—	—
Outlay effect	$55	$139	—	—
Establishing association health plans	—	—	—	—
Creating a competitive marketplace across state lines	—	—	—	—
Reforming medical liability law	—	—	—	—
Fostering affordable choices	—	—	—	—

Source: OMB, *Budget of the United States Government, Fiscal Year 2008*, available at [http://www.whitehouse.gov/omb/budget/fy2008/]; JCT, *Estimating The Revenue Effects of the Administration's Fiscal Year 2008 Proposal Providing a Standard Deduction for Health Insurance: Modeling and Assumptions*, Mar. 20, 2007, available at [http://www.house.gov/jct/x-17-07.pdf]; and JCT, *Description of Revenue Provisions Contained in the President's Fiscal Year 2008 Budget Proposal*, March 2007, available at [http://www.house.gov/jct/s-2-07.pdf].

Note: Numbers in parentheses are negative. Estimates for proposals that do not show a dollar figure were not provided in the documents cited above.

Health Insurance: Tax Deduction and Other Tax Changes

The President's budget proposes repealing the income and FICA exclusions for employer-paid health coverage, the self-employed health deduction, and itemized medical expenses for individuals not enrolled in Medicare. Instead, a new standard deduction for health insurance would be available. Other provisions would expand the availability and attractiveness of Health Savings Accounts. Background on these proposals is provided below.

Background on Tax Deduction. Health insurance paid by employers generally is excluded from employees' gross income in determining their income tax liability;

it also is not considered for either the employee's or the employer's share of employment taxes (i.e., Social Security, Medicare, and unemployment taxes). The income and employment tax exclusions apply to both single and family coverage, which includes the employee's spouse and dependents. The employee's share of the premium may be paid with after-tax dollars (in which case they can be taken in consideration for the medical expenses itemized deduction) or subject to a premium conversion arrangement.

Insurance benefits paid from employment-based plans are generally excluded from gross income if they are reimbursements for medical expenses or payments for permanent physical injuries. Benefits not meeting these tests are taxable in proportion to the share of the insurance costs paid by the employer that were previously excluded from gross income. Benefits received by highly compensated employees under discriminatory self-insured plans may be partly taxable. A self-insured plan is one in which the employer assumes the risk for a health care plan and does not shift it to a third party.

Employers may deduct their insurance and other health care payments as a business expense. The deduction is not a tax benefit but a calculation necessary for the proper measurement of the net income that is subject to taxation. Revenue loss attributable to this deduction is not considered a tax expenditure.

Background on Premium Conversions. Under a cafeteria plan option known as premium conversion, employees may elect to reduce their taxable wages in exchange for having their share of health insurance premiums paid on a pretax basis.[15] The arrangement saves both income and employment taxes. Premium conversion is not available to retirees. However, employer payments for retiree health insurance is excluded from taxes, just as they are for active workers. For many retirees, the employer pays much of the premium.

Background on Flexible Spending Accounts. Flexible spending accounts (FSAs) are employer-established benefit plans that reimburse employees for specified expenses as they are incurred. FSA reimbursements funded through salary reduction agreements (the most common arrangement) are exempt from income and employment taxes under cafeteria plan provisions because employees have a choice between cash (their regular salary) and a nontaxable benefit. In contrast, FSA reimbursements funded by nonelective employer contributions are exempt from taxation directly under provisions applying to employer-paid dependent care or health insurance.

Background on Unreimbursed Medical Expenses Itemized Deduction. Taxpayers who itemize their deductions may deduct unreimbursed medical expenses that exceed 7.5% of adjusted gross income (AGI). Medical expenses include health insurance premiums paid by the taxpayer, principally premiums for individual market

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[15] Cafeteria plans are employer-established benefit plans under which employees may choose between receiving cash (typically additional take-home pay) and certain normally nontaxable benefits (such as employer-paid health insurance) without being taxed on the value of the benefits if they select the latter.

policies and the employee's share of premiums for employment based coverage (aside from those subject to a premium conversion arrangement). More generally, medical expenses include amounts paid for the "diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." They also include certain transportation and lodging expenditures, qualified long-term care costs, and long-term care insurance premiums that do not exceed certain amounts.

The JCT estimated that the FY2007 tax expenditure attributable to the medical expense deduction (including long-term care expenses) will be about $8.2 billion.

Proposal. The President's budget proposes a new health insurance tax deduction of $7,500 for self-only coverage or $15,000 for family coverage. The deduction would apply to both income and payroll taxes and would be the same regardless of the cost of the insurance or whether it was obtained in the individual and small group markets or through one's employer.

The proposal would terminate:

- the exclusion for employer provided health insurance;
- the self-employed premium deduction;
- the exclusion or deduction of health care spending for insurance premiums and out-of-pocket expenses (except for expenses covered under HSAs);
- the exclusion of FSAs from income and employment taxes; and
- the itemized deduction for medical expenses for those not enrolled in Medicare.

Employers would be required to report the value of health insurance coverage to their employees on their annual Form W-2 and such amounts would be subject to withholding and employment taxes. Businesses would continue to deduct employer-provided health insurance as a business expense.

The exclusion and deduction for Health Savings Account contributions would not be affected.

Effective for tax years beginning after 2008, OMB estimates that the proposal would increase outlays by $231 million and reduce revenue by $31.433 billion in 2009; increase outlays by $14.280 billion and reduce revenue by $121.201 billion over the 2008-2012 period; and increase outlays by $37.886 billion and increase revenue by $5.150 billion over the 2008-2017 period.

JCT estimates that repealing the provisions of existing law and providing the new standard health insurance deduction would reduce *net* revenue (including outlay effects) by $13.790 billion in 2009; reduce net revenue by $22.757 billion over the 2008-2012 period; and increase net revenue by $333.6 billion over the 2008-2017 period.

Reports. See CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by Bob Lyke and Julie M.

Whitaker; CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Bob Lyke and Chris L. Peterson; and CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris L. Peterson.

Health Insurance: Health Savings Accounts

Background. Health Savings Accounts (HSAs) are one way people can pay for unreimbursed medical expenses (deductibles, copayments, and services not covered by insurance) on a tax-advantaged basis. HSAs can be established and funded by eligible individuals when they have a qualifying high deductible health plan (HDHP, i.e., high deductible insurance) with a deductible in 2007 of at least $1,100 for self-only coverage and $2,200 for family coverage. Qualifying HDHPs must also limit out-of-pocket expenses for covered benefits to certain amounts. With some exceptions, eligible individuals cannot have other health insurance coverage.

HSA tax advantages can be significant for some people: contributions are deductible (or excluded from income that is taxable if made by employers), withdrawals are not taxed if used for medical expenses, and account earnings are tax exempt. HSAs are included in what some call "consumer-driven health plans." One objective of these plans is to encourage individuals and families to set money aside for their health care expenses. Another is to give them a financial incentive for spending health care dollars prudently. Still another goal is to give them the means to pay for health care services of their own choosing, without constraint by insurers or employers.

Proposal. The President's FY2008 budget proposes to allow health plans to be considered HSA-eligible if they meet all the existing requirements of an HDHP except that, in lieu of satisfying the minimum deductible requirement, they have at least a 50% coinsurance requirement and a minimum out-of-pocket risk that, under guidelines established by the Secretary, would result in the same (or lower) premium as a HDHP would under current law.

The proposal includes additional changes be made to HSAs, including (1) allowing family coverage to include coverage where each individual in the family can receive benefits once they have reached the minimum deductible for an individual HDHP; (2) allowing both spouses to contribute the catch-up contribution to a single HSA owned by one spouse if both spouses are eligible individuals; (3) allowing an individual to be covered by a flexible spending arrangement (FSA) or health reimbursement arrangement (HRA) with first dollar coverage and still contribute to an HSA, but offset the maximum allowable HSA contribution by the level of FSA or HRA coverage; (4) allowing qualified medical expenses to include any medical expense incurred on or after the first day of HDHP coverage if individuals have established an HSA by their return filing date for that year; and (5) excluding from the comparability rules extra employer contributions to HSAs on behalf of employees who are chronically ill or employees who have spouses or dependents who are chronically ill. All of the HSA-related proposals would be effective for years beginning after December 31, 2007.

While the President's proposal would replace the current law tax exclusion of employer-provided health insurance with a flat deduction, the current exclusion or deduction for HSA contributions would not be affected.

OMB estimates that the proposal would reduce revenue by $318 million in 2008, by $3.669 billion for 2008 through 2012, and by $10.366 billion for 2008 through 2017. JCT estimates that the proposal would reduce net revenue by $19 million in 2008, by $389 million for 2008 through 2012, and by $1.451 billion for 2008 through 2017.

Reports. For more information on HSAs, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2007*, by Bob Lyke and CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris L. Peterson.

Health Insurance: Health Coverage Tax Credit

Background. The Trade Act of 2002 (P.L. 107-210) authorized a federal income tax credit of 65% of what eligible taxpayers pay for qualified health insurance for themselves and their family members. The credit is refundable, so taxpayers may claim the full credit even if they have little or no federal income tax liability. The credit can also be advanced, so taxpayers need not wait until they file their tax returns in order to benefit from it.

Eligibility for the HCTC is limited to three groups of taxpayers. The first two consist of individuals who are eligible for Trade Adjustment Assistance allowances because they have lost manufacturing jobs due to increased foreign imports or shifts in production outside the United States. The third consists of individuals whose defined benefit pension plans were taken over by the Pension Benefit Guaranty Corporation (PBGC) due to financial difficulties. Eligible individuals cannot be enrolled in certain other health insurance (e.g., Medicaid) or entitled to certain other coverage (e.g., Medicare Part A).

Eligible individuals can claim the HCTC only if they make payments for qualified insurance. The statute limits qualified insurance to ten different categories of coverage. Three of the coverage categories are known as automatically qualified health plans. The other seven categories of coverage are known as state qualified plans; individuals may choose these options only if their state has chosen or established these plans to be included as qualified coverage.

Coverage under state qualified plans must provide consumer protections to all qualifying individuals. Plans must guarantee issue (offer coverage to all qualifying applicants) and not deny coverage based on preexisting conditions. Premiums (without regard to subsidies) must not be greater for qualifying individuals than for other similarly situated individuals, and benefits for qualifying individuals must be the same as or substantially similar to those for others. In short, the statute attempts to ensure that state qualified plans are open to all qualifying applicants and do not charge more or provide fewer benefits to people who are receiving the credit. The consumer protections do not preclude use of medical underwriting to set premiums.

Proposal. The President's FY2008 budget includes a proposal that would allow state qualified plans to impose a pre-existing condition exclusion for a period of up to 12 months, provided the plan reduces the restriction period by the length of the eligible individual's creditable coverage as of the date of application for the state qualified plan.

The FY2008 budget also proposes allowing the spouse of an HCTC-eligible individual to claim the credit when the HCTC-eligible individual becomes entitled to Medicare. The spouse would have to be at least 55 years of age.

OMB estimates that the proposal would increase outlays by $4 million and reduce revenue by $1 million in 2008, increase outlays by $55 million and reduce revenue by $18 million for 2008 through 2012, and increase outlays by $139 million and reduce revenue by $51 million for 2008 through 2017.

JCT estimates that the proposal would reduce *net* revenue by $15 million in 2008, by $116 million for 2008 through 2012, and by $265 million for 2008 through 2017.

Reports. For information on the Health Care Tax Credit, see CRS Report RL32620, *Health Coverage Tax Credit Authorized by the Trade Act*, by Bernadette Fernandez and CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by Bob Lyke and Julie M. Whitaker.

Health Insurance: Establishing Association Health Plans

Background. Most individuals obtain their health insurance at work, with both employers and workers contributing to the cost, or monthly premiums, of the health insurance plans. Sometimes employers will sponsor health insurance coverage offered through trade or professional associations. For smaller employers, insurance purchased through such an association can be easier to obtain compared with having to negotiate through the confusing offerings of the private insurance market on their own. Associations with members that cross state lines, however, have argued that their plans could be more affordable if they were exempt from multiple state insurance laws. Under current law, plans offered by any insurer or multiple employer[16] group, such as an association, are subject to the entire body of state insurance law for any state in which those products are offered.

Proposal. The President's budget proposes an initiative to establish "Association Health Plans." Such plans could allow small employers, civic groups and community organizations to band together and use their purchasing power to obtain health coverage for their employees, members, and their families.

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[16] Under federal law, the term for groups of two or more employers that purchase insurance together is multiple employer welfare arrangement (MEWA).

Reports. For a description of Association Health Plan legislation during the 109th Congress, see CRS Report RL31963, *Association Sponsored Health Plans: Legislation in the 109th Congress*, by Jean Hearne.

Health Insurance: Creating a Competitive Marketplace Across State Lines

Background. States have primary jurisdiction over the regulation of health insurance carriers and products. States have passed laws on numerous topics in this area: benefit mandates, patient protections, rating laws, grievance and appeals processes, just to name a few. This has resulted in health insurance requirements totaling in the thousands. Insurance carriers and other health insurers, particularly those that operate in multiple states, have sought relief from these requirements. They argue that reducing the number of applicable state laws will lead to more plan options at affordable prices in the private market. One possible approach to reducing state regulation of health insurance is for multi-state carriers to designate one state as the "primary" state with respect to applicable insurance laws. Another approach is to allow qualified insurers to offer coverage that does not meet any state benefit mandates. Both approaches could provide flexibility to carriers to design cheaper, less-generous health insurance products, but maintain some level of existing consumer protections.

Proposal. The President's budget proposes an initiative to create a competitive marketplace across state lines that maintains strong consumer protections.

Reports. For information on issues related to offering insurance products across state lines, see CRS Report RS22476, *Standardizing State Health Insurance Regulation*, by Jean Hearne and Bernadette Fernandez and CRS Report RL31963, *Association Sponsored Health Plans: Legislation in the 109th Congress*, by Jean Hearne.

Health Insurance: Reforming Medical Liability Law

Background. The rising cost of medical malpractice insurance is a public policy concern because of its potential impact on the availability of health care providers and services. As malpractice insurance becomes increasingly expensive, some physicians claim that premium increases have forced them to limit the services they provide, move their practice locations, or leave medicine altogether. They cite "frivolous" lawsuits and unreasonably large jury awards as the causes of the malpractice insurance "crisis." However, lawyer and consumer groups counter that the insurance industry is to blame for the rapid rise in malpractice insurance premiums. These groups contend that bad investment choices, in addition to the underwriting cycle, have led to dwindling profits for insurers, who then try to recoup their losses through expensive insurance products. There is a third perspective, which has not generated the same level of attention or controversy, that sees the overall medical error rate as the root of the problem.

Proposal. The President's budget proposes an initiative to reform medical liability law, with the expectation it will increase access to quality, affordable health

care while reducing non-meritorious lawsuits against doctors and other health care providers.

Reports. For more information on reforming medical liability, see CRS Report RL33358, *Medical Malpractice: An Overview*, by Bernadette Fernandez and Baird Webel.

Health Insurance: Fostering Affordable Choices

Background. Under current law, uninsured individuals in need of medical care must either self-pay for health care services or forego them. For very large inpatient hospital costs, uninsured individuals are sometimes able to negotiate a price reduction. The unpaid portion of the bills are written off as bad debt or charity care. Certain hospitals provide a disproportionate share of charity care and uncompensated care to people who are not able to pay. Under Medicaid, states are required to make special payments to hospitals that provide a disproportionate amount (relative to other hospitals) of uncompensated care and care to Medicaid beneficiaries.

Proposal. The President's budget proposes to have the Secretary of HHS work with Congress on establishing a more efficient distribution of institutional payments, redirecting some portion toward health insurance for people with poor health or limited income. The proposal seeks to focus on helping the uninsured purchase private insurance in order to improve the likelihood that people would receive the care they need in the most appropriate setting. Such health care reforms would be state-based and budget neutral.

Reports. For background information on Medicaid DSH payments, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

Congressional Action

FY2008 Budget Resolution

The House and Senate adopted their respective budget resolutions for FY2008 in March of 2007. A conference agreement was adopted by both chambers on May 17. Although it is not binding, the budget resolution provides a framework for subsequent legislative action.

Senate. On March 15, 2007, the Senate Budget Committee reported an FY2008 budget resolution (S.Con.Res. 21), which was amended and passed by the Senate on March 23. Relevant provisions include:

- Up to $50 billion over five years for SCHIP reauthorization, with language specifying that it should be a top priority for the remainder of FY2007. The resolution provides a deficit-neutral reserve fund of up to $20 billion for this purpose. It also provides a $30 billion increase in spending for the budget function that includes SCHIP ($15 billion of which might be paid for with Medicare savings

assumed in the resolution,[17] and $15 billion of which is paid for out of an FY2012 surplus assumed in the resolution[18]). The resolution specifies that an increase in the federal tobacco tax could be among the policy changes considered to achieve offsets for the remaining $20 billion.

- Deficit-neutral reserve funds for: (1) comparative effectiveness research, (2) small business health insurance, (3) health care reform (if an SCHIP reauthorization bill is enacted), (4) long-term care, (5) health information technology, (6) mental health parity, (7) delayed implementation of a proposed rule that would affect Medicaid and SCHIP financing (see the "Revise Payments for Government Providers" proposal described earlier), (8) the use of Medicare data to evaluate a variety of health care issues in federal programs and the private health care system, and (9) improving health insurance.
- Up to $383 million in FY2008 discretionary funding for the health care fraud and abuse control program at HHS.

House. On March 23, 2007, the House Budget Committee reported its own budget resolution (H.Con.Res. 99), which was passed by the House on March 29. Relevant provisions include:

- A deficit/surplus-neutral reserve fund of up to $50 billion over five years for expanding coverage and improving children's health through SCHIP and Medicaid.
- A deficit/surplus-neutral reserve fund for extending Medicaid transitional medical assistance through FY2008.
- Up to $183 million in FY2008 discretionary funding for the health care fraud and abuse control program at HHS. In addition, all House committees are directed to review programs within their jurisdiction for waste, fraud, and abuse in spending and to provide annual recommendations for improved performance.
- A finding that the most significant factor affecting entitlement programs is a rapid increase in health care costs that is not unique to Medicare and Medicaid, and a "sense of the House" that the growing cost of entitlements should be dealt with in a way that addresses the causes of cost growth in the broader health care system.
- A sense of the House that legislation consistent with PAYGO that makes health insurance more affordable and accessible (with attention to the special needs of small businesses), and lowers costs and improves health care quality, should be adopted.

Conference Agreement. On May 17, 2007, the House and Senate adopted a conference agreement on the budget resolution (H.Rept. 110-153 accompanying S.Con.Res. 21). Relevant provisions in the FY2008 budget resolution include:

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[17] Senate Budget Committee, *Chairman's Mark: FY2008 Budget*, March 14, 2007, p. 12, available at [http://budget.senate.gov/democratic/documents/2007/Budreschairmansmark031407.pdf].

[18] *Congressional Record*, March 21, 2007, pp. S3468-S3471.

- A reserve fund of up to $50 billion for SCHIP legislation that is deficit-neutral in the Senate and deficit/surplus-neutral in the House.
- Deficit-neutral reserve funds for: (1) health information technology; (2) comparative effectiveness research; (3) the use of Medicare data to evaluate a variety of health care issues in federal programs and the private health care system; (4) small business health insurance; (5) legislation to improve health care, provide quality health insurance for the uninsured and underinsured, and protect individuals with current health coverage (if an SCHIP reauthorization bill is enacted); (6) long-term care; (7) mental health parity; (8) delayed implementation of administrative proposals that would affect Medicaid and SCHIP financing, graduate medical education, rehabilitation services, and school-based services (see the "Revise Payments for Government Providers," "Eliminate Graduate Medical Education," "Clarify Rehabilitation Services," and "School-Based Services" proposals described earlier); (9) a demonstration project regarding Medicaid coverage of low-income individuals with HIV; (10) extending Medicaid transitional medical assistance.
- Up to $383 million in FY2008 discretionary funding for the health care fraud and abuse control program at HHS.
- Two "sense of the Congress" provisions regarding health care cost growth and affordable health coverage.

Appropriations

In general, spending for Medicaid and SCHIP is not controlled through the annual appropriations process. Medicaid is an entitlement program, meaning that its spending level is based on the underlying benefit and eligibility criteria established in law.[19] SCHIP is capped grant program, with appropriation amounts authorized for a set period of time (currently, through March 31, 2009). However, the annual appropriations process does provide an opportunity for Congress to place limitations on the availability of funds for specified activities.[20] For example, the Labor, Health and Human Services, and Education bill regularly contains restrictions that limit the circumstances under which federal funds can be used to pay for abortions.[21]

Spending for other health insurance provisions is more complicated, and must be examined on a case-by-case basis. As with Medicaid and SCHIP, some spending (including tax expenditures) may be based on underlying statute. Other spending may occur through the annual appropriations process (e.g., certain state grants associated with the health coverage tax credit).

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[19] See CRS Report RS20129, *Entitlements and Appropriated Entitlements in the Federal Budget Process*, by Bill Heniff Jr.

[20] See CRS Report 98-518, *Earmarks and Limitations in Appropriations Bills*, by Sandy Streeter.

[21] See CRS Report RL34076, *Labor, Health and Human Services, and Education: FY2008 Appropriations*, by Pamela W. Smith.

Other Legislation

In the 110th Congress, a number of Medicaid and SCHIP issues have seen legislative action. P.L. 110-28, P.L. 110-48, P.L. 110-90, and P.L. 110-173 included provisions to address SCHIP funding, delay implementation of certain Medicaid administrative proposals, require (and subsequently delay) the use of tamper-resistant pads for Medicaid prescriptions, provide a Medicaid Pharmacy Plus waiver extension, temporarily extend Medicaid transitional medical assistance and the QI-1 program, apply an asset verification pilot to Medicaid for five years, and extend Medicaid disproportionate share hospital payments for Tennessee and Hawaii.

On the issue of SCHIP reauthorization, numerous bills have been introduced, including the Senate-passed S. 1893/H.R. 976 and the House-passed H.R. 3162. A bicameral agreement on SCHIP reauthorization was passed as an amendment to H.R. 976 and then vetoed by President Bush on October 3. A modified version of the agreement was passed as H.R. 3963 and then vetoed on December 12. In lieu of reauthorization, continuing resolutions (P.L. 110-92, P.L. 110-116, P.L. 110-137, P.L. 110-149) contained temporary FY2008 appropriations for SCHIP allotments through December 31, 2007. P.L. 110-173 provides appropriations through March 31, 2009.

S. 1893/H.R. 976 as Passed by the Senate. Major elements of H.R. 976 (The Children's Health Insurance Program Reauthorization Act of 2007), as passed by the Senate on August 2, include:[22]

- national allotment appropriations totaling $61.4 billion over five years (an increase of $36.2 billion over the current law baseline of $25.2 billion), distributed to states and territories using a new formula;
- a new incentive bonuses pool (for making payments to states exceeding certain Medicaid/SCHIP enrollment levels), which would receive an FY2008 appropriation of $3 billion and deposits of certain unspent SCHIP funds through FY2012;
- a new contingency fund (for making payments to states for certain shortfalls of federal SCHIP funds), which would receive deposits through a separate appropriation each year through FY2012 and make payments of up to 12.5% of the available national allotment for SCHIP;
- additional grants for outreach and enrollment totaling $100 million each year through FY2012;
- provisions to remove barriers to enrollment, including a new option for meeting citizenship documentation requirements;
- provisions to eliminate barriers to providing premium assistance;

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[22] See CRS Report RL34107, *S. 1893/H.R. 976: The Children's Health Insurance Program Reauthorization Act of 2007*, by Evelyne Baumrucker et al., and CRS Report RL34129, *Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R. 976*, by Evelyne Baumrucker et al.

- provisions to strengthen quality of care and health outcomes of children;
- miscellaneous provisions, including improved data collection; and
- tobacco tax changes.

An August 24 estimate from CBO and JCT[23] indicates that the Senate bill would increase net outlays by $35.2 billion over 5 years and by $71.0 billion over 10 years.[24] These costs would be offset by an increase in the federal tobacco tax and other changes, which CBO and JCT estimate would increase net revenue by $36.1 billion over 5 years and by $72.8 billion over 10 years.

H.R. 3162 as Passed by the House. H.R. 3162 (The Children's Health and Medicare Protection Act of 2007), as passed by the House on August 1, contains SCHIP provisions to reauthorize and increase funding levels for the program; improve enrollment and retention; change certain benefit and coverage requirements; and address access, quality, and program integrity issues.[25] It also contains a variety of Medicaid provisions, numerous changes to the Medicare program, and an increase in the federal tobacco tax.

An August 1 estimate from CBO[26] indicates that the SCHIP title of H.R. 3162 would increase outlays by $47.4 billion over 5 years and by $128.7 billion over 10 years, and that the Medicaid title of the bill would increase outlays by $4.4 billion over 5 years and by $4.6 billion over 10 years. Including Medicare and miscellaneous provisions, CBO estimates that the entire bill would increase outlays by $25.6 billion over 5 years and by $58.0 billion over 10 years. These costs would be offset by an increase in the federal tobacco tax and other changes, which CBO estimates would increase revenue by $28.1 billion over 5 years and by $58.1 billion over 10 years.

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[23] CBO, letter to the Honorable Max Baucus (August 24, 2007), available at [http://www.cbo.gov/ftpdocs/85xx/doc8584/08-28-CHIP.pdf].

[24] As described above, the Senate bill would specify national allotment funding for five years. In FY2012, this funding would consist of two semi-annual allotments of $1.75 billion each plus a one-time appropriation of $12.5 billion to accompany the first semi-annual allotment. For years beyond FY2012, CBO is required to assume that national allotment funding continues at the level prescribed by existing law, which appears to be $3.5 billion under the Senate bill. In contrast, 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.

[25] See CRS Report RL34122, *H.R. 3162: Provisions in the Children's Health and Medicare Protection Act of 2007*, by Richard Rimkunas et al., and CRS Report RL34129, *Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R. 976*, by Evelyne Baumrucker et al.

[26] CBO, *Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, for the Rules Committee* (August 1, 2007), available at [http://www.cbo.gov/ftpdocs/85xx/doc8519/HR3162.pdf].

H.R. 976 as Vetoed. Major elements of the bicameral agreement on SCHIP reauthorization that was passed as an amendment to H.R. 976 and then vetoed on October 3 include:[27]

- national allotment appropriations totaling $61.4 billion over five years (an increase of $36.2 billion over the current law baseline of $25.2 billion), distributed to states and territories using a new formula that builds on provisions in the House and Senate reauthorization bills;
- a new contingency fund (for making payments to states for certain shortfalls of federal SCHIP funds), which would receive deposits through a separate appropriation each year through FY2012 and make payments of up to 20% of the available national allotment for SCHIP;
- new performance bonus payments (for states exceeding certain Medicaid/SCHIP enrollment levels), which are funded with an FY2008 appropriation of $3 billion and deposits of certain unspent SCHIP funds through FY2012;
- additional grants for outreach and enrollment totaling $100 million each year through FY2012;
- provisions to remove barriers to enrollment, including a new option for meeting citizenship documentation requirements;
- provisions to eliminate barriers to providing premium assistance;
- provisions to strengthen quality of care and health outcomes of children;
- program integrity and miscellaneous provisions, including some that affect the Medicaid program; and
- tobacco tax changes.

A September 24 estimate from CBO and JCT[28] indicates that the vetoed H.R. 976 would increase net outlays by $34.9 billion over 5 years and by $71.5 billion over 10 years.[29] These costs would be offset by an increase in the federal tobacco tax and other changes, which CBO and JCT estimate would increase net revenue by $36.3 billion over 5 years and by $72.8 billion over 10 years.

H.R. 3963 as Vetoed. A modified version of the vetoed H.R. 976 was passed as H.R. 3963 and subsequently vetoed on December 12. A summary of differences between the bills across key provisions is provided in another CRS report.[30]

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[27] See CRS Report RL34129, *Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R. 976*, by Evelyne Baumrucker et al.

[28] CBO, letter to the Honorable Max Baucus (September 25, 2007), available at [http://www.cbo.gov/ftpdocs/86xx/doc8655/hr976.pdf].

[29] For an explanation of why CBO's cost estimate for national allotments in the agreement shows savings in years beyond FY2012, see earlier footnote on the Senate bill.

[30] CRS Report RS22746, *SCHIP: Differences Between H.R. 3963 and H.R. 976*, by Evelyne P. Baumrucker et al.

A cost estimate from CBO indicates that the vetoed H.R. 3963 would increase outlays by $35.4 billion over 5 years and by $71.5 billion over 10 years.[31] As with the vetoed H.R. 976, these costs would be offset by an increase in the federal tobacco tax and other changes, which JCT estimates would increase net revenue by $36.3 billion over 5 years and by $72.8 billion over 10 years.

[31] CBO, *CBO's Estimate of the Effects on Direct Spending and Revenues of the Children's Health Insurance Program* (October 24, 2007), available at [http://www.cbo.gov/ftpdocs/87xx/doc8741/hr976DingellLtr10-24-2007.pdf].

Table 3. CRS Staff Contact Information by Medicaid and SCHIP Topic Area

Topic	Staff member	Phone number
Medicaid		
Administration	April Grady	7-9578
Benefits and eligibility		
Aged	Julie Stone	7-1386
Children, families, immigrants, other non-disabled adults	Evelyne Baumrucker Jean Hearne Elicia Herz	7-8913 7-7362 7-1377
Individuals with disabilities, medically needy	Julie Stone	7-1386
Dual eligibles	Julie Stone	7-1386
Expenditures	April Grady	7-9578
Financing		
Disproportionate share hospital payments	Jean Hearne	7-7362
Federal medical assistance percentage	April Grady	7-9578
General issues	April Grady Jean Hearne Elicia Herz	7-9578 7-7362 7-1377
Intergovernmental transfers	Jean Hearne Elicia Herz	7-7362 7-1377
Upper payment limits	Elicia Herz	7-1377
Integrity (waste, fraud, and abuse)	April Grady	7-9578
Long-term care	Julie Stone	7-1386
Managed care	Elicia Herz	7-1377
Prescription drugs	Jean Hearne	7-7362
Provider payment issues	Jean Hearne	7-7362
Territories	Evelyne Baumrucker Jean Hearne Elicia Herz	7-8913 7-7362 7-1377
Waivers		
Section 1115	Evelyne Baumrucker	7-8913
Section 1915(c)	Carol O'Shaughnessy Julie Stone	7-7329 7-1386
SCHIP		
Financing	Evelyne Baumrucker Chris Peterson	7-8913 7-4681
General issues	Evelyne Baumrucker Elicia Herz	7-8913 7-1377
Section 1115 waivers	Evelyne Baumrucker	7-8913

Table 4. CRS Staff Contact Information by Health Insurance Topic Area

Topic	Staff member	Phone number
Health care expenditures	Jennifer Jenson Paulette C. Morgan	7-4453 7-7317
Health insurance		
Association Health Plans	Jean Hearne	7-7362
Employee Retirement Income Security Act of 1974 (ERISA)	Hinda Chaikind Jean Hearne	7-7569 7-7362
Federal Employee Health Benefits Program (FEHBP)	Hinda Chaikind	7-7569
Genetic nondiscrimination	Erin D. Williams	7-4897
Health Coverage Tax Credit	Bernadette Fernandez	7-0322
Health Insurance Portability and Accountability Act of 1996 (HIPAA) — Insurance reforms	Jean Hearne Hinda Chaikind	7-7362 7-7569
HIPAA — Privacy and health information technology (IT)	C. Stephen Redhead	7-2261
Health Savings Accounts	Bob Lyke	7-7355
High risk pools	Bernadette Fernandez	7-0322
Insurance market laws on rating and benefits	Bernadette Fernandez Jean Hearne	7-0322 7-7362
Medical malpractice	Bernadette Fernandez	7-0322
Mental health parity	Ramya Sundararaman	7-7285
Non-group coverage	Bernadette Fernandez	7-0322
Patient protections	Jean Hearne Hinda Chaikind Bernadette Fernandez	7-7362 7-7569 7-0322
Retiree health care	Hinda Chaikind	7-7569
Small employer coverage	Jean Hearne Bernadette Fernandez	7-7362 7-0322
State reforms	April Grady Bernadette Fernandez Jean Hearne	7-9578 7-0322 7-7362
Statistics	Chris L. Peterson	7-4681
Tax policies	Bob Lyke Julie M. Whittaker	7-7355 7-2587