The Children's Health Insurance Program Reauthorization Act of 2009

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Summary

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009, H.R. 2) was passed in the House on January 14, 2009, and in the Senate on January 29, 2009. The overall structure of CHIPRA 2009 is similar to its two predecessors, H.R. 976 and H.R. 3963 from the 110th Congress.

Most of this report summarizes changes to current law across the major provisions of CHIPRA 2009. Where the provisions of the House and Senate versions are identical, the references in this report will simply be to "CHIPRA 2009." Where the provisions differ, the House and Senate versions will be described separately.

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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 nearly 7.4 million children and nearly 335,000 adults in FY2008. 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, H.R. 2) as passed in the House on January 14, 2009, and in the Senate on January 29, 2009.[2] The overall structure of CHIPRA 2009 is similar to its two predecessors, H.R. 976 and H.R. 3963 from the 110th Congress. Most of this report summarizes changes to current law across the major provisions of CHIPRA 2009. Where the provisions of the House and Senate versions are identical, the references in this report are simply to "CHIPRA 2009." Where the provisions differ, the House and Senate versions are described separately.

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.[3] 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

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

[2] The Senate Finance Committee ordered reported its version of CHIPRA2009 on January 15, 2009, which was then introduced for Senate floor consideration as S. 275. The Senate then took up H.R. 2 as passed by the House and replaced it with language from S. 275 (S.Amdt. 39 to H.R. 2). The Senate then passed six additional amendments.

[3] A complete legislative history of the SCHIP program is contained in CRS Congressional Distribution Memorandum SCHIP Legislative History, by (name redacted) and (name redacted), available upon request.

- 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. **Table 1** includes a timeline of the legislative floor action on the major SCHIP reauthorization bills during 2007.

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

Bill		House Vote (result)	Senate Vote (result)	Conference		Presidential Action (result)	House Override (result)[a]
Name	Number			House (result)	Senate (result)		
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	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)	1/29/2009 (66-32)				

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).

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

[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.*

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;
- 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 children 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 average monthly 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]

[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.

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

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009, H.R. 2) was passed in the House on January 14, 2009, and in the Senate on January 29, 2009. The overall structure of CHIPRA 2009 is similar to its two predecessors (H.R. 976 and H.R. 3963 from the 110th Congress). The remainder of this report summarizes changes to current law across the major provisions of CHIPRA 2009.

Cost estimates from the Congressional Budget Office (CBO) indicated that the House-passed version of 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 increases in federal tobacco taxes (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 cost estimates initially indicated that the Senate version would increase outlays by $32.8 billion over 5 years and by $66.1 billion over 10 years. Like the House version, those costs would be offset by increases in federal tobacco taxes, which were estimated to increase on-budget revenue by $32.8 billion over 5 years and by $66.6 billion over 10 years.[11]

CBO estimated both versions of CHIPRA 2009 would increase average monthly 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 occur 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 be uninsured.

Funding/Financing

Federal SCHIP Allotments

Under current law, 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.[12] 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

[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] These cost estimates were from S. 275, the version of CHIPRA 2009 voted out of the Senate Finance Committee on January 29, 2009, which served as the basis of the Senate-passed version of H.R. 2. On the Senate floor, there were six amendments accepted to the original version of S. 275.

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

available for child health assistance [SCHIP expenditures] for items and services furnished after March 31, 2009."[13]

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.[14]

For FY2009, the current-law MMSEA 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%.[15] 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 uninsured.[16] 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, and 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 billion in FY2009;
- $12.52 billion in FY2010;
- $13.459 billion in FY2011;
- $14.982 billion in FY2012; and
- $3 billion for the first half of FY2013 and $3 billion for the second half of FY2013 under the House version. Under the Senate version, the semiannual amounts would be $2.85 billion.

A "one-time appropriation"—of $11.406 billion under the House version and $11.706 billion under the Senate version—would be added to the half-year amounts provided for FY2013. These provisions for FY2013 are intended to annually reduce by the "one-time appropriation" the amount of allotments assumed by the Congressional Budget Office (CBO) for fiscal years after FY2013.[17]

[13] §201(a)(2) of MMSEA.

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

[15] 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.

[16] 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/.

[17] This would result in annual appropriations for allotments for FY2014 forward assumed at $6 billion under the House version and $5.7 billion under the Senate version. Although this provides a much smaller baseline compared to the total appropriation for FY2013 of $17.706 billion, the baseline amount into future years would have been $3.5 billion under (continued...)

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[18] would be based on the largest of three state-specific amounts:

- the state's *FY2008* federal SCHIP *spending*, multiplied by a growth factor;[19]
- the state's *FY2008* federal SCHIP *allotment*, multiplied by a growth factor; and
- 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.[20] 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.

(...continued)

CHIPRA I and $2.3 billion under CHIPRA II.

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

[19] 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.

[20] 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.

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 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 increase their Medicaid (not SCHIP) enrollment among low-income children above a defined baseline.[21] To qualify for bonus payments, states would also have to implement four of the following seven outreach and enrollment activities under the House version:

- 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.

[21] By excluding SCHIP enrollment from bonus payments, CHIPRA 2009 reflects CHIPRA II.

Under the Senate version, an eighth activity would be added, implementation of premium assistance, and states would have to implement five of those eight.[22]

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 state's average monthly number of enrolled Medicaid 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.[23]

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.[24]

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.

[22] The House version reflects the four of seven activities specified in CHIPRA I, while the Senate version includes premium assistance as added in CHIPRA II.

[23] Under both CHIPRA I and CHIPRA II the bonus baseline was increased annually by only one percentage point. Thus, CHIPRA 2009 sets a higher bar for obtaining bonus payments.

[24] Under both CHIPRA I and CHIPRA II, the second tier was at 3% above baseline. By being set at 10% above baseline, CHIPRA 2009 again sets a higher growth requirement for obtaining bonus payments.

Under current law, a number of entities may make Medicaid "presumptive eligibility" determinations for children (e.g., medical providers, entities that determine eligibility for Head Start). Presumptive eligibility allows children who appear to be eligible for Medicaid based on an initial determination to be enrolled for up to two months of coverage while a final determination of eligibility is made. The bonus payment section of the Senate version of CHIPRA 2009 specifies that children who were enrolled in Medicaid through presumptive eligibility would only count for a state's bonus payments if the child was ultimately enrolled through a final determination.

"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"[25] 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 on 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 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. It would specify that the regular FMAP would be used for SCHIP 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.[26]

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

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

[26] CHIPRA 2009 reflects CHIPRA I in this regard. Under CHIPRA II, no federal SCHIP funds would have been available above 300% of poverty and the exception would not include states that had enacted a state law to go above 300% of poverty.

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 supposed to be 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; SCHIP 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 could 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).[27] 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 at least 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,[28] Minnesota). As of January 7, 2009, 4 states[29] have CMS authority to use SCHIP funds to extend coverage to certain childless adult populations, and 7 states[30] have such authority to cover parent populations.

[27] 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.

[28] Despite the fact that the state of Wisconsin has CMS authority (as of 10/1/07) to extend SCHIP coverage to parents with annual income between 130% FPL and 185% FPL, the state did not report SCHIP parent enrollment on the FY2008 SCHIP annual enrollment report.

[29] States with CMS authority for SCHIP childless adult waivers include Arizona, Idaho, Michigan, and New Mexico. Arizona has not used this authority under SCHIP since FY2006.

[30] States with CMS authority for SCHIP parent coverage waivers include Arizona, Arkansas, Idaho, Nevada, New
(continued...)

CHIPRA 2009 would phase out SCHIP coverage of nonpregnant childless adults. Under the House version, SCHIP coverage of nonpregnant childless adults would be phased out after two years. In FY2011, allowable spending under the waivers would be (1) subject to a set-aside amount 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.[31]

The Senate version would terminate SCHIP coverage of nonpregnant childless adults by the end of calendar year 2009.[32] Like the House version, under Senate version states with existing childless adult waivers would be permitted to apply for Medicaid waivers to continue coverage for these individuals subject to a specified budget neutrality standard, but in FY2010 childless adult spending under the waiver would be tied to the state's 2009 waiver spending on this population. The Senate version would require budget neutrality standards for succeeding fiscal years to be tied to waiver spending in the preceding fiscal year.

Under CHIPRA 2009, 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 CHIPRA 2009.

Legal Immigrants

Under current law, 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 bar is permitted at state option if they meet other eligibility requirements for that program. For legal immigrants (but not refugees and asylees), the law requires that their sponsor's income and resources will be taken into account in determining eligibility for those who have signed a legally binding affidavit of support. Generally speaking, for federally means-tested programs (e.g., Medicaid, TANF), the affidavit of support requires the sponsor to ensure that the new immigrant will not become a public charge and makes the sponsor financially responsible for the individual.[33]

(...continued)

Jersey, New Mexico, and Wisconsin.

[31] The House version resembles CHIPRA I regarding childless adults.

[32] The Senate version resembles CHIPRA II regarding nonpregnant childless adults.

[33] CMS (then the Health Care Financing Administration, HCFA) guidance from 1999 states that "the receipt of Medicaid or SCHIP benefits will not be considered in making a public charge determination, except in the case of an alien who is primarily dependent on the government for subsistence as demonstrated by institutionalization for long-term care at government expense. This exception will not include short-term rehabilitation stays in long-term care (continued...)

CHIPRA 2009 would permit states to waive the five-year bar for 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 be available only 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. The Senate version has two additional provisions not contained in the House version of H.R. 2. First, it would assure that for states that elect to extend such coverage, the cost of care would not be deemed under an affidavit of support against an individual's sponsor. Second, as a part of states' redetermination processes (i.e., to redetermine eligibility at least every 12 months with respect to circumstances that may change and affect eligibility), individuals made eligible under this provision whose initial documentation showing legal residence is no longer valid would be required to show "further documentation or other evidence" that the individual continues to lawfully reside.

Illegal Aliens and Unauthorized Expenditures

CHIPRA 2009 restates current law that federal funding for individuals who are not lawfully residing in the United States is not allowed and that the law provides for the disallowance of federal funding of erroneous expenditures under Medicaid and SCHIP.

Enrollment and Access

Outreach and Enrollment

CHIPRA 2009 would include provisions to facilitate access and enrollment in Medicaid and SCHIP. Besides the bonus payments described above, 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. While both versions would include outreach to Native Americans as a part of the National Enrollment Campaign, the House version would also permit grants for specific outreach efforts of Native Americans, and require the Secretary of HHS to report to Congress on the cost-effectiveness of such projects.

Express Lane Eligibility

CHIPRA 2009 would create a state option to rely on a finding from specified "Express Lane" agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families,

(...continued)

facilities." The guidance further provided that the receipt of Medicaid or SCHIP benefits would not disqualify a legal permanent resident (LPR) from sponsoring other immigrants. U.S. Department of Health and Human Service, Health Care Financing Administration, Center for Medicaid and State Operations, letter to State Health Officials, May 26, 1999. For more information on Medicaid and SCHIP coverage of Noncitizens, see CRS Report R40144, *State Medicaid and SCHIP Coverage of Noncitizens*, by (name redacted).

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. There are a couple differences between the House version and the Senate version of H.R. 2. While both versions give states the option of automatic enrollment through an Express Lane eligibility determination contingent on a family's signature of consent, the Senate version permits consent to also be obtained "in writing, by telephone, orally, through electronic signature, or any other means specified by the Secretary" of HHS. The Senate version would also provide states with the option to rely on an applicant's reported income as shown by state income tax records or returns. Under CHIPRA 2009, states would also be required 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. CHIPRA 2009 would also drop the requirement for signatures on a Medicaid or SCHIP 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.) CHIPRA 2009 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 insurance in SCHIP if the employer plan is cost effective relative to the amount paid to cover only the targeted low-income children and does not substitute for coverage under group health plans otherwise being provided to the children. In addition, states using SCHIP funds for employer-based plan premiums must ensure that SCHIP minimum benefits are provided and SCHIP cost-sharing ceilings are met. Under Medicaid, including a Medicaid expansion SCHIP program, 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 or Medicaid premium assistance programs do so under waivers.

CHIPRA 2009 would create a new state plan option for providing premium assistance. 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, a wrap-around 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. 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. The Senate version states that the new premium assistance provisions under Medicaid, not SCHIP, would apply to children enrolled in a Medicaid-expansion SCHIP program.

Quality of Care

CHIPRA 2009 includes several provisions designed to improve the quality of care under Medicaid and SCHIP. First, both bills 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 child obesity, and (4) a program to encourage the creation and dissemination of a 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, CHIPRA 2009 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. CHIPRA 2009 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 current law, states may provide SCHIP 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 SCHIP. Both bills also address payment of premiums and related sanctions.

Dental Benefits

Under CHIPRA 2009, 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). CHIPRA 2009 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.

Under current law, children who are enrolled in a group health plan or employer-sponsored health insurance are not eligible for SCHIP coverage. Under Medicaid, beneficiaries may have such private coverage. With respect to beneficiary cost-sharing under current SCHIP law, states that implement SCHIP Medicaid expansions must follow the cost-sharing rules of the Medicaid program. For states that implement SCHIP through a separate state program, the maximum allowable amounts vary by family income level, and aggregate cost-sharing may not exceed 5% of family income for the year.

The Senate version of H.R. 2 would provide a state option under separate SCHIP programs, subject to certain conditions, to provide dental-only supplemental coverage to children enrolled in group or employer coverage who otherwise meet SCHIP eligibility criteria. The provision would allow states to provide dental coverage consistent with the new dental benchmark benefits plans or cost-sharing protections for dental coverage applicable under SCHIP. States would be allowed to set the upper income level for this new benefit up to the level otherwise applicable under their separate SCHIP programs. States would not be allowed to offer dental-only supplemental coverage unless (1) the state has implemented the highest income eligibility permitted in federal

SCHIP statute (or a waiver) as of January 1, 2009; (2) the state does not limit acceptance of applications for children or impose any enrollment caps, waiting lists, or similar eligibility limitations under SCHIP; and (3) the state provides benefits to all children in the state who apply for and meet the eligibility standards. In addition, states may not provide more favorable dental coverage or related cost-sharing protections for children provided dental-only supplemental coverage than the dental coverage or related cost-sharing protections for SCHIP children eligible for the full range of SCHIP benefits. States would have the option to not apply an eligibility waiting period for children provided dental-only supplemental coverage.

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.

The Senate version would add a definition for "school-based health center" to include a health care clinic that (1) is located in or near a school facility of a school district or board of an Indian tribe (IT) or tribal organization (TO); (2) is organized through school, community, and health provider relationships; (3) is administered by a sponsoring facility (e.g., hospital, public health department, community health center, nonprofit health care agency, school or school system, or a program administered by the Indian Health Service or Bureau of Indian Affairs, or operated by an IT or TO); (4) provides primary health services through health professionals to children in accordance with state and local law, including laws relating to licensure and certification; and (5) satisfies such other requirements as a state may establish for the operation of such a clinic.

Medicaid and CHIP Payment and Access Commission

The Senate version of CHIPRA 2009 would establish a new federal commission, called the Medicaid and CHIP Payment and Access Commission, or MACPAC. This commission would engage in a number of activities. MACPAC would review program policies under both Medicaid and SCHIP affecting children's access to benefits, including (1) payment policies, including the process for updating fees for different types of providers, payment methodologies, and the impact of these factors on access and quality of care; (2) the interaction of Medicaid and SCHIP payment policies with health care delivery generally; and (3) other policies, including those relating to transportation and language barriers. The commission would make recommendations to Congress concerning such access policies. Beginning in 2010, by March 1 of each year, the commission would submit a report to Congress containing the results of these reviews and MACPAC's recommendations regarding these policies. Also beginning in 2010, by June 1 of each year, the commission would submit another report to Congress containing an examination of issues affecting Medicaid and SCHIP, including the implications of changes in health care delivery in the U.S. and in the market for health care services.

MACPAC would also be required to create an early warning system to identify provider shortage areas or other problems that threaten access to care or the health care status of Medicaid and SCHIP beneficiaries.

In addition, if the Secretary of HHS submits a report to Congress (or any such committee) that is required by law and that relates to access policies, including payment policies, under Medicaid or SCHIP, a copy of that report must also be submitted to MACPAC. MACPAC would review such a report and submit written comments, along with any recommendations, to the House Committee on Energy and Commerce and the Senate Finance Committee not later than six months after the date of submittal of the Secretary's report to Congress.

MACPAC would also be required to consult periodically with the chairmen and ranking minority members of these two congressional committees regarding MACPAC's agenda and progress toward achieving that agenda. MACPAC may conduct additional reviews, and submit additional reports to these congressional committees on such topics relating to Medicaid and SCHIP as requested by such chairmen and members, and as MACPAC deems appropriate. In addition, MACPAC would be required to transmit to the Secretary a copy of each report submitted to Congress, and must make such reports available to the public. With respect to each recommendation made in reports by MACPAC, each commission member must vote on said recommendation, and MACPAC must include, by member, the results of that vote in the report containing that recommendation. Before making any recommendations, MACPAC would be required to examine the budget consequences of such actions, directly or through consultation with appropriate experts.

MACPAC would be composed of 17 members appointed by the Comptroller General. Additional provisions in the bill would further define (1) qualifications for Commission members, (2) length of tenure (three years) and procedures for filling vacancies, (3) compensation for members, (4) designation of a Chairman and Vice Chairman among members, and (5) meetings. The provision would also allow the commission to establish a paid, professional staff to assist in the commission's work. MACPAC would have the power to obtain official data from any department or agency of the U.S. government that is necessary to enable it to carry out its mission. MACPAC must (1) utilize existing information where possible, collected by its own staff or under other arrangements; (2) carry out, or award grants or contracts, for original research when existing

information is inadequate; and (3) adopt procedures to allow submission of information by outside parties for MACPAC's use. The Comptroller General must have unrestricted access to the work of the commission, immediately upon request, and MACPAC may be subject to periodic audits by the Comptroller General.

With respect to funding, MACPAC must submit requests for appropriations in the same manner as the Comptroller General submits such request, but amounts appropriated to MACPAC must be separate from amounts appropriated for the Comptroller General. In addition, the provision would authorize to be appropriated such sums as may be necessary to carry out the provisions of this section.

The provision also requires the Comptroller General to appoint the initial members of the commission no later than January 1, 2010. Finally, not later than January 1, 2010, and annually thereafter, the Secretary of HHS, in consultation with the Secretaries of the Treasury and Labor, and the states, must submit an annual report to Congress on the financial status of, enrollment in, and spending trends for Medicaid for the fiscal year ending on September 30 of the preceding fiscal year.

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 applicability 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. Both bills 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. In the House version of CHIPRA 2009, this activity would begin with FY2009, while in the Senate version, this activity would begin with the first fiscal year that begins on or after the date on which the new final rule is in effect for all states. The Senate version would also require that the new final rule be promulgated not later than six months after the enactment of CHIPRA 2009. 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' current law 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 (e.g., 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 certain state-specified groups through enrollment in benchmark and benchmark-equivalent coverage that is nearly identical to plans available under SCHIP. For any child under age 19 in one of the major mandatory and optional eligibility groups in Medicaid, wrap-around benefits to the DRA benchmark and benchmark-equivalent coverage includes EPSDT.

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 Medicaid and SCHIP Provisions

CHIPRA 2009 also includes additional provisions that affect the Medicaid and/or SCHIP programs. These would

- permit territories that qualify for the enhanced federal match that is available under Medicaid for improvements in data reporting systems to be reimbursed for such improvements outside of the territory's Medicaid spending cap;
- eliminate counting Medicaid child presumptive eligibility costs against SCHIP allotments;

- improve outreach and enrollment of Indians under Medicaid and SCHIP, and exclusion of expenditures related to these activities from the 10% limit on SCHIP expenditures related to outreach and certain other activities;
- require the Secretary of HHS, in consultation with other organizations, to develop a model process (and report for Congress) for the coordination of enrollment, retention, and coverage of children who frequently change their residency due to migration of families, emergency evacuations, educational needs, etc.;
- amend applicable federal laws to streamline coordination between public and private coverage, including making the loss of Medicaid/SCHIP eligibility a "qualifying event" for the purpose of purchasing employer-sponsored coverage, and require employers to notify families of their potential eligibility for premium assistance;
- prohibit the Secretary of HHS from approving any new Health Opportunity Account demonstrations as of the date of enactment of this Act;
- make technical corrections to selected Medicaid provisions in the Deficit Reduction Act of 2005 (P.L. 109-171) that would (1) correct references to children in foster care receiving child welfare services and (2) require the Secretary to publish the provisions that the Secretary has determined do not apply in order for a state to implement a state plan amendment to provide benchmark benefits to selected Medicaid populations, and the reason for such determinations;
- change references to the "State Children's Health Insurance Program" and the term "SCHIP" currently used in official federal communications to "Children's Health Insurance Program" and "CHIP," respectively;
- provide an adjustment in the computation of the Medicaid federal medical assistance percentage (FMAP) to disregard an extraordinary employer pension contribution;
- prohibit the Secretary from denying federal matching payments when the state share has been transferred from or certified by certain publicly owned regional medical centers in other states if the Secretary determines that the use of such funds is proper and in the interest of the Medicaid program;
- extend the special disproportionate share hospital (DSH) allotment arrangements under Medicaid for Tennessee and Hawaii through a portion of FY2012;
- require the Comptroller General to submit a report to the Committee on Finance in the Senate and the Committee on Energy and Commerce in the House of Representatives analyzing the extent to which state payment rates for Medicaid managed care organizations are actuarially sound (in the Senate version of H.R. 2 only);
- establish a task force to conduct a nationwide campaign of education and outreach for small businesses regarding the availability of coverage for children through private insurance, Medicaid, and SCHIP; and
- include a Sense of Senate regarding access to affordable and meaningful health insurance coverage.

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 the House version of H.R. 2, 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.

The Senate version does not include this provision.

Revenue Provisions

The source of revenue for CHIPRA 2009 would be an increase in tobacco excise taxes. The legislation would also incorporate a revision in corporate estimated tax payments to shift revenues into the five-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 per ounce; and
- pipe and roll-your-own tobacco: $.07 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).

The House version of H.R. 2 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 $1.00 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.

These provisions in the Senate version of H.R. 2 are essentially identical to the House version, with very small increases in tax rates across the tobacco products. However, the Senate version proposes to increase the tax on small cigars to the same level as cigarettes immediately;

- federal cigarette taxes would be increased to $1.0066 per pack;
- small cigars would have their taxes increased to the same level as cigarettes;
- large cigars would be subject to a tax of 52.75% of sales price with a maximum of $0.4026 per cigar;
- chewing tobacco would be increased to approximately $.03 cents per ounce (and $0.5033 per pound);

- snuff would be increased to $.09 per ounce ($1.51 per pound);
- pipe tobacco would be increased to $.18 per ounce ($2.8311 per pound);
- roll-your-own tobacco would be increased to $1.55 per ounce ($24.78 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 $3.15;
- cigarette tubes would rise from $2.44 to $6.30.

Estimated Corporate Tax Payments

Under current law, quarterly estimated corporate tax payments due in July, August, and September of 2013 are 120% of the normal required payment, with the next such payment reduced accordingly. The House version of H.R. 2 would increase this ratio to 121%, shifting $600 million of corporate taxes from FY2014 to FY2013. The Senate version of H.R. 2 would increase the ratio to 120.5% and shift $300 million of corporate taxes from FY2014 to FY2013. The current-law 120% withholding provision does not apply to firms with assets of less than $1 billion, and the withholding increase under CHIPRA 2009 would not alter that exemption.

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