H.R. 2: The Children's Health Insurance Program Reauthorization Act of 2009

Evelyne P. Baumrucker
Analyst in Health Care Financing

Elicia J. Herz
Specialist in Health Care Financing

Chris L. Peterson
Specialist in Health Care Financing

Sibyl Tilson
Specialist in Health Care Financing

Jane G. Gravelle
Senior Specialist in Economic Policy

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Summary

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009) was passed in the House (H.R. 2) on January 14, 2009. The overall structure of CHIPRA 2009 is similar to its two predecessors (H.R. 976 and H.R. 3963 from the 110th Congress).

Cost estimates from the Congressional Budget Office (CBO) indicated that H.R. 2 would increase outlays by $32.3 billion over 5 years and by $65.4 billion over 10 years. Those costs would be offset by an increase in the federal tobacco tax (mostly from an increase in the federal tax by 61 cents per pack of cigarettes) and other changes, which the Joint Committee on Taxation (JCT) estimated would increase on-budget revenue by $32.5 billion over 5 years and by $65.6 billion over 10 years. CBO estimated the bill would increase FY2013 Medicaid and SCHIP enrollment by 6.5 million, for a total of 37.7 million projected enrollees. About 80% of the increased enrollment would have occurred among current eligibility groups, rather than new ones. Of the 6.5 million increased average monthly enrollment in FY2013, CBO estimates that 2.4 million (37%) would have private coverage in the absence of the legislation and that 4.1 million (63%) would have been uninsured.

Most of this report summarizes changes to current law across the major provisions of H.R. 2 that would occur if CHIPRA 2009 were enacted.

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Background

The Balanced Budget Act of 1997 (P.L. 105-33, BBA-97) established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act. SCHIP builds on Medicaid by providing health care coverage to low-income, uninsured children in families with incomes above applicable Medicaid income standards. The latest official numbers show that SCHIP enrollment reached a total of 7.1 million children and nearly 587,000 adults in FY2007. In FY2008, federal SCHIP spending totaled $7.0 billion, with states projected spending expected to equal $7.9 billion in FY2009.

In BBA 97, Congress authorized and appropriated funds for FY1998-FY2007, with no federal appropriations slated for FY2008 and beyond.[1] The absence of future federal appropriations triggered SCHIP legislative attention during the 110th Congress, as reviewed in the next section. After this brief summary of past legislative action, the report provides a description of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009) as introduced as (H.R. 2) on January 13, 2009, and passed by the House Rules Committee on January 13, 2009.

Summary of Major SCHIP Legislation During the 110th Congress

During the 110th Congress, a number of SCHIP bills saw legislative action. A majority of the SCHIP changes enacted in public laws included provisions to add additional appropriations to SCHIP, but did not make any major substantive changes to the program.[2] The 110th Congress enacted provisions to:

- address certain states' shortfalls in FY2007 federal SCHIP funding (U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007, P.L. 110-28);
- provide temporary FY2008 appropriations for SCHIP through December 31, 2007 through continuing resolutions (P.L. 110-92, P.L. 110-116, P.L. 110-137, P.L. 110-149); and
- provide additional appropriations through March 31, 2009 (The Medicare, Medicaid, and SCHIP Extension Act of 2007, P.L. 110-173).

The 110th Congress also considered SCHIP reauthorization legislation that would have made important changes to Medicaid and SCHIP. Numerous bills were introduced, and two that were passed by Congress (H.R. 976 and H.R. 3963) were vetoed by President Bush.[3] **Table 1** provides a time line of the legislative action on the major SCHIP reauthorization bills during 2007.

[1] For more information on SCHIP funding see CRS Report R40075, *What Happens to SCHIP After March 31, 2009?*

[2] A complete legislative history of the SCHIP program is contained in CRS Congressional Distribution Memorandum SCHIP Legislative History, by Elicia J. Herz and Chris L. Peterson, available upon request.

[3] For detailed information about the provisions in each of these bills see CRS Report RL 34129, *Medicaid and SCHIP Provisions in H.R. 3162, S. 1893/H.R. 976, and Agreement*, and CRS Report RS22746, *SCHIP: Differences Between H.R. 3963 and H.R. 976*.

Table 1. Timeline of Legislative Action on the Major SCHIP Reauthorization Bills

Bill				Conference			
Name	Number	House Vote (result)	Senate Vote (result)	House (result)	Senate (result)	Presidential Action (result)	House Override (result)[a]
			110th Congress				
CHAMP[b]	H.R. 3162	8/1/2007 (225-204)					
CHIPRA I[c]	H.R. 976		8/2/2007 (68-31)	9/25/2007 (265-159)	9/27/2007 (67-29)	10/3/07 (veto)	10/18/2007 (273-156)
CHIPRA II[d]	H.R. 3963	10/25/2007 (265-142)	11/1/2007 (64-30)			12/12/07 (veto)	1/23/2008 (260-152)
			111th Congress				
CHIPRA 2009	H.R. 2	1/14/2009 (289-139)					

Source: Prepared by the Congressional Research Service.

a. Two-thirds majority required for veto override. Both votes were short of that margin.

b. Children's Health and Medicare Protection Act of 2007 (CHAMP).

c. Children's Health Insurance Program Reauthorization Act of 2007 (also referred to as CHIPRA I or S. 1893/H.R. 976).

d. The Children's Health Insurance Program Reauthorization Act of 2007 (also referred to as CHIPRA II) was a bicameral agreement that passed as an amendment to H.R. 976.

Overview of the Vetoed H.R. 3963 and H.R. 976

The 110th Congress's H.R. 976 (CHIPRA I) and H.R. 3963 (CHIPRA II) shared many common elements,[4] including

- national allotment appropriations totaling $61.4 billion over five years (which represented an increase of $36.2 billion over the current law baseline of $25.2 billion), distributed to states and territories using a new formula primarily based on their past and/or projected federal SCHIP spending;
- a new contingency fund (for making payments to states for certain shortfalls of federal SCHIP funds), which would have received deposits through a separate appropriation each year through FY2012 and made payments of up to 20% of the available national allotment for SCHIP;
- new performance bonus payments (for states exceeding certain child enrollment levels and states that implement certain outreach and enrollment initiatives), which were to be funded with an FY2008 appropriation of $3 billion and deposits of certain unspent SCHIP funds through FY2012;

[4] A description of the major differences between the two bills across major provisions can be found in CRS Report RS22746, *SCHIP: Differences Between H.R. 3963 and H.R. 976.*

- additional grants for outreach and enrollment that would have totaled $100 million each year through FY2012;
- provisions to remove barriers to enrollment;
- provisions related to benefits (e.g., dental, mental health and Early and Periodic, Screening, Diagnosis and Treatment [EPSDT]);
- 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.

Cost estimates from the Congressional Budget Office (CBO) indicated that H.R. 976 would have increased outlays by $34.9 billion over 5 years and by $71.5 billion over 10 years,[5] and H.R. 3963 would have increased outlays by $35.4 billion over 5 years and by $71.5 billion over 10 years.[6] Costs in both bills would have been offset by an increase in the federal tobacco tax (mostly from an increase in the federal tax by 61 cents per pack of cigarettes) and other changes, which the Joint Committee on Taxation (JCT) estimated would have increased on-budget revenue by $35.5 billion over 5 years and by $71.7 billion over 10 years.

On any given day in 2007, approximately nine million were without health insurance. Most of these children came from two-parent families (53%). Most had a parent who worked full time all year (60%).[7] And other data indicate most uninsured children are *eligible* for Medicaid or SCHIP (62%).[8] According to the Congressional Budget Office (CBO), the two vetoed CHIPRA bills both would have increased FY2012 Medicaid and SCHIP enrollment by 5.8 million, for a total of 34.1 million projected enrollees. In both bills, about 80% of the increased enrollment would have occurred among current eligibility groups, rather than new ones.[9]

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009) was passed in the House (H.R. 2) on January 14, 2009. The overall structure of CHIPRA 2009 is similar to its two predecessors (H.R. 976 and H.R. 3963 from the 110th Congress).

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

[6] 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].

[7] CRS Report 97-975, *Health Insurance Coverage of Children, 2007*.

[8] Julie L. Hudson and Thomas M. Selden, "Children's Eligibility And Coverage: Recent Trends And A Look Ahead," Health Affairs Web exclusive, August 16, 2007, pp. w618-629.

[9] Previously cited CBO cost estimates.

Cost estimates from the Congressional Budget Office (CBO) indicated that H.R. 2 would increase outlays by $32.3 billion over 5 years and by $65.4 billion over 10 years.[10] Those costs would be offset by an increase in the federal tobacco tax (mostly from an increase in the federal tax by 61 cents per pack of cigarettes) and other changes, which the Joint Committee on Taxation (JCT) estimated would increase on-budget revenue by $32.5 billion over 5 years and by $65.6 billion over 10 years. CBO estimated the bill would increase FY2013 Medicaid and SCHIP enrollment by 6.5 million, for a total of 37.7 million projected enrollees. About 80% of the increased enrollment would have occurred among current eligibility groups, rather than new ones. Of the 6.5 million increased average monthly enrollment in FY2013, CBO estimates that 2.4 million (37%) would have private coverage in the absence of the legislation and that 4.1 million (63%) would have been uninsured.

The remainder of this report summarizes changes to current law across the major provisions of H.R. 2 that would occur if CHIPRA 2009 were enacted.

Funding/Financing

Federal SCHIP Allotments

BBA97 created the State Children's Health Insurance Program (SCHIP) and appropriated $40 billion for SCHIP original allotments from FY1998 to FY2007. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) appropriated allotments and additional funding to prevent any state from running out of federal SCHIP funds before March 31, 2009.[11] The SCHIP appropriation for original allotments in FY2007, the last year provided for in BBA97, totaled $5.04 billion. MMSEA provided that same amount annually for SCHIP allotments in FY2008 and FY2009, stating, however, that these funds "shall not be available for child health assistance [SCHIP expenditures] for items and services furnished after March 31, 2009."[12]

MMSEA also provided up to $275 million to cover any shortfalls of federal SCHIP funds for the first half of FY2009—that is, through March 31, 2009. However, even if unspent FY2008 and FY2009 allotments were available past March 31st, 27 states would still need an additional $1.9 billion to prevent any shortfalls for the second half of FY2009.[13]

For FY2009, the current-law allotments were determined consistent with the past several years' allotments. Of the national appropriation ($5 billion for each of FY2007, FY2008 and FY2009), the territories receive 0.25%.[14] The remainder ($4.9875 billion for each of FY2007, FY2008 and FY2009) is divided, or allotted, among the states based on a formula using survey estimates of the number of low-income children in the state and the number of those children who were

[10] CBO, H.R. 2: *Children's Health Insurance Program Reauthorization Act of 2009* (January 13, 2009), available at http://www.cbo.gov/ftpdocs/99xx/doc9963/hr2.pdf.

[11] For additional information on the current-law status of SCHIP, see CRS Report R40075, *What Happens to SCHIP After March 31, 2009?*

[12] §201(a)(2) of MMSEA.

[13] See the last column in Table 1 of CRS Report R40075, *What Happens to SCHIP After March 31, 2009?*

[14] Another part of the SCHIP statute, §2104(c)(4), makes additional SCHIP allotments available to the territories—$40 million for each of FY2007, FY2008 and FY2009.

uninsured.[15] These amounts are adjusted by a geographic adjustment factor and are limited by various floors and ceilings to ensure that a state's allotment does not vary substantially from certain past allotments.

The overall structure of federal SCHIP allotments and financing in CHIPRA 2009 is similar to its two predecessors (H.R. 976 and H.R. 3963 from the 110th Congress). Allotment determinations under these versions of CHIPRA are markedly different from current law. Rather than dividing a fixed national appropriation on the basis of state survey estimates, CHIPRA 2009 would calculate a state's allotment as described below, and if the total of all the states' and territories' allotments did not exceed the national appropriation, that would be the state's allotment. The national appropriations for SCHIP allotments under CHIPRA 2009 are as follows:

- $10,562,000,000 in FY2009;
- $12,520,000,000 in FY2010;
- $13,459,000,000 in FY2011;
- $14,982,000,000 in FY2012; and
- $3,000,000,000 for the first half of FY2013 and $3,000,000,000 for the second half of FY2013.

A "one-time appropriation" of $11,406,000,000 would be added to the half-year amounts provided for FY2013. These provisions for FY2013 are intended to reduce by $11.406 billion per year the amount of allotments assumed by the Congressional Budget Office (CBO) for fiscal years after FY2013.

Although federal SCHIP allotments under BBA97 were made available for three years, allotments for FY2009 onward under CHIPRA 2009 would be available for two years, with unspent funds available for redistribution first to shortfall states and then toward bonus payments, described below.

FY2009 Allotment

FY2009 federal SCHIP allotments for states under CHIPRA 2009[16] would be based on the largest of three state-specific amounts:

- the state's *FY2008* federal SCHIP *spending*, multiplied by a growth factor;[17]
- the state's *FY2008* federal SCHIP *allotment*, multiplied by a growth factor; and

[15] Low-income children are those at or below 200% of the federal poverty level (FPL), which was approximately $35,000 for a family of three in 2008. For additional information, see http://aspe.hhs.gov/poverty/.

[16] States' and territories' federal SCHIP allotments under CHIPRA 2009 are estimated in CRS Report R40129, *Projections of FY2009 Federal SCHIP Allotments Under CHIPRA 2009*.

[17] This growth factor, called the "allotment increase factor" in the legislation, would be the product of (a) 1 plus the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for 2009 over 2008, and (b) 1.01 plus the percentage change in the child population in each state (except for the territories, for which the national amount is used) from July 1, 2008, to July 1, 2009, based on the most recent published estimates of the Census Bureau.

- the state's own *projections* of federal SCHIP spending for *FY2009*, submitted by states to the Secretary of Health and Human Services (HHS) in February 2009.

The largest of these three amounts would be increased by 10% and would serve as the state's FY2009 federal SCHIP allotment, as long as the national appropriation is adequate to cover all the states' and territories' FY2009 allotments.[18] If not, allotments would be reduced proportionally.

FY2010 Allotment

For FY2010, the allotment for a state (or territory) would be calculated as the sum of the following four amounts, if applicable, multiplied by the applicable growth factor for the year:

- the FY2009 SCHIP allotment;
- FY2006 unspent allotments redistributed to and spent by shortfall states in FY2009;
- Spending of funds provided to shortfall states in the first half of FY2009; and
- Spending of Contingency Fund payments (discussed below) in FY2009, although there may be none.

FY2011 and FY2013 Allotments

For FY2011 and FY2013, the allotment for a state (or territory) would be "rebased," based on prior year spending. This would be done by multiplying the state's growth factor for the year by the new base, which would be the prior year's federal SCHIP spending from allotments, redistribution and Contingency Fund payments.

FY2012 Allotment

For FY2012, the allotment for a state (or territory) would be calculated as the FY2011 allotment and any FY2011 Contingency Fund spending, multiplied by the state's growth factor for the year.

Contingency Fund

A Child Enrollment Contingency Fund would be established and funded initially by a separate appropriation of 20% of the available national allotment for SCHIP in FY2009 (approximately $2.1 billion). For FY2010 through FY2013, the appropriation would be such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual payments do not exceed 20% of that fiscal year's available national SCHIP allotment.

If a state's federal SCHIP spending in FY2009 through FY2013 exceeds its available allotments (excluding unspent allotments redistributed from other states) and if the state experienced

[18] Since FY2009 SCHIP appropriations have already been obligated to states for the first half of FY2009 under current law, Sec. 3(c) of the legislation provides for an accounting adjustment: The full-year FY2009 allotment amounts available to states under CHIPRA 2009 are to be reduced by amounts already obligated in the first half of FY2009 under current law.

enrollment that exceeded its target average number (FY2008 enrollment plus annual state child population growth plus one percentage point per year), payments from the Contingency Fund would be the projected federal SCHIP costs for those enrollees above the target number in the state.

Bonus Payments

Funds for bonus payments would be payable in FY2009 to FY2013 to states that (1) increase their Medicaid (not SCHIP) enrollment among low-income children above a defined baseline, and (2) implement four of the following seven outreach and enrollment activities:

- 12 months of continuous eligibility for Medicaid and CHIP children;
- Elimination of an assets test in Medicaid and CHIP, or use of administrative verification of assets;
- Elimination of in-person interview requirement;
- Use of a joint application for Medicaid and CHIP;
- Implementation of certain options to ease enrollees' renewal processes;
- Presumptive eligibility for children; and
- Implementation of "Express Lane," described in a separate section below.

The payments would be funded by an initial appropriation in FY2009 of $3.225 billion, along with transfers from four different potential sources:

- National appropriation amounts for FY2009 through FY2013 provided but not used for allotments;
- Redistribution amounts not spent;
- On October 1 of FY2010 through FY2013, any amounts in the CHIP Contingency Fund that exceed its cap (described above); and
- On October 1 of FY2011, any unspent amounts in the transitional coverage block grant for non-pregnant childless adults, described in a separate section below, not spent by September 30, 2011.

For FY2009, the Medicaid bonus baseline would be equal to the average monthly number of children in 2007, increased by state child population growth between 2007 and 2008 (estimated by the U.S. Census Bureau) plus four percentage points, further increased by state child population growth between 2008 and 2009 plus four percentage points. For subsequent years, the Medicaid bonus baseline is the prior year's plus state child population growth plus additional percentage point increases that are lower than the 4 percentage points for FY2009: for FY2010 to FY2012, 3.5 percentage points; for FY2013 to FY2015, 3 percentage points; and FY2016 onward, 2 percentage points.

The first tier of bonus payments would be for child Medicaid enrollees that represent growth above the baseline less than 10%. For these Medicaid child enrollees, the bonus payment would be equal to 15% of the state share of these enrollees' projected per capita Medicaid expenditures. (Projected per capita Medicaid expenditures would be the average per capita Medicaid expenditures for children for the most recent year with actual data, increased by necessary

projected annual increases in per capita National Health Expenditures.) For the second tier, 10% or more above baseline, the bonus payment would be 62.5% of the state share of these enrollees' projected per capita expenditures.

An eligibility expansion would not qualify a state for additional bonus payments. In order for new Medicaid children to count toward bonus payments, they must have been able to meet the state's eligibility criteria in place on July 1, 2008.

If the available funding for bonus payments to states in a given year is inadequate, the payments would be reduced proportionally.

"Qualifying States" Provision

Under BBA97, states faced a maintenance of effort so they could not draw federal SCHIP funds for child populations already covered under Medicaid. States that had expanded Medicaid coverage to higher income children prior to SCHIP expressed that this was a penalty against their early expansion efforts. A provision was added later in SCHIP to permit 11 early expansion "qualifying states"[19] to draw some SCHIP funds for Medicaid children above 150% of poverty, although with an additional limit in the amount besides just their available federal SCHIP funds (that is, no more than 20% from each original allotment could be spent toward these Medicaid children). Like the two vetoed versions of CHIPRA from the 110th Congress, CHIPRA 2009 would permit this spending for Medicaid children above *133%* of poverty, and without the 20% limitation.

Limitations on SCHIP Matching Rate and Availability of Federal Funds

The federal medical assistance percentage (FMAP) is the state-specific percentage of Medicaid service expenditures paid by the federal government. It is based on a formula that provides higher reimbursement rates to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The enhanced FMAP (E-FMAP) for SCHIP reduces the state's share under the regular FMAP by an additional 30%. The E-FMAP has a statutory minimum of 65% and maximum of 85%.

CHIPRA 2009 would reduce federal SCHIP payments for certain higher-income SCHIP children. CHIPRA 2009 would specify that the regular FMAP would be used for CHIP enrollees whose effective family income would exceed 300% of poverty using the state's policy of excluding "a block of income that is not determined by type of expense or type of income," with an exception for states that already had a federal approval plan or that had enacted a state law to submit a plan for federal approval.

Under current law, children in a Medicaid-expansion SCHIP program must be paid for out of SCHIP funds at the E-FMAP. Medicaid funding cannot be used until a state's available SCHIP funding is exhausted. CHIPRA 2009 gives states the option to draw Medicaid funds at the regular FMAP for Medicaid-expansion SCHIP children.

[19] Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin.

Eligibility

Pregnant Women

Under current SCHIP law, states can cover pregnant women ages 19 and older through waiver authority or by providing coverage to unborn children as permitted through regulation. In the latter case, coverage is limited to prenatal and delivery services. CHIPRA 2009 would allow states to cover pregnant women under SCHIP through a state plan amendment when certain conditions are met (e.g., the Medicaid income standard for pregnant women must be at least 185% FPL; no pre-existing conditions or waiting periods may be imposed; CHIP cost-sharing protections would apply). The upper income limit may be as high as the standard applicable to SCHIP children in the state. Other eligibility restrictions applicable to SCHIP children (e.g., must be uninsured, ineligible for state employee health coverage, etc.) would also apply. The period of coverage would be during pregnancy through the postpartum period (roughly through 60 days postpartum). States would be allowed to temporarily enroll pregnant women for up to two months until a formal determination of eligibility is made. Benefits would include all services available to SCHIP children in the state as well as prenatal, delivery and postpartum care. Infants born to these pregnant women would be deemed eligible for Medicaid or SCHIP, as appropriate, and would be covered up to age one year. States would be allowed to continue to cover pregnant women through waivers and the unborn child regulation. In the latter case, states would be allowed to offer postpartum services.

Adults

Under current law, Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) broad authority to modify many aspects of the Medicaid and SCHIP programs including expanding eligibility to populations who are not otherwise eligible for Medicaid or SCHIP (e.g., childless adults, pregnant women age 19 and older, and parents of Medicaid and SCHIP-eligible children).[20] Certain states that have covered adults with SCHIP funds were permitted to do so almost entirely through the use of these waivers. Adult coverage waivers, which initially are effective for five years, are subject to renewal every three years. Prior to 2007, waiver renewals for states with adult coverage waivers were approved, even for those states that were projected to face federal SCHIP shortfalls (e.g., New Jersey, Rhode Island). Beginning in 2007, however, such waiver renewals have not been approved (e.g., Illinois, Oregon) or states have begun to transition adult populations out of SCHIP coverage (e.g., Wisconsin). As of January 7, 2009, 4 states[21] have CMS authority to use SCHIP funds to extend coverage to certain childless adult populations, and 8 states have such authority to cover parent populations.[22]

CHIPRA 2009 would phase out SCHIP coverage of nonpregnant childless adults after two years. In FY2011, allowable spending under the waivers would be (1) subject to a set-aside amount

[20] The Deficit Reduction Act of 2005 prohibited the Administration from approving any new waivers after February 8, 2006 that permitted SCHIP funds to be used for nonpregnant childless adults. States that already had childless adult waivers could continue them.

[21] States with CMS authority for SCHIP childless adult waivers include Arizona, Idaho, Michigan, and New Mexico.

[22] States with CMS authority for SCHIP parent coverage waivers include Arizona, Arkansas, Idaho, Minnesota, Nevada, New Jersey, New Mexico, and Wisconsin.

from a separate allotment that is tied to waiver spending for such populations in FY2010; (2) matched at the state's regular Medicaid FMP rate; and (3) available only for individuals who were actually enrolled in FY2010. States would be permitted to apply for Medicaid waivers to continue coverage for these populations, but for FY2012, such waivers would be subject to a specified budget-neutrality standard (tied to the state's 2011 spending on this population). For succeeding fiscal years, allowable spending under the waiver would be tied to the state's spending on this population in the preceding fiscal year.

Coverage of parents would still be allowed, but beginning in FY2012, allowable spending under the waivers would be subject to a set-aside amount from a separate allotment and would be matched at the state's regular Medicaid FMAP unless the state was able to prove it met certain coverage benchmarks (related to performance in providing coverage to children). In FY2013, even states meeting the coverage benchmarks would not get the enhanced FMAP for parents but an amount between the regular and enhanced FMAPs. Finally, the provision would prohibit waiver spending under the set-aside for parents whose family income exceeds the income eligibility thresholds that were in effect under the existing waivers as of the date of enactment of this act.

Illegal Aliens and Unauthorized Expenditures

Legal immigrants arriving in the United States after August 22, 1996 are ineligible for Medicaid or SCHIP benefits for their first five years here. Coverage of such persons after the five-year ban is a state option. CHIPRA 2009 would permit states to waive certain restrictions which result in a five-year delay for coverage of necessary health services in order to allow states to provide Medicaid or SCHIP coverage to pregnant women and children who are (1) lawfully residing in the United States, and (2) are otherwise eligible for such coverage. The SCHIP state plan option made available under this provision would only be available to states that (1) elect this state plan option under Medicaid, and (2) in the case of pregnant women coverage, elect the SCHIP state plan option to provide assistance for pregnant women. This provision would be effective upon the date of enactment of this act. CHIPRA 2009 would prohibit federal funding for individuals who are not lawfully residing in the United States, and would provide for the disallowance of federal matching funds for erroneous expenditures made on behalf of such individuals under Medicaid and CHIP.

Enrollment and Access

Outreach and Enrollment

CHIPRA 2009 would include provisions to facilitate access and enrollment in Medicaid and SCHIP. As described above, CHIPRA 2009 would establish bonus payments to states that (1) increased child enrollment in Medicaid or SCHIP by certain amounts, and (2) performed a certain number of specified outreach or enrollment activities. CHIPRA 2009 would authorize $100 million in outreach and enrollment grants above and beyond the regular SCHIP allotments for fiscal years 2009 through 2013. Ten percent of the allocation would be directed to a national enrollment campaign, and 10 percent would be targeted to outreach for Native American children. The remaining 80 percent would be distributed among state and local governments and to community-based organizations for purposes of conducting outreach campaigns with a particular focus on rural areas and underserved populations. Grant funds would also be targeted at proposals that address cultural and linguistic barriers to enrollment.

Express Lane Eligibility

In addition, the bill would create a state option to rely on a finding from specified agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, SCHIP, and Food Stamps) to determine whether a child under age 19 (or an age specified by the state not to exceed 21 years of age) has met one or more of the eligibility requirements (e.g., income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid or SCHIP. CHIPRA 2009 would not relieve states of their obligation to determine eligibility for Medicaid, and would require the state to inform families that they may qualify for lower premium payments or more comprehensive health coverage under Medicaid if the family's income were directly evaluated by the state Medicaid agency. The bill would also drop the requirement for signatures on a Medicaid application form under penalty of perjury.

Citizenship Documentation

The Deficit Reduction Act of 2005 (DRA) requires citizens and nationals applying for Medicaid who claim to be citizens to provide both proof of citizenship and identity. Before DRA, states could accept self-declaration of citizenship for Medicaid, although some chose to require additional supporting evidence. CHIPRA 2009 would provide a specific alternative, which would allow a state to use the Social Security Number (SSN) provided by individuals and verified by the Social Security Administration (SSA), and provide an enhanced match for certain administrative costs. (SSNs by themselves do not denote citizenship, because certain noncitizens are eligible for them.) The bill also would also add a requirement for citizenship documentation in SCHIP.

Premium Assistance

Under current law, states may pay a beneficiary's share of costs for group (employer-based) health in SCHIP if the employer plan (1) covers SCHIP minimum benefits, (2) meets SCHIP cost-sharing ceilings (5% of family income), and (3) ensured enrollees have not had group coverage for a specified period of time (typically four to six months). Under Medicaid, states may implement a premium assistance program if the employer plan is comprehensive, and cost-effective for the state. Under Medicaid, an individual's enrollment in an employer plan is considered cost-effective if paying the premiums, deductible, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the state's expected cost of directly providing Medicaid-covered services. To meet the comprehensiveness test under Medicaid , states are required to provide coverage for those Medicaid-covered services that are not included in the private plans. In other words, they must provide wrap-around benefit coverage. It has proved prohibitive for many employer plans and states to meet all of these requirements. To circumvent these restrictions, most states operating SCHIP premium assistance programs do so under waivers.

Under CHIPRA 2009, states would have the option to offer premium assistance for Medicaid and SCHIP-eligible children and/or parents of Medicaid and/or SCHIP-eligible children where the family has access to employer-sponsored insurance (ESI) coverage, if the employer pays at least 40% of the total premium (and meets certain other requirements). Under CHIPRA 2009, a state offering premium assistance could not require SCHIP-eligible individuals to enroll in an employer's plan; individuals eligible for SCHIP and for employment-based coverage could choose to enroll in regular SCHIP rather than the premium assistance program. The premium

assistance subsidy would generally be the difference between the worker's out-of-pocket premium that included the child(ren) versus only covering the employee. For employer plans that do not meet SCHIP benefit requirements, not only is a wrap-around permitted but would be required.

For the child's coverage using premium assistance, no cost-effectiveness test would be required regarding the cost of the private coverage (plus any necessary wrap-around) relative to regular SCHIP coverage. However, for SCHIP-eligible children who receive coverage under an expansion of Medicaid and elect to receive a premium assistance subsidy under this provision, Medicaid current law requirements regarding comprehensiveness and cost-effectiveness would still apply. CHIPRA 2009 would establish a separate test for family coverage. If the SCHIP cost of covering the entire family in the employer-sponsored plan is less than regular SCHIP coverage for the eligible individual(s) alone, then the premium assistance subsidy could be used to pay the entire family's share of the premium. In states that offered premium assistance, CHIPRA 2009 would require states and participating employers to do outreach. Finally, states would be permitted to establish an employer-family premium assistance purchasing pool for employers with less than 250 employees who have at least one employee who is a SCHIP-eligible pregnant woman or at least one member of the family is a SCHIP-eligible child.

Quality of Care

CHIPRA 2009 includes several provisions designed to improve the quality of care under Medicaid and SCHIP. First, this bill would direct the Secretary of HHS to develop (1) child health quality measures, and (2) a standardized format for reporting information, and procedures to encourage states to voluntarily report on the quality of pediatric care in these two programs. Examples of these initiatives would include (1) grants and contracts to develop, test, update and disseminate evidence-based measures, (2) demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and SCHIP, (3) a demonstration to develop a comprehensive and systematic model for reducing children obesity, and (4) a program to encourage the creation and dissemination of model electronic health record format for children enrolled in these two programs. The federal share of the costs association with developing or modifying existing data systems to store and report child health measures would be based on the matching rate applicable to benefits rather than one of the (typically) lower matching rates applied to different types of administrative expenses.

Second, this bill would improve the availability of public information regarding enrollment of children in Medicaid and SCHIP. Several reporting requirements would be added to states' annual SCHIP reports, including for example, data on eligibility criteria, access to primary and specialty care, and data on premium assistance for employer-sponsored coverage. The bill would also require the Secretary to improve the timeliness of the enrollment and eligibility data for Medicaid and SCHIP children contained in the Medicaid Statistical Information System (MSIS) maintained by CMS and based on annual state reported enrollment and claims data. Finally, certain managed care safeguards applicable to Medicaid (e.g., process for enrollment, termination, and change in enrollment; beneficiary protections; quality assurance standards) would also be applied in the same manner to SCHIP.

Benefits

Under SCHIP, states may provide coverage under their Medicaid programs, create a new separate SCHIP program, or both. Under separate SCHIP programs, states may elect any of three benefit options: (1) a benchmark plan, (2) a benchmark-equivalent plan, or (3) any other plan that the Secretary of HHS deems would provide appropriate coverage for the target population (Secretary-approved coverage). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under the Federal Employees Health Benefits Program (FEHBP), (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state. Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and outpatient hospital services, physician services, lab/x-ray, and well-child care including immunizations), and must include at least 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services).

CHIPRA 2009 would add or modify several benefits available to children under CHIP. The bill also addresses payment of premiums and related sanctions.

Dental Benefits

Under this bill, dental services would become a required benefit under SCHIP and would include services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. States would have the option to provide dental services through "benchmark dental benefit packages" modeled after the benchmark plans for medical services described above (e.g., FEHBP, state employees and commercial HMO options). The bill also includes provisions for dental education for parents of newborns and dental services through federally qualified health centers. Information on dental providers and covered dental services would be available to the public via the federal *Insure Kids Now* website and hotline. The child health quality improvement activities described above would include measurement of dental treatment and services to maintain dental health. GAO would conduct a study on children's access to dental care under Medicaid and SCHIP. The report on this study would include recommendations for federal and state actions to address barriers to dental care, and the feasibility and appropriateness of using qualified mid-level providers to improve access.

Mental Health Parity

Medicaid and SCHIP state plans may define what constitutes mental health benefits (if any). Current law prohibits group health plans from imposing annual and lifetime dollar limits on mental health and substance abuse benefits that are more restrictive than those applicable to medical and surgical coverage. Similarly, group health plans may not impose more restrictive treatment limits (e.g., total outpatient hospital visits or inpatient days) or cost-sharing requirements on mental health or substance abuse coverage compare to medical and surgical services. Under Medicaid, most individuals under age 21 receive comprehensive basic screening services (i.e., well-child visits, immunizations) as well as dental, vision and hearing services, through the Early and Periodic Screening, Diagnostic and Treatment Services or EPSDT benefit. In addition, EPSDT guarantees access to all federally coverable services necessary to treat a problem or condition among eligibles.

CHIPRA 2009 would ensure that, in the case of a state SCHIP plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such a plan must ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan. Generally, this means that the financial requirements and treatment limits applicable to mental health or substance use disorder benefits must be no more restrictive than the financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered under the state SCHIP plan. In addition, state SCHIP plans must also conform to additional mental health parity provisions in section 2705(a) of the Public Health Service Act with respect to availability of plan information and out-of-network providers. State SCHIP plans that include coverage of EPSDT services (as defined in Medicaid statute) would be deemed to satisfy this mental health parity requirement.

Payments for Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

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

CHIPRA 2009 would require states that operate separate and/or combination SCHIP programs to reimburse FQHCs and RHCs based on the Medicaid prospective payment system. This provision would apply to services provided on or after October 1, 2009. For FY2009, $5 million would be appropriated (to remain available until expended) to states with separate SCHIP programs for expenditures related to transitioning to a prospective payment system for FQHCs/RHCs under SCHIP. Finally, the Secretary would be required to report to Congress on the effects (if any) of the new prospective payment system on access to benefits, provider payment rates or scope of benefits.

Premium Grace Period

No statutory provision specifies a grace period for payment of SCHIP premiums. Federal regulations require states' SCHIP plans to describe the consequences for an enrollee or applicant who does not pay required premiums and the disenrollment protections adopted by the state. These protections must include the following: (1) the state must give enrollees reasonable notice of and an opportunity to pay past due premiums prior to disenrollment, (2) the disenrollment process must give the individual the opportunity to show a decline in family income that may qualify the individual for lower or no cost-sharing, and (3) the state must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program, during which time the individual will continue to be enrolled.

CHIPRA 2009 would require states to provide SCHIP enrollees with a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage may be terminated. Within 7 days after the first day of the grace period, the state would have to provide the individual with notice that failure to make a premium payment within the grace period will result in termination of coverage and that the individual has the right to challenge the proposed termination pursuant to the applicable federal regulations. This provision would be effective for new coverage periods beginning on or after the date of enactment of this act.

Clarification of Coverage of Services Provided Through School-Based Health Centers

A number of coverable benefits are listed in the SCHIP statute, such as "clinic services (including health center services) and other ambulatory health care services." CHIPRA 2009 provides that nothing in Title XXI shall be construed as limiting a state's ability to provide SCHIP for covered items and services furnished through school-based health centers.

Program Integrity

Payment Error Rate Measurement (PERM)

Federal agencies are required to annually review programs that are susceptible to significant erroneous payments, and to estimate the amount of improper payments, to report those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous payments. On August 21, 2007, CMS issued a final rule for PERM for Medicaid and SCHIP (effective October 1, 2007) which responded to comments received on a interim final rule, and included some changes to that interim final rule. Assessments of payment error rates related to claims for both fee-for-service and managed care services, as well as eligibility determinations are made. A predecessor to PERM, called the Medicaid Eligibility Quality Control (MEQC) system, is operated by state Medicaid agencies for similar purposes.

CHIPRA 2009 includes a number of detailed requirements with respect to the applicable of PERM requirements to SCHIP. For example, the provision requires that the final PERM rule include (1) clearly defined criteria for errors for both states and providers, (2) a clearly defined process for appealing error determinations by review contractors, and (3) clearly defined responsibilities and deadlines for states implementing corrective action plans. The bill would also require the Secretary to review the MEQC requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing redundancies. The Secretary would also be required to establish state-specific sample sizes for application of PERM requirements to SCHIP for the first fiscal year that begins after the date on which the new final rule is in effect for all states. In establishing such sample sizes, the Secretary must minimize the administrative cost burden on states under Medicaid and SCHIP, and must maintain state flexibility to manage these programs. Finally, the bill would apply a federal matching rate of 90% to expenditures related to administration of PERM requirements applicable to SCHIP. The provision would also exclude from the 10% cap on SCHIP administrative expenses all expenditures related to administration of PERM requirements applicable to SCHIP.

Improving Data Collection

Under current law, the Secretary of Commerce was required to make appropriate adjustments to the Current Population Survey (CPS) which is the primary data source for determining states' SCHIP allotments (1) to produce statistically reliable annual state data on the number of low-income children who do not have health insurance coverage, (2) to produce data that categorizes such children by family income, age, and race or ethnicity, and (3) where appropriate, to expand the sample size used in the state sampling units, to expand the number of sampling units in a state, and to include an appropriate verification element. For this purpose, $10 million was appropriated annually, beginning in FY2000.

CHIPRA 2009 would provide $20 million for FY2009 and each subsequent year thereafter to produce these data for SCHIP purposes. In addition to the current-law requirements of the appropriation, for data collection beginning with FY2009, in consultation with the Secretary of HHS, the Secretary of Commerce would be required to (1) make adjustments to the CPS to develop more accurate state-specific estimates of the number of children enrolled in SCHIP or Medicaid, (2) to make adjustments to the CPS to improve the survey estimates used to determine the child population growth factor in the new financing structure under this bill and any other necessary data, (3) to include health insurance survey information for the American Community Survey (ACS) related to children, and (4) to assess whether estimates from the ACS produce more reliable estimates than the CPS for the child population growth factor in the new SCHIP financing structure established under this bill. On the basis of that assessment, the Commerce Secretary would recommend to the HHS Secretary whether ACS estimates should be used in lieu of, or in some combination with, CPS estimates for these purposes.

Updated Federal Evaluation of SCHIP

The Secretary of HHS was required to conduct an independent evaluation of 10 states with approved SCHIP plans, and to submit a report on that study to Congress by December 31, 2001. Ten million dollars was appropriated for this purpose in FY2000 and was available for expenditure through FY2002. The 10 states chosen for the evaluation were to be ones that utilized diverse approaches to providing SCHIP coverage, represented various geographic areas (including a mix of rural and urban areas), and contained a significant portion of uninsured children. A number of matters were included in this evaluation, including (1) surveys of the target populations, (2) an evaluation of effective and ineffective outreach and enrollment strategies, and identification of enrollment barriers, (3) the extent to which coordination between Medicaid and SCHIP affected enrollment, (4) an assessment of the effects of cost-sharing on utilization, enrollment and retention, and (5) an evaluation of disenrollment or other retention issues.

CHIPRA 2009 would require the Secretary of HHS to conduct a new, independent federal evaluation of 10 states with approved SCHIP plans, directly or through contracts or interagency agreements, as before. The new evaluation would be submitted to Congress by December 31, 2011. Ten million dollars would be appropriated for this purpose in FY2010 and made available for expenditure through FY2012. The current-law language for the types of states to be chosen and the matters included in the evaluation would also apply to this new evaluation.

Access to Records for IG and GAO Audits and Evaluations

Every third fiscal year (beginning with FY2000), the Secretary (through the Inspector General of the Department of Health and Human Services) must audit a sample from among the states with an approved SCHIP state plan that does not, as a part of that plan, provide health benefits coverage under Medicaid. The Comptroller General of the United States must monitor these audits and, not later than March 1 of each fiscal year after a fiscal year in which an audit is conducted, submit a report to Congress on the results of the audit conducted during the prior fiscal year.

Under CHIPRA 2009, for the purpose of evaluating and auditing the SCHIP program, the Secretary, the Office of Inspector General, and the Comptroller General would have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of federal SCHIP funds and that are in the possession, custody, or control of states, political subdivisions of states, or their grantees or contractors. This provision would also apply for the purpose of evaluating and auditing the Medicaid program.

Deficit Reduction Act Technical Corrections—Clarification of Requirements to Provide EPSDT Services for All Children in Benchmark Benefit Packages Under Medicaid

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

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

CHIPRA 2009 identifies specific sections of current Medicaid law (instead of all of Title XIX as specified in DRA) that would be disregarded in order to provide benchmark benefit coverage. It also specifies that an individual's entitlement to EPSDT services would remain in tact under the Medicaid benchmark benefit package option under DRA.

Other Medicare Provisions

Under current law, physicians are generally prohibited from referring Medicare patients for certain designated services to facilities in which they (or their immediate family members) have financial interests. However, among other exceptions, physicians are not prohibited from referring patients to whole hospitals in which they have ownership or investment interests. Under this legislation, a hospital with physician ownership and a Medicare provider agreement on January 1, 2009, would be required to meet other specified requirements to be exempt from the self-referral ban. The hospital would have to comply with requirements that prevent conflicts of interest, ensure bona fide investment, and address patient safety concerns. Also, the percentage of total assets held in the hospital by physician owners or investors could not exceed that as of the

date of enactment. With certain exceptions, these hospitals would not be able to increase the number of operating rooms, procedure rooms, and beds after the date of enactment. To the extent that such expansions are permitted, any increase would be restricted to the main campus of the applicable hospital. Hospitals that are converted from ambulatory surgical centers after the date of enactment would not be eligible for an exception from the self referral prohibition.

Revenue Provisions

The source of revenue for CHIPRA 2009 would be an increase in tobacco excise taxes. H.R. 2 would also incorporate a revision in corporate estimated tax payments to shift revenues into the 5-year budget horizon.

Tobacco Excise Taxes

The vast majority of tobacco taxes are on cigarettes, which account for 97% of federal tobacco tax revenue. Under current law, excise taxes on cigarettes and other tobacco products include the following rates:

- federal cigarette taxes: $0.39 per pack;
- small cigars: $.04 per package of 20;
- large cigars: 20.719% of sales price, not to exceed $48.75 per 1,000 units (i.e., a maximum tax of almost $.05 cents per cigar);
- chewing tobacco: $.01 per ounce;
- snuff: $.04 cents per ounce; and
- pipe and roll-your-own tobacco: $.07 cents per ounce.

There are also taxes on cigarette paper and cigarette tubes. These taxes are imposed per pound and the rates are as follows: (1) $0.195 for chewing tobacco, (2) $0.585 for snuff, and (3) $1.0606 for pipe and roll-your-own tobacco. There are also taxes on large cigarettes that are essentially non-existent (although a tax is necessary for administrative reasons).

CHIPRA 2009 would increase taxes on cigarettes and tobacco-related products (effective April 1, 2009) to the following rates:

- federal cigarette taxes would be increased to $1.00 per pack;
- small cigars would have their taxes gradually increased to the same level as cigarettes: $0.25 per pack in 2009-2010, $0.50 in 2011-2012, $0.75 in 2013-2014, and $0.50 in 2015 and thereafter;
- large cigars would be subject to a tax of 52.4% of sales price with a maximum of $0.40 per cigar;
- chewing tobacco would be increased to approximately $.03 cents per ounce (and $0.50 per pound);
- snuff would be increased to $.09 per ounce ($1.50 per pound);
- pipe tobacco would be increased to $.18 per ounce ($2.8126 per pound);

- roll-your-own tobacco would be increased to $1.53 per ounce ($24.62 per pound). The definition of roll–your-own tobacco would be expanded to include tobacco that could be used to make cigars. The large increase in roll-your-own tobacco reflects concerns that this tobacco might substitute for cigarettes;
- cigarette papers taxes would rise from $1.22 per 40, to $3.13;
- cigarette tubes would rise from $2.44 to $6.26.

CHIPRA 2009 also would include provisions affecting floor stock taxes that would apply to items removed from the manufacturer before the April 1, 2009, effective date, and subsequently sold after that date. The person holding the items on April 1, 2009, would be liable, and there would be a $500 credit per person. (A person is considered to be a controlled group. For example, a corporation can not receive the $500 credit for each of its subsidiaries.) The floor stocks tax would also apply to products in a foreign trade zone (i.e., imports). The purpose of the floor stock tax would be to prevent the stockpiling of tobacco products before the April 1, 2009, effective date for future sales.

CHIPRA 2009 would also impose some regulatory and reporting requirements on manufacturers and importers of processed tobacco other than the tobacco products subject to excise taxes. Finally, CHIPRA 2009 would expand the scope of penalties for not paying the tobacco-related tax, clarify the statute of limitations, and mandate a study of tobacco smuggling.

Author Contact Information

Evelyne P. Baumrucker
Analyst in Health Care Financing
ebaumrucker@crs.loc.gov, 7-8913

Elicia J. Herz
Specialist in Health Care Financing
eherz@crs.loc.gov, 7-1377

Chris L. Peterson
Specialist in Health Care Financing
cpeterson@crs.loc.gov, 7-4681

Sibyl Tilson
Specialist in Health Care Financing
stilson@crs.loc.gov, 7-7368

Jane G. Gravelle
Senior Specialist in Economic Policy
jgravelle@crs.loc.gov, 7-7829