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SENATE REPUBLICAN POLICY COMMITTEE

Legislative Notice

No. 25 July 30, 2007

S. 1893 - State Children's Health Insurance Program Reauthorization Act of FY 2007

Calendar No. 288

S. 1893 was reported by the Finance Committee on July 27, 2007 by a vote of 17-4. No committee report was issued.

Noteworthy

- At 5:30 p.m. Monday, July 30, the Senate will vote on cloture on the motion to proceed to H.R. 976, a House small business tax bill which will serve as the vehicle for S. 1893, the Senate SCHIP legislation.
- S. 1893 extends coverage for the 6.6 million children currently enrolled in SCHIP, as well as an additional 3.3 million currently uninsured children. Most of these increases come from providing coverage to children currently eligible for SCHIP or Medicaid but not enrolled: 2.7 million of the 3.3 million are currently eligible or entitled to coverage, while only 600,000 come from expanding coverage to higher income levels. Additionally, S. 1893 provides funds to continue coverage of 800,000 children (included among the 6.6 million currently covered) who would otherwise lose eligibility under the baseline budget.
- CBO estimates S. 1893 will cost $60.2 billion over five years, which includes $25 billion contained in the budget baseline and a $35.2 billion expansion. Funding for the program will expire on September 30, 2007 if not reauthorized.
- States will be permitted to expand coverage to families earning up to 300 percent of the Federal Poverty Level (FPL) ($61,950 for a family of four in 2007) at the enhanced SCHIP matching rate. States that have an approved state plan amendment or that have passed a state law to cover children above 300 percent of FPL will be allowed to continue coverage at the higher eligibility level.
- S. 1893 prohibits the approval or renewal of any state waivers providing coverage to childless nonpregnant adults. New waivers for parents will be prohibited. States that currently have waivers to cover parents will receive a reduced match for coverage of parents. States will be required to meet certain child coverage benchmarks or have

their funding further reduced to the Medicaid level.

- There is a reduction in private insurance coverage, also known as "crowd-out," of 2.1 million children. This is the sum of: the effect of providing funding to maintain current SCHIP programs (500,000 children); the effect of additional enrollment within existing eligibility groups (1 million children); and the effect of expansion of SCHIP eligibility to new populations (600,000 children). Among newly eligible populations covered by S. 1893, CBO estimates a one-for-one match between additional enrolled individuals and the reduction in private coverage.
- The expansion will be paid for by an increase on tobacco products and cigarette papers and tubes. Notably, the cigarette tax will be increased by 61 cents to $1 per pack, and the tax on cigars will be increased to 53 percent of the manufacturer or importer's sales price, up to $10.00 per cigar.
- Senate Budget Committee Republican staff have indicated that a long-term spending point of order lies against S. 1893 because it causes changes in direct spending and revenues that would cause an increase in the on-budget deficit greater than $5 billion in at least one of the 10-year periods between FYs 2018-2057. This point of order would be subject to a 60 vote threshold.

Highlights

On July 19, 2007, the Senate Finance Committee approved the Children's Health Insurance Program Reauthorization Act of 2007 by a 17-4 vote. The legislation will reauthorize and expand the State Children's Health Insurance Program (SCHIP). The authorization and the funding stream for the program will expire on September 30, 2007 if not reauthorized.

S. 1893 maintains coverage for the 6.6 million children currently receiving health insurance coverage through SCHIP, and expands coverage to 3.3 million additional children.[1] The Congressional Budget Office (CBO) estimates the reauthorization will cost $60.2 billion over five years, which includes $25 billion in the budget baseline and a $35.2 billion expansion.[2] A reserve fund in the FY 2008 Budget Resolution passed by Congress set aside $50 billion for the purpose of expanding SCHIP. The expansion will be paid for by increasing the excise tax on tobacco products, including raising the cigarette tax by 61 cents a pack.

[1] Note that the Congressional Budget Office number for the reduction of the uninsured is actually 3.2 million children when rounded. However, the CBO adds the number of children enrolled within existing eligibility groups (2.7 million) with the children enrolled in expanded populations (600,000) to reach 3.2 million. *See* CBO "Cost estimate for the legislative language provided by the Committee on Finance on July 26, 2007," July 26, 2007. Available at: http://www.cbo.gov/ftpdocs/84xx/doc8489/BaucusSCHIP7-26-07.pdf.

[2] Congressional Budget Office, "Cost estimate for the legislative language provided by the Committee on Finance on July 26, 2007," July 26, 2007.

Under S. 1893, states will be permitted to expand coverage to families earning up to 300 percent of the Federal Poverty Level (FPL) ($61,950 for a family of four in 2007)[3] at the enhanced SCHIP matching rate.[4] States that have an approved state plan amendment or that have passed a state law to cover children above 300 percent of FPL will be allowed to continue coverage at the higher eligibility level.[5] S. 1893 provides incentives to states to increase enrollment of children below 200 percent of FPL in order to target low-income children currently eligible for Medicaid and SCHIP but not enrolled in the programs.

S. 1893 also addresses coverage of adults. Childless adults will be phased out over two years. New waivers for parents will be prohibited. States that currently have waivers to cover parents will receive a reduced match for coverage of parents. States will be required to meet certain child coverage benchmarks or have their funding further reduced to the Medicaid level. States will have an additional option to cover pregnant women through a state plan amendment. Nothing in the Senate bill will affect a state's ability to cover pregnant women through waiver or regulation.

Background

SCHIP Program Summary and Background on the Uninsured

In 1997, Congress passed SCHIP as part of the Balanced Budget Act of 1997 to help states provide health coverage to the children of working-poor families who did not qualify for Medicaid. The program was designed to cover low-income children under age 19 between 100- and 200-percent of FPL (between $20,650 and $41,300 per year for a family of four in 2007).[6] These families earned too much to qualify for Medicaid, but may not have been able to afford private health coverage for their children.

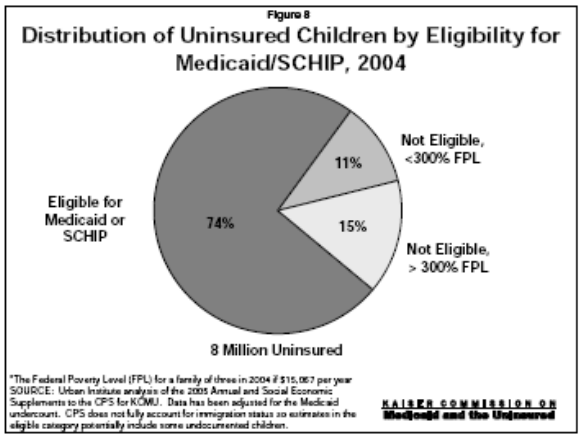
SCHIP has successfully reduced the number of uninsured children. Last year, 6.6 million children received health insurance through SCHIP.[7] The percentage of uninsured children between 100- and 200-percent of FPL has dropped by one-quarter (from 22.5 percent in 1996 to 16.9 percent in 2005).[8]

All 56 states and territories have approved SCHIP plans, and 45 percent of U.S. children are now covered by either SCHIP or Medicaid.[9] Eligibility rates for the program vary by state. The

[3] The FPL in 2007 for a family of four is $20,650. United States Department of Health and Human Services, 2007 Poverty Guidelines, available at http://aspe.hhs.gov/poverty/07poverty.shtml.
[4] It should be noted that states can expand coverage to this income level under current law by using income disregards.
[5] This appears to benefit New Jersey, which covers children up to 350 percent of FPL, and New York—which submitted a plan amendment pursuant to the state budget—to increase eligibility to 400 percent of FPL. *See* Governor Eliot Spitzer, "Let's Complete the Job: Expanding SCHIP," Commentary in the Commonwealth Fund, April 23, 2007. Available at: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=478902.
[6] Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.
[7] Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.
[8] Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.
[9] Center for Medicare and Medicaid Services, "The State Children's Health Insurance Program," June 1, 2007.

lowest eligibility in a state is 140 percent of FPL, and the highest is 350 percent of FPL.[10] In 2006, 15 states had thresholds above 200 percent of FPL, 26 set eligibility at 200 percent, and 9 had thresholds below.[11]

Estimates on the number of remaining uninsured children vary. Census data reports that there were approximately 8 million children without health insurance at some point in 2005.[12] Of those uninsured, two-thirds are eligible for SCHIP or Medicaid but not enrolled in either program (3.7 million are eligible for Medicaid, and 1.7 million are eligible for SCHIP).[13]



Funding Levels

From 1998-2007, Congress has provided roughly $40 billion to fund SCHIP. For FY 2007, the funding level is set at $5 billion, and CBO assumed in its budget baseline that funding will continue at this level over the next five years. The President's budget provides $4.8 billion for FY 2009-2012. It also redistributes approximately $3.8 billion in existing state SCHIP surpluses to address SCHIP shortfalls.

CBO has estimated that, because of population growth and the increasing cost of medical care, it will cost an additional $14 billion (on top of the $25 billion currently in the baseline budget) over 5 years to maintain current SCHIP programs.[14]

A reserve fund in the budget resolution passed by Congress set aside $50 billion for the purpose of expanding SCHIP, which is on top of the $25 billion built into the budget baseline.

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[10] Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.
[11] Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.
[12] The census data is actually closer to 9 million, but researchers believe that these numbers undercount the number of children on Medicaid. *See* Kaiser Family Foundation, "SCHIP Reauthorization, Key Questions in the Current Debate," July 2007.
[13] The Department of Health and Human Services released an Urban Institute study which showed that only 4.9 million children were uninsured for the entire year, as opposed to at some point during the year. CBO has indicated that it believes the Census data figures are more appropriate and uses those numbers in analyzing changes to the program. *See* Congressional Budget Office Memorandum from Jeanne De Sa and Eric Rollins, "Clarifications to our estimates of the costs of covering more children in Medicaid and SCHIP," March 13, 2007.
[14] However, because additional federal funds for SCHIP will reduce states' need for some Medicaid funds, CBO estimates the net cost of the program to the federal government (including savings to Medicaid) will be $8 billion over the 5-year period. Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.

CBO estimates that S. 1893 will cost $60.2 billion over five years, which includes $25 billion in the budget baseline and a $35.2 billion expansion. This is $15 billion less than is permitted by the FY 2008 Budget Resolution. The expansion will be paid for by a tax increase on tobacco products and cigarette papers and tubes. Notably, the cigarette tax will be increased by 61 cents to $1 per pack, and the tax on cigars will be increased to 53 percent of the sale price, up to $10.00 per cigar.[15]

In contrast to Medicaid, which has no predetermined limit on funding and instead varies according to enrollment, funding for SCHIP is set on an annual basis. States receive an annual allotment pursuant to a formula, but they are not required to use the full allotment during the fiscal year.[16] Currently the allotments are available for up to three years, and then the allotments are reallocated to other states and, ultimately, to the U.S. Treasury.

S. 1893 bill will provide states access to their allotment for two years. Unspent funds will go to an incentive fund to encourage the enrollment of low-income children. No federal financing is available for states if they exceed their allocation, although in practice Congress has repeatedly passed legislation to assist states with shortfalls. S. 1893 establishes a contingency fund for states that face unanticipated state shortfalls, including for sustained high rates of unemployment.

As a five-year authorization, S. 1893 is compliant with the Senate's "Pay-Go" rules. However, the Senate bill reduces the allotment in the fifth year in order to comply with "Pay-Go" over a 10-year window. According to CBO, SCHIP outlays are projected to go from $8.4 billion in 2012 to only $600 million in 2013. CBO estimates that the total cost of the bill over the 2008-2017 period would be $112 billion if program costs increased according to enrollment projections, which is significantly above the $71 billion in revenues provided by the tobacco tax.

Senate Budget Committee Republican staff have indicated that a long-term spending point of order lies against S. 1893 because it causes changes in direct spending and revenues that would cause an increase in the on-budget deficit greater than $5 billion in at least one of the 10-year periods between FYs 2018-2057. This point of order would be subject to a 60 vote threshold.

Income Levels Covered

The SCHIP statute allows states to cover children with incomes up to 200 percent of FPL, or 50 percentage points above their Medicaid threshold. However, under current law, states have been able to disregard certain types of income in determining eligibility for the program.[17] States receive an enhanced matching rate, known as the Enhanced Federal Medical Assistance Percentage (E-FMAP), for children they enroll in SCHIP. E-FMAP rates provide between 65-85 percent of the cost of insuring a child, as compared to 50-83 percent in Medicaid.

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[15] It should be noted that the reduced consumption of cigarettes and tobacco products caused by the increased tax will steadily reduce revenues from this provision. *See* Joint Committee on Taxation, "Estimated Revenue Effects of the Revenue Provisions Relating to the State Children's Health Insurance Program," July 13, 2007.

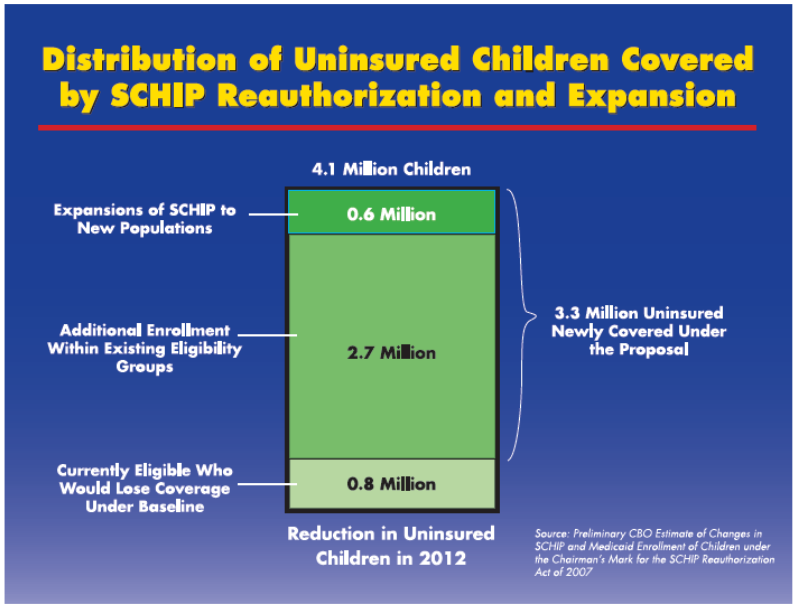
[16] The current formula has been criticized for undercounting kids in certain smaller, rural states and for rewarding states that have high rates of uninsured low-income children.

[17] Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.

S. 1893 allows states to receive the enhanced match for families with incomes up to 300 percent of FPL ($61,950 for a family of four in 2007).[18] States that expand eligibility above 300 percent of FPL will receive only the lower Medicaid federal matching rate for those families. An exception will be made for states that have an approved state plan amendment or have passed a state law to cover children above 300 percent of FPL. These states will be allowed to continue coverage at the higher level. This provision appears intended to allow New Jersey to continue enrolling families up to 350 percent of FPL, and, pending approval from the Centers for Medicare and Medicaid Services (CMS), would allow New York to expand its program to 400 percent of FPL, or $82,600 per year for a family of four.

Effects on Enrollment

S. 1893 extends coverage for the 6.6 million children currently enrolled in SCHIP, as well as an additional 3.3 million currently uninsured children. Most of these increases come from providing coverage to children currently eligible for SCHIP or Medicaid but not enrolled: 2.7 million of the 3.3 million are currently eligible or entitled to coverage, while only 600,000 come from expanding coverage to higher income levels. Additionally, S. 1893 provides funds to continue coverage of 800,000 children (included among the 6.6 million currently covered) who would otherwise lose eligibility under the baseline budget. There is also a reduction in private insurance of 2.1 million children due to the "crowd-out" effect, discussed more fully below.



The "Crowd-Out" Effect

CBO concluded that SCHIP has a significant "crowd-out" effect – meaning that children or families will drop private insurance to enroll in the public program. CBO includes this in measuring the total cost of the program. The effects of "crowd out" are more acute as states expand eligibility to higher-income families. As noted above, there is a reduction in private

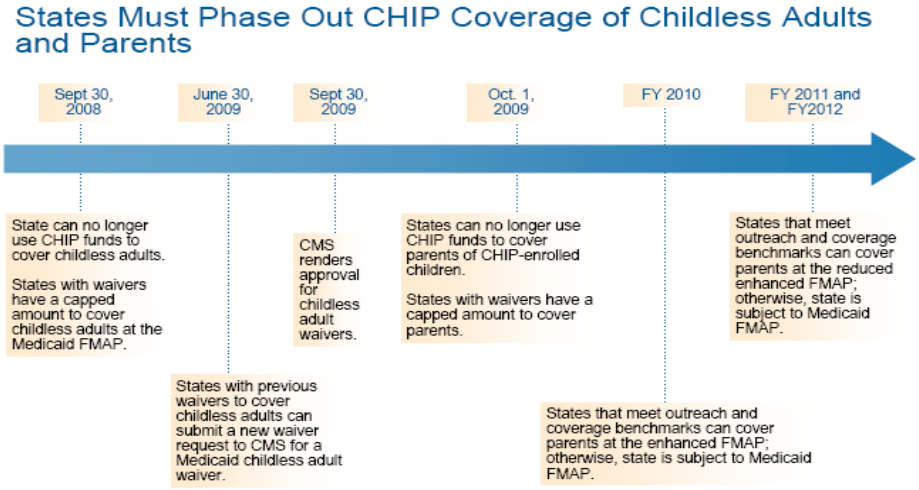
[18] United States Department of Health and Human Services, 2007 Poverty Guidelines, available at http://aspe.hhs.gov/poverty/07poverty.shtml.

insurance coverage under S. 1893 of 2.1 million children.[19] This is the sum of: the effect of providing funding to maintain current SCHIP programs (500,000 kids); the effect of additional enrollment within existing eligibility groups (1 million kids); and the effect of expansion of SCHIP eligibility to new populations (600,000 kids). Among newly eligible populations covered by S. 1893, CBO estimates a one-for-one match between additional enrolled individuals and the reduction in private coverage.

Coverage of Adults

Designed as a program to provide health insurance to low-income children, many states have received waivers, from both the Clinton and Bush Administrations, to use SCHIP funds to cover childless adults, parents, and pregnant women. In addition to the 6.6 million children enrolled in the program, approximately 670,000 adults were enrolled at some point in 2006.[20] Fourteen states have SCHIP waivers that permit them to use SCHIP funds to cover adults. This year, 13 percent of SCHIP funds will go to adults other than expectant mothers, and currently three states cover more adults than children.[21]

S. 1893 prohibits the approval or renewal of any state waivers providing coverage to childless nonpregnant adults. States with applicable existing waivers for childless adults will be allowed to continue extending coverage through FY 2009, although this will be subject to the lower Medicaid reimbursement rate. The bill also prohibits new state waivers to expand coverage to parents. States with existing parent waivers will be permitted to continue coverage until 2009, at which point a lower Reduced Enhanced Matching Assistance Percentage [REMAP] rate will apply.[22] States will be allowed to offer optional coverage to pregnant women up to the coverage level for low-income children provided they cover pregnant women up to 185 percent of FPL in Medicaid and meet other conditions.



Source: Analysis of Senate Finance Bill by Avalere Health LLC

[19] When SCHIP was enacted in 1997, CBO assumed there would be approximately a 40-percent reduction in private coverage or, "crowd-out," as a result.
[20] Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.
[21] Remarks by Secretary of Health and Human Services Michael Leavitt to the American Enterprise Institute, April 24, 2007.
[22] This rate is between the FMAP and E-FMAP rate, and is determined by a formula established in the bill that is applied individually to each state.

Bill Provisions

Title I − Financing of CHIP

Section 101. Extension of CHIP

The bill appropriates the following amounts for fiscal years 2008−2012:
FY 2008: $9.125 billion.
FY 2009: $10.675 billion.
FY 2010: $11.85 billion.
FY 2011: $13.75 billion.
FY 2012: $ 1.75 billion for the period beginning October 1, 2011 and ending on March 31, 2012; and $1.75 billion for the period beginning April 1, 2012 and ending on September 30, 2012.

Note that a one-time appropriation is made in Section 103 to make up for the funding reduction in FY 2012. As a five-year authorization, S. 1893 is compliant with the Senate's "Pay-Go" rules. However, the Senate bill reduces the allotment in the fifth year in order to comply with "Pay-Go" over a 10-year window. According to CBO, SCHIP outlays are projected to go from $8.4 billion in 2012 to only $600 million in 2013. CBO estimated that the total cost of the bill over the 2008-2017 period would be $112 billion if program costs increased according to enrollment projections, which is significantly above the $71 billion in revenues provided by the tobacco tax.

Section 102. Allotments for the 50 States and the District of Columbia

S. 1893 establishes a new allotment formula to determine each state's share of annual SCHIP appropriations. The current SCHIP formula is replaced with a new methodology set forth in this section.[23]

Section 103. One-time appropriation for FY 2012

The section makes a one-time appropriation in FY 2012 of $12.5 billion. This is necessary because of the drop in funding in FY 2012, as explained in Section 101.

Section 104. Improving funding for the territories under CHIP and Medicaid

Establishes a new formula for computing allotments to the territories.

Section 105. Incentive bonuses for states

A bonus pool is established at the U.S. Treasury to encourage the enrollment of low-income children (individuals below age 21 with incomes at or below 200 percent of the Federal Poverty Level (FPL)) in both Medicaid and SCHIP. An initial $3 billion appropriation is made in FY 2008. Additional funds will be deposited from unspent state allotments, amounts set aside for the transition of childless adults, and unspent contingency fund payments. Payments from the

[23] The Congressional Research Service (CRS) has provided a description of the funding formula on pages 2-4 of its CRS Report for Congress, "S. 1893: The Children's Health Insurance Program Reauthorization Act of 2007," Updated July 27, 2007, available at: http://www.congress.gov/erp/rl/pdf/RL34107.pdf.

incentive pool can be used for any purpose that the state determines is likely to reduce the percentage of low-income children in the state without health insurance. Payments are made if a state's average monthly enrollment exceeds a baseline monthly average. The section establishes a formula to determine the monthly average, taking into account previous enrollment trends and the growth in the population of low-income children. Payments made to a state under the incentive fund are available until expended.

Section 106. Phase-out of coverage for nonpregnant childless adults under SCHIP; conditions for coverage of parents

This section limits the availability of state waivers covering nonpregnant childless adults and parents. It addresses these specific categories of adults:

Childless Adults: New state waivers allowing coverage of nonpregnant childless adults are prohibited. No waivers providing coverage of nonpregnant childless adults can be renewed or granted after the date of enactment. Rules will be established for states with existing waivers which will prohibit SCHIP funds from being used to cover nonpregnant childless adults after September 30, 2008. States with applicable waivers can seek one year of transitional coverage in 2009 through a block grant funded from state allotments. States may submit a Medicaid nonpregnant childless adults waiver to continue coverage of these populations, but states will receive the Medicaid matching rate rather than the higher SCHIP Enhanced Federal Medical Assistance Percentage (E-FMAP) rate. This request will also be subject to "budget neutrality" rules set forth in the section.

Parents: The bill prohibits the approval of waivers that allow federal SCHIP funds to be used to provide coverage for parents of an SCHIP-eligible child. States with existing waivers could be extended through September 30, 2009 at the enhanced FMAP rate. In FY 2010, a state will have to meet a coverage benchmark established in the section to receive the enhanced match rate; otherwise the state will receive the Medicaid match rate. States that meet outreach and coverage benchmarks in FYs 2011-2012 can be reimbursed at a new Reduced Enhanced Matching Assistance Percentage (REMAP) percentage, which will be established for each individual state pursuant to a formula based in part on whether the state meets certain coverage benchmarks. Otherwise the state is subject to the lower Medicaid FMAP reimbursement.

Section 107. State option to cover low-income pregnant women under CHIP through a State plan amendment

This provision allows states to provide coverage to pregnant women up to the level of coverage for low-income children under SCHIP. Under current Medicaid rules, states must provide coverage for pregnant women up to 133 percent of FPL, and may extend coverage to pregnant women with income up to 185 percent of FPL. The state also must establish an income eligibility level of 185 percent of FPL for pregnant women under Medicaid in order to extend its SCHIP coverage of pregnant women. The state also must meet a number of other conditions, including no pre-existing exclusion or waiting period, and cost-sharing requirements cannot be different than those applied to other similarly situated beneficiaries. States will have the option to provide presumptive eligibility to pregnant women. Infants born to targeted low-income pregnant women eligible for benefits under SCHIP and Medicaid are deemed eligible for Medicaid for one year.

Section 108. CHIP contingency fund

Establishes a contingency fund, funded through a separate appropriation, equal to 12.5 percent of the national allotment for SCHIP. A one-time appropriation of 12.5 percent of the national SCHIP allotment is made in FY 2008. For FYs 2009−2012 appropriations of "such sums as are necessary" shall be made to ensure the fund maintains a balance of 12.5 percent of the national allotment. Payments from the fund are designated for eliminating state shortfalls. However, no payments can be made to alleviate shortfalls attributed to nonpregnant childless adults. The incentive fund will be available to assist states with more than a five-percent funding shortfall if the shortfall is attributable to a natural disaster, a significant increase in the unemployment rate, or an event that results in a significant increase in the number of low-income children without health insurance and such event was outside the control of the state.

Section 109. Two-year availability of allotments; expenditures counted against oldest allotments

Under current law, SCHIP allotments are available for use by the state for three years and then reallocated. Unused allotments after that period are then available for reallocation. Under this section, allotments made for FY 2006−FY 2012 are available only for two years.[24]

Section 110. Limitation on matching rate for States that propose to cover children with effective family income that exceeds 300 percent of the poverty line

S. 1893 allows states to receive the enhanced match for families with incomes up to 300 percent of FPL ($61,950 for a family of four in 2007). States that expand eligibility above 300 percent of FPL will receive only the lower Medicaid federal matching rate for those families. An exception will be made for states that have an approved state plan amendment or have passed a state law to cover children above 300 percent of FPL. These states will be allowed to continue coverage at the higher level. This provision appears intended to allow New Jersey to continue enrolling families up to 350 percent of FPL, and, pending approval from CMS, would allow New York to expand its program to 400 percent of FPL, or $82,600 per year.

Section 111. Option for qualifying States to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children

This provision applies to the 11 states that had expanded their Medicaid coverage before SCHIP was enacted (Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin). The section increases the amount of SCHIP allotments that these states can use to pay the difference between the FMAP and the enhanced E-FMAP rate for Medicaid enrollees under age 19 whose family incomes exceed 133 percent of the poverty level.

[24] The Congressional Research Service (CRS) has provided a description of the rules regarding allotments on page 4 of its CRS Report for Congress, "S. 1893: The Children's Health Insurance Program Reauthorization Act of 2007," Updated July 27, 2007, available at: http://www.congress.gov/erp/rl/pdf/RL34107.pdf.

Title II – Outreach and Enrollment

Section 201. Grants to improve outreach and enrollment

The section establishes a new grant program to finance outreach and enrollment activities to increase enrollment in either SCHIP or Medicaid. Each year, from FYs 2008−2012, $100 million is appropriated for these purposes. Ten percent of the money will be set aside for a national enrollment campaign, and another 10 percent will be set aside to help enroll children who are Indians. The section also establishes rules for awarding the grants. Translation and interpretation services will be added to the list of health care activities that can be reimbursed under SCHIP.

Section 202. Increased outreach and enrollment of Indians

States are encouraged to take steps to enroll Indian children who live on or near a reservation by requiring the Secretary of Health and Human Services to facilitate cooperation with Indian governing bodies.

The 10-percent cap on payments for designated health care activities (which includes administrative costs, outreach activities, and health service and child health assistance initiatives) will not apply to expenditures for outreach and enrollment activities which target Indian children likely to be eligible for SCHIP or Medicaid.

Section 203. Demonstration program to permit states to rely on findings by an express lane agency to determine components of a child's eligibility for Medicaid or SCHIP

A three-year demonstration program is set up for 10 states for "Express Lane" determination of eligibility for Medicaid or SCHIP. Express Lane Eligibility works by establishing connections with programs that have similar income eligibility rules to Medicaid and SCHIP—such as Food Stamps, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and the National School Lunch Program (NSLP)—to find and more quickly enroll uninsured children in the health insurance programs. A state can provide for presumptive eligibility if an Express Lane agency determines that a child qualifies. If a state finds a child to be ineligible under the Express Lane procedures, the state will then be required to determine eligibility using its regular procedures. For FYs 2008−FY 2012, $49 million is appropriated for these purposes.

Section 204. Authorization of certain information disclosures to simplify health coverage determinations

A federal or state agency possessing information or data directly relevant to an eligibility determination under this title is authorized to give the data to the state agency responsible for administering the state Medicaid or SCHIP plan provided that certain conditions are met.

Title III – Reducing Barriers to Enrollment

Section 301. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP

The section revises the citizenship documentation requirements established under the Deficit Reduction Act of 2005 (DRA) for individuals receiving SCHIP and Medicaid benefits. Pursuant to statute, individuals must be a citizen, a national of the United States, or a qualified alien to receive full benefits under Medicaid and SCHIP. The DRA requires that citizens and nationals present documentation to prove citizenship in order for states to receive reimbursement for Medicaid and SCHIP services. Under this section, a state can submit the name and social security number of an applicant and meet the legal requirements for Medicaid reimbursement. An individual with an invalid social security number will have 90 days to present evidence of citizenship, or they must be disenrolled within 30 days after they fail to meet the documentation requirement. States will receive a 90-percent reimbursement for the costs of designing and implementing an electronic verification system, and 75 percent of the costs of operating the system. It also changes the requirements for documents issued by a federally-recognized Indian tribe.

The provision will also create an exemption for "deeming of newborns" for children who are deemed eligible for Medicaid because they are born to a mother for whom medical assistance is available for treatment of an emergency condition. This would make statutory a CMS ruling from this year.

Section 302. Reducing administrative barriers to enrollment

The section requires state plans to identify and revise procedures used to reduce administrative barriers to enrollment of children and pregnant women in SCHIP. A state will be deemed to comply if the state does not require a face-to-face interview in the application process, and the state's application and renewal forms are the same under Medicaid and SCHIP for establishing and renewing eligibility for children and pregnant women.

Title IV – Elimination of Barriers to Providing Premium Assistance

Subtitle A – Additional State Option for Providing Premium Assistance

Section 401. Additional State option for providing premium assistance

Under current law, states can pay premiums for a Medicaid beneficiary with employer-based health coverage when the coverage is comprehensive and cost-effective for the state, meaning that it costs the state less to pay premiums than it would to directly provide services. For SCHIP, states can provide funding for the purchase of family coverage only if it is cost-effective relative to the cost of covering the targeted low-income child. The administrative burden makes this option unpopular with states.

The section revises the requirements for providing premium assistance to encourage states to help individuals enroll in qualified employer-sponsored health plans. However, a qualified employer-sponsored plan will not include a health savings account. States will be required to inform parents about the availability of premium assistance subsidies for SCHIP. A new test of cost effectiveness will be established. States will have to provide supplemental insurance to ensure that the benefits of the private coverage correspond to those required by SCHIP. The state will also be allowed to offer premium assistance to parents enrolled under SCHIP. States will also be allowed to provide premium assistance subsidies for coverage under a group health plan if the plan meets benchmark benefits requirements. Finally, the provision will require a GAO study regarding the cost and coverage issues relating to premium assistance.

Section 402. Outreach, education, and enrollment assistance

Requires states to describe the procedures in place to engage in outreach and enrollment for families, children, and employers who are likely to benefit from premium assistance.

Subtitle B – Coordinating Premium Assistance with Private Coverage

Section 411. Special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage or eligibility for assistance in purchase of employment-based coverage; coordination of coverage

Currently, group health plans have to provide special enrollment opportunities under designated circumstances which allow a qualified individual to enroll in a health plan without waiting for a late enrollment opportunity or open season. This section amends applicable laws to provide that an employee who is eligible but not enrolled in a group health plan can enroll outside the set enrollment period if: 1) the employee's coverage under Medicaid or SCHIP is terminated and, as a result of that loss of coverage, the employee requests coverage by the group health plan within 60 days after coverage was terminated; or 2) the employee becomes eligible for coverage under SCHIP or Medicaid and requests coverage within 60 days of becoming eligible.

Employers that maintain group health plans in states which provide premium assistance for SCHIP or Medicaid will be required to provide written notice to their employees about options for premium assistance. The Secretaries of Labor and HHS will be required to establish a joint working group within 60 days of enactment to develop a model premium support notification form and to identify the impediments of effective coordination of coverage available to families. Civil penalties of up to $100 per day will be available for employers who fail to meet the notice requirements under the law, and each employee will be treated as a separate violation.

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

Section 501. Child health quality improvement activities for children enrolled in Medicaid or CHIP

This section appropriates $25 million for FY 2008 through FY 2012 for a childhood obesity study and $45 million is appropriated for FY 2008 through FY 2012 to implement the rest of the section. Provisions include:

- Development of Child Health Quality Measures For Children Enrolled in Medicaid or SCHIP: A new section will be added to the Social Security Act defining a core set of child health quality measures for children enrolled in Medicaid and SCHIP. Beginning in 2010, the Secretary of HHS must report to Congress yearly on efforts to improve these measures.
- Advancing and Improving Pediatric Quality Measures: The Secretary will be required to establish a pediatric quality measures system by no later than January 1, 2010.
- Annual State Reports Regarding State-Specific Quality of Care Measures Applied Under Medicaid or SCHIP: Each state with an approved Medicaid or SCHIP program must report annually on state-specific child health quality measures and provide state-specific information on the quality of care provided to children under Medicaid and SCHIP.
- Demonstration Projects for Improving the Quality of Children's Health Care and the Use of Health Information Technology: $20 million is made available for the Secretary of HHS to award through no more than 10 grants to states and child health providers to conduct demonstration projects to evaluate promising ways to improve the quality of children's health care offered under SCHIP or Medicaid.
- Childhood Obesity Demonstration Project: The Secretary, in consultation with the Centers for Medicare and Medicaid Services (CMS), shall conduct a demonstration project to develop a comprehensive model to reduce childhood obesity.
- Development of Model Electronic Health Record Format for Children Enrolled in Medicaid or SCHIP: The Secretary must establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled under state plans for Medicaid or SCHIP.
- Study of Pediatric Health and Health Quality Measures: By July 1, 2009, the Institute of Medicine must study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children, including preventive care, treatments for acute conditions, and treatments to address physical, mental, and developmental conditions in children.

Section 502. Improved information regarding access to coverage under CHIP

The section adds additional requirements regarding eligibility and enrollment to the SCHIP report that states must file each year. Additionally, GAO is required to conduct a study of children's access to primary and specialty services under Medicaid and SCHIP.

Section 503. Application of certain managed care quality safeguards to CHIP

The provision adds the same requirements for SCHIP managed care entities as currently exist under Medicaid. Specifically, the provision adds a reference to Medicaid's statutory requirements on: the process for plan enrollment, termination, and change of enrollment; the type of information provided to enrollees and potential enrollees on providers, covered services, enrollee rights, and other forms of information; beneficiary protections; quality assurance standards; protections against fraud and abuse; and sanctions against managed care plans for noncompliance.

Title VI – Miscellaneous

Section 601. Technical correction regarding current State authority under Medicaid

The section provides a technical correction for FY 2007 and FY 2008 that allows states to apply the least restrictive income methodologies to certain income groups and receive FMAP. It allows states to raise eligibility for Medicaid and provide coverage for children that had been previously enrolled in SCHIP through Medicaid, but only through 2008.

Section 602. Payment Error Rate Measurement ("PERM")

States are required to submit information regarding improper payments made to Medicaid and SCHIP beneficiaries in order for the federal government to take steps to limit these improper payments. The provision increases the reimbursement for PERM activities from the enhanced federal match to 90 percent and excludes PERM spending from inclusion in a state's 10-percent administrative cap. It also makes technical changes related to the PERM process and the applicability of federal rules.

Section 603. Elimination of counting Medicaid child presumptive eligibility costs against Title XXI Allotment

Under Medicaid rules, states can enroll—for up to two months—children whose family income appears to make them applicable for the program until a formal eligibility determination is made. States are reimbursed at the Medicaid rate during this period of presumptive eligibility, but pay these funds out of their SCHIP allotments. This provision revises the requirement that payment be made out of SCHIP allotments and eliminates the provision setting the federal share of costs during the period of presumptive eligibility.

Section 604. Improving data collection

An additional $10 million is appropriated annually for data collection, which will be added to the $10 million already appropriated. The section requires the Secretary of Commerce to take certain steps to improve survey estimates to improve data used to determine state allotment payments.

Section 605. Deficit Reduction Act technical correction

The section revises provisions related to the determination of Medicaid patient days for Disproportionate Share Hospital (DSH) computations. It clarifies that Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits must be provided for all children in benchmark benefit packages.

Section 606. Elimination of confusing program references

This section changes all references to the program from "SCHIP" to "CHIP" and from the "State Children's Health Insurance Program" to the "Children's Health Insurance Program."

Section 607. Mental health parity in SCHIP plans

Where a state child health plan provides both medical and mental health or substance abuse benefits, financial requirements for mental health and substance abuse benefits cannot be more restrictive than for medical benefits.

Section 608. Dental Health Grants

The section appropriates $200 million for FYs 2008−2012 to improve dental services and strengthen dental coverage for targeted low-income children enrolled in SCHIP or Medicaid. States must submit an application for a grant, and no state match is required.

Section 609. Application of Prospective Payment System for Services Provided by Federally-Qualified Health Centers and Rural Health Clinics

The section appropriates $5 million for grants to states for expenditures related to applying the prospective payment system to services provided by Federally-qualified health centers and rural health clinics.

Title VII – Revenue Provisions

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have estimated that S. 1893 will increase net revenues by $36.1 billion over five years and $72.8 billion over 10 years. The tax-related provisions include tax increases on cigarettes, cigars, and other tobacco products. Notably, the cigarette tax will be increased by $0.61to $1 per pack, and the tax on cigars will be increased to 53 percent of the sale price, or $10.00 per cigar.

The rates under the bill are as follows:

- Small cigarettes are taxed at the rate of $50.00 per thousand ($1.00 per pack);
- Large cigarettes are taxed at the rate of $104.9999 per thousand;
- Small cigars are taxed at the rate of $50.00 per thousand (the same rate applied to small cigarettes);
- Large cigars are taxed at the rate equal to 53.13 percent of the manufacturer's or importer's sales price but not more than $10.00 per cigar;
- Cigarette papers are taxed at the rate of $0.0313 for each 50 papers or fractional part thereof;

- Cigarette tubes are taxed at the rate of $0.0626 for each 50 tubes or fractional part thereof;
- Snuff is taxed at the rate of $1.50 per pound, and proportionately at that rate on all fractional parts of a pound;
- Chewing tobacco is taxed at the rate of $0.50 per pound, and proportionately at that rate on all fractional parts of a pound;
- Pipe tobacco is taxed at the rate of $2.8126 per pound, and proportionately at that rate on all fractional parts of a pound; and
- Roll-your-own tobacco is taxed at the rate of $8.9286 per pound, and proportionately at that rate on all fractional parts of a pound. The rate for roll-your-own tobacco is intended to approximate the rate for small cigarettes.

Title VIII – Effective Date

Section 801. Effective date

The effective date is October 1, 2007, regardless of whether final regulations have been issued. A state that must pass new state legislation to comply with the requirements of the bill will not be considered out of compliance solely on the basis of its failure to meet such requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

Administration Position

On July 17, 2007, Secretary of Health and Human Services Michael Leavitt issued a views letter which said that the President would veto the legislation if it was presented as currently proposed. Instead of expanding SCHIP, as S. 1893 does, the President supports reauthorizing the program and including a broad change in tax policy to eliminate the uneven tax treatment between those who receive insurance through their employer and those who buy insurance on the private market.

The letter objects to the legislation on several grounds. The views letter says that the bill relies on a "budget gimmick" that leaves the program severely under-funded and will cause millions of newly insured children to lose coverage in the future. In addition, the letter objects to the increased costs of the program, and says that the legislation would increase dependence on the federal government. The letter also criticizes the new Incentive Bonus Pool and Contingency Fund created in the legislation as unaccountable and unnecessary given the increased spending in the bill. Finally, the letter objects to the tobacco tax increase because it is both regressive and an uncertain revenue stream for future funding.

A similar veto threat has been issued against the SCHIP reauthorization bill pending in the House of Representatives.

Cost

CBO estimates S. 1893 will cost $60.2 billion over five years, which includes $25 billion contained in the budget baseline and a $35.2 billion expansion. The expansion will be paid for by an increase on tobacco products and cigarette papers and tubes. Notably, the cigarette tax will be increased by $0.61 to $1 per pack, and the tax on cigars will be increased to 53 percent of the manufacturer or importer's sales price, up to $10.00 per cigar.

As a five-year authorization, S. 1893 is compliant with the Senate's "Pay-Go" rules. However, the Senate bill reduces the allotment in the fifth year in order to comply with "Pay-Go" over a 10-year window. According to CBO, SCHIP outlays are projected to go from $8.4 billion in 2012 to only $600 million in 2013. CBO estimates that the total cost of the bill over the 2008-2017 period would be $112 billion if program costs increased according to enrollment projections, which is significantly above the $71 billion in revenues provided by the tobacco tax. Also, it should be noted that the reduced consumption of cigarettes and tobacco products caused by the increased tax will steadily reduce revenues from this provision.[25]

Senate Budget Committee Republican staff have indicated that a long-term spending point of order lies against S. 1893 because it causes changes in direct spending and revenues that would cause an increase in the on-budget deficit greater than $5 billion in at least one of the 10-year periods between FYs 2018-2057. This point of order would be subject to a 60 vote threshold.

Possible Amendments

Numerous amendments addressing a variety of issues are anticipated. It should be noted that tax amendments may be considered germane because H.R. 976, the bill which will serve as the vehicle for consideration of S. 1893, is a revenue bill. Amendment possibilities known at press time include:

- A Kerry amendment to increase the cost of the SCHIP expansion to $50 billion, the amount provided in the FY 2008 Budget Resolution reserve fund;
- A McConnell amendment to reauthorize the program, limit the number of adults in the program, and provide for other health insurance reforms;
- A Burr, Coburn, Martinez, and Corker amendment to reform the tax code to increase health insurance options for Americans; and
- Amendments addressing the income levels that SCHIP will be permitted to cover, the treatment of adults on the program, the "crowd-out" effect, and other topics.

[25] *See* Joint Committee on Taxation, "Estimated Revenue Effects of the Revenue Provisions Relating to the State Children's Health Insurance Program," July 13, 2007.