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H.R. 2—Children's Health Insurance Program Reauthorization Act

FLOOR SITUATION

On February 14, 2009, the Senate amendments to H.R. 2 are expected to be considered on the floor under a closed rule, requiring a majority vote for passage. The rule is expected to waive all points of order against the bill, except those arising under clauses 10 of rule XXI (PAYGO), and provide for one hour of debate, equally divided between the Majority and the Minority.

This legislation was introduced by Representative Frank Pallone (D-NJ) on January 13, 2009, and originally passed by the House by a vote of 289-139 on January 14, 2009. The Senate passed its version of the bill by a vote of 66-32 on January 29, 2009.

SUMMARY OF SENATE CHANGES MADE

During consideration of H.R. 2 in the Senate, several changes were made to the legislation; those changes will be voted on by the House. Among the more important changes, the Senate bill:

- Accelerates the phase-out of childless adults from September 30, 2010 to December 31, 2009;
- Removes a requirement that parents provide a signature on documents allowing their children to be enrolled by "Express Lane" agencies, as outlined below. Some Members may be concerned that removing the signature requirement would further increase the risk of fraud associated with the new "Express Lane" procedures;
- Expands States' ability to cover legal aliens in Medicaid and SCHIP, permitting coverage for all children under age 21, instead of permitting coverage for all children under age 19 as in the original House bill;
- Permits States to establish dental-only supplemental "wrap-around" SCHIP coverage for children enrolled in group health insurance coverage;
- Establishes a new Medicaid Payment and Access Commission (MACPAC), similar to the Medicare Payment Advisory Commission (MedPAC). Some Members may be concerned that this provision first would establish a new federal bureaucracy, and second that both its membership—which will include consumer and advocacy groups—and its stated purpose—which focuses on maintaining access—will result in a primary focus on expanding the scope and reach of federal Medicaid spending, rather than restoring the program's fiscal integrity and improving its quality of care;
- Removes restrictions on physician-owned specialty hospitals originally contained in the House legislation; and
- Raises the amount of the tobacco tax increase from 61 cents to 62 cents per pack (which would increase total federal tobacco taxes from 39 cents to $1.01). Some Members may be concerned that this further increase would place additional tax burdens on working families during an economic downturn.

SUMMARY

The State Children's Health Insurance Program (SCHIP), established under the Balanced Budget Act (BBA) of 1997, is a state-federal partnership originally designed to provide low-income children with health insurance—specifically, those children under age 19 from families with incomes under 200 percent of the federal poverty level (FPL), or $42,400 for a family of four in 2008. Funds are provided to states on the basis of capped allotments, and states receive an "enhanced" federal match greater than the federal Medicaid matching rate in order to enroll covered children. SCHIP received nearly $40 billion in funding over ten years as part of BBA, and legislation passed by Congress in December 2007 (P.L. 110-173) extended the program through March 2009, while providing additional SCHIP funds for states.

H.R. 2 would reauthorize and expand the State Children's Health Insurance Program (SCHIP), as follows:

Funding and Allotments: The bill would maintain the current capped allotment method of SCHIP financing but would increase the allotments over the four and a half year period of the reauthorization (through September 30, 2013). Including funding for the first half of the current fiscal year (i.e. through March 30, 2009) already provided under P.L. 110-173, the bill would include total SCHIP funding of nearly $69 billion—an increase of almost $44 billion in SCHIP outlays when compared to the statutory baseline.

The bill increases funding levels for the five fiscal years covered in the program—a total of $10.6 billion in FY09, $12.5 billion in FY10, $13.5 billion in FY11, and nearly $15 billion in FY12. For Fiscal Year 2013, the bill includes a total of $17.4 billion in funding. However, this funding would be delivered in two installments—one appropriation of $14.55 billion in October 2012, and a second six-month appropriation of $2.85 billion in March 2013. Some Members may be concerned that this funding "cliff"—which presumes a 66% reduction in SCHIP expenses, from $17.4 billion in FY13 to $5.7 billion in FY14—is a budgetary gimmick designed primarily to mask the true costs of an SCHIP expansion.

The bill shortens from three years to two years the amount of time states have to utilize their allotment funding and provides that unused state allotments would be redirected to states projected to have allotment shortfalls after that period. The bill rebases state allotments every two years to reflect actual state expenditures and provides that state allotments will increase annually to reflect increases in health care expenditures and the growth of child populations within each state. The bill language would permit states to obtain increases in their allotments to reflect planned future expansions of SCHIP coverage and would allow certain states to receive the enhanced SCHIP federal matching rate (if funds are available from the state's allotment) for Medicaid coverage of children in families with incomes above 133% FPL ($28,196 for a family of four in 2008).

Child Enrollment Contingency Fund The bill would establish a new contingency fund within the U.S. Treasury for states that exceed their allotments, while also increasing enrollment at a rate that exceeds the states' child population growth by at least 1%. The money within the contingency fund would be carved out from the SCHIP allotments described above and could not exceed 20% of overall SCHIP funding. Some Members may be concerned that the fund—which does not include provisions making additional payments contingent on enrolling the *low-income children* for which the program was designed—will therefore help to subsidize wealthier children in states which have expanded their programs to higher-income populations, diverting SCHIP funds from the program's original purpose.

Performance Bonus Payments The bill creates a new performance bonus payment mechanism to offset state costs associated with enrollment outreach and retention activities. States which increase coverage of eligible low-income children in Medicaid by at least 2% will be eligible for bonuses of up to 15% of each beneficiary's projected costs, and states which exceed their targets for enrolling eligible children by at least 10% will become eligible for additional bonus payments of up to 62.5%.

Funding for the performance bonus system under the bill totals at least $3.3 billion, which would be increased by any allotments not obligated to the states or any state allotments not expended or redistributed to other states. State eligibility for the performance bonuses would remain contingent on states' use of several practices designed to increase ease of enrollment, including continuous eligibility for at least 12 months, eliminating or liberalizing asset tests associated with enrollment applications, automatic administrative renewal, presumptive eligibility for children, and participation in the "Express Lane" process outlined below.

As there are no provisions linking payment of performance bonuses to the enrollment of *low-income children*, some Members may be concerned that these performance bonuses may provide an inducement to instead enroll children from wealthier families, diverting the program from its original intent. Some Members may also be concerned that the provision linking performance bonuses to the adoption of at

least four so-called best practices for enrollment—including the "Express Lane" process—will provide a strong financial incentive for states not to scrutinize the eligibility of certain applicants.

Coverage of Pregnant Women The bill adds new language permitting states to utilize SCHIP funding to cover low-income, pregnant women. The bill imposes several requirements on states seeking to use SCHIP funds to cover pregnant women, including a minimum eligibility threshold of at least 185% FPL (and not below the Medicaid eligibility threshold) for pregnant women only after covering all children under and 200% FPL without a waiting list or other enrollment cap to limit children's participation in the program. The provision provides that children born to certain low-income pregnant women participating in SCHIP will automatically be enrolled in the program for the child's first year.

Coverage of Childless Adults The bill prohibits the Centers for Medicare and Medicaid Services (CMS) from approving further waivers to cover childless adults under the SCHIP program and phases out SCHIP coverage of childless adults effective December 31, 2009. The bill also allows states to apply for a Medicaid waiver to continue to cover childless adults but at the lower Medicaid matching rate instead of the enhanced SCHIP rate. Some Members may be concerned that the bill would permit the continued coverage of childless adults within SCHIP for nearly a year—and for indefinite periods beyond that using the lower Medicaid match rate—diverting its focus from the targeted low-income children for whom it was created.

Coverage of Low-Income Parents The bill also prohibits the issuance of new SCHIP waivers permitting the coverage of low-income parents and phases out parent coverage. States may request an automatic two-year extension to cover low-income parents, and may continue coverage of low-income parents through the length of the authorization legislation (i.e. until October 2013), provided the state does not increase its income eligibility thresholds for parent coverage. Some Members may be concerned that the bill would permit the continued coverage of low-income adults within SCHIP for at least five years, diverting its focus from the targeted low-income children for whom it was created.

Coverage of Higher-Income Children The bill places certain restrictions on states' matching rate for coverage of children in families with "effective family income" higher than 300% FPL—$63,600 for a family of four in 2008—to the lower Medicaid match rate, rather than the enhanced SCHIP federal match. Specifically, the bill would prohibit states from using a "general exclusion of a block of income that is not determined by type of expense or type of income." This provision is designed to address an issue related by New Jersey's SCHIP program, which disregards all income between 200-350% FPL for purposes of eligibility—thus making children in families with incomes up to $74,200 eligible for federal health benefits.

However, the bill expressly retains states' ability to disregard unlimited amounts of income by type of income (i.e. salary, capital gains) or type of expense (i.e. disregard all housing-related expenses)—thus permitting states to continue to use "income disregards" effectively to ignore some or all of a family's income for purposes of determining whether the family income falls below the 300% FPL threshold. And the bill grandfathers in states (i.e. New Jersey) that already have programs in place using blanket income disregards.

Some Members may be concerned first that this provision does not prohibit states from expanding their Medicaid programs to families with incomes above $64,000, and second that the provisions allowing continued use of "income disregards" will only encourage states to use such mechanisms to expand their SCHIP programs to wealthier families—rather than covering poor children first.

Crowd-Out Provisions The bill **does not contain** provisions to reduce "crowd-out"—that is, individuals leaving private coverage in order to join a government program—included in both versions of SCHIP legislation (H.R. 976, H.R. 3963) in 2007. Those provisions included several studies about the extent to which crowd-out occurs within SCHIP, best practices on how to reduce crowd-out, and authority for the

Secretary to reduce payments to states enrolling too many children above 300% FPL. Some Members may be concerned that removal of these provisions will remove the last disincentive for states to enroll large numbers of children in families with incomes above $64,000—and possibly well above that threshold.

According to the Congressional Budget Office, the bill would result in 2.4 million individuals dropping private health insurance coverage to enroll in government programs—a higher level of crowd-out in both number and percentage terms than the first SCHIP bill (H.R. 976) presented to President Bush in 2007.

Outreach and Enrollment Provisions The bill includes $100 million in new mandatory funding for grants to various entities—including states, localities, elementary and secondary schools, and other non-profit or faith-based organizations—to conduct outreach and enrollment activities, including 10% for a national enrollment campaign and an additional 10% set-aside for the Indian Health Service. The bill also provides a minimum 75% Medicaid and SCHIP match for translation or interpretation services under the two programs.

"Express Lane" Enrollment Option The bill permits states to use eligibility determinations from "Express Lane" agencies as a means to facilitate enrollment in Medicaid and SCHIP, including renewals and re-determinations of coverage. Agencies—including but not limited to those which determine eligibility for Temporary Assistance to Needy Families (TANF), food stamps, federal school lunch programs, Head Start, and federal housing assistance—may not deem children ineligible for coverage based solely on an initial adverse determination with respect to income eligibility.

Under the program, states may establish an income threshold 30 percentage points above the Medicaid or SCHIP eligibility limit (i.e. if the SCHIP eligibility limit is 300% FPL, the state may establish a threshold of 330% FPL for purposes of Express Lane determinations). States may also temporarily enroll children in SCHIP if the child in question "appears eligible" (criteria undefined) based on the Express Lane agency's income determination, subject to a "prompt follow up" (time limit undefined) by the State as to whether or not the child actually qualifies. The bill also allows states to "initiate and determine eligibility" for Medicaid or SCHIP "without a program application from, or on behalf of" children based on data from other sources, and only requires parental consent through "affirmation in writing, by telephone, orally, through electronic signature, or through any other means" the Secretary may provide. Some Members may be concerned that removal of the written signature requirement in the original House bill will increase the risk of fraudulent enrollments in Medicaid and SCHIP.

The bill provides for a annual sample audit of Express Lane cases to establish whether or not the eligibility determinations made comport with eligibility determinations made using the full Medicaid review process and provides for state remedial actions (and eventually payment reductions) if the error rate for such audits exceeds 3%. The bill sunsets the Express Lane option at the end of the authorization and includes $5 million for a report on its effectiveness.

Some Members may be concerned first that the streamlined verification processes outlined above will facilitate individuals who would not otherwise qualify for Medicaid or SCHIP, due either to their income or citizenship, to obtain federally-paid health benefits.

Citizenship Verification Current law applies citizenship verification requirements differently to state SCHIP programs, depending upon the nature of the program. The BBA permitted states to establish separate SCHIP programs, utilize Medicaid expansions to cover eligible populations, or some combination of the two. The eight states and the District of Columbia that chose Medicaid expansions, along with Medicaid beneficiaries of the 24 states that chose combination programs, must comply with citizenship verification provisions enacted as part of the Deficit Reduction Act (DRA, P.L. 109-171) in 2006. These procedures—which include verification of citizenship and nationality by presenting any of a variety of documents (e.g.

birth certificate, passport, etc.)—were prompted in part by a July 2005 Inspector General report, which found that 47 states (including the District of Columbia) often relied on an applicant's self-attestation of citizenship to determine Medicaid eligibility and that 27 of these states undertook no effort to determine whether the self-attestation was accurate. Beneficiaries in the 18 states with separate SCHIP programs are not subject to the DRA verification requirements with respect to either citizenship or nationality.

The bill provides an alternative to the Medicaid citizenship verification process enacted in DRA—and extends this process to beneficiaries in stand-alone SCHIP programs—for children up to age 21 by allowing states to verify applicants' citizenship through a name and Social Security number match. If the Social Security Administration finds an invalid match, the state must make "a reasonable effort to identify and address the causes of such invalid match;" in the event the state cannot resolve the discrepancy, it must dis-enroll the individual within 120 days, during which time the individual in question has 90 days to respond and present satisfactory evidence to resolve the mis-match.

States will be required to submit data for each applicant to determine the states' invalid match rates, but errors will only include cases where the individual has been dis-enrolled by the state after having received SCHIP benefits. The bill provides that states with error rates above 3% will be required to pay back funds used to pay for ineligible individuals in excess of the 3% threshold—except that the Secretary may waive such a return requirement "if the state is unable to reach the allowable error rate despite a good faith effort."

Some Members may echo the concerns of Social Security Commissioner Michael Astrue, who in a September 2007 letter stated that the verification process proposed in the bill would not keep ineligible individuals from receiving federal benefits—since many applicants would instead submit another person's name and Social Security number to qualify. Some Members may believe the bill, by laying out a policy of "enroll and chase," will permit ineligible individuals, including illegal aliens, to obtain federally-paid health coverage for at least four months during the course of the verification process. Finally, some Members may be concerned that the bill, by not taking remedial action against states for enrolling illegal aliens—which can be waived entirely at the Secretary's discretion—until states' error rate exceeds 3%, effectively allows states to provide benefits to illegal aliens.

Coverage of Legal Aliens The bill would permit states to cover pregnant women and children under 21 who are legal aliens within Medicaid and SCHIP without imposing the five-year waiting period for most legal aliens to receive federal welfare benefits established as part of the welfare reform law (P.L. 104-196) signed by President Clinton in 1996. For decades, Medicare has maintained a five-year residency requirement for legal aliens to obtain access to benefits; this waiting period was upheld by the Supreme Court in 1976, when Justice John Paul Stevens, writing for a unanimous Court in the case of *Mathews v. Diaz*, held that "it is obvious that Congress has no constitutional duty to provide all aliens with the welfare benefits provided to citizens."

Some Members may be concerned that permitting states to cover legal aliens without imposing waiting periods will override the language of bipartisan welfare reform legislation passed by a Republican Congress and signed by a Democrat President, conflict with decades-long practices in other federally-sponsored entitlement health programs (i.e. Medicare), and encourage migrants to travel to the United States for the sole or primary purpose of receiving health benefits paid for by federal taxpayers.

Premium Assistance The bill permits states to establish premium assistance programs—which provide state and federal funds to finance employer-sponsored health insurance. The bill provides that employers must pay at least 40% of premium costs in order for the policy to qualify for premium assistance but prohibits high-deductible policies associated with Health Savings Accounts (HSAs) from qualifying under any circumstances.

The bill changes the current premium assistance criteria within SCHIP, such that rather than requiring the cost of covering ***the entire family*** through the employer policy be less than the costs to enroll a child in government-run coverage, states should instead use an "apples-to-apples" comparison of the marginal costs of ***covering the applicable child*** (or children) when compared to enrolling the child in SCHIP. The bill also permits states to "wrap-around" coverage to supplement the employer policy if the latter does not meet appropriate SCHIP benchmark standards, and to establish a purchasing pool for small employers (i.e. those with fewer than 250 employees) with low-income workers to provide workers options to utilize premium assistance to enroll their families.

The bill requires states that have created premium assistance programs to inform SCHIP applicants of the program and includes provisions regarding coordination with employer coverage and outreach to workers to inform them of premium assistance. However, the bill does not require states to establish premium assistance programs. Some Members may therefore be concerned that the bill does not ensure that all children with access to employer-sponsored coverage will be able to maintain their current coverage.

Quality Measures The bill requires CMS to develop an initial set of child health quality measures for state Medicaid and SCHIP programs, including those administered by managed care organizations, and establish programs allowing states to report such measures and disseminate information to the states on best practices. The bill includes further requirements for the Department to create a second pediatric quality measures program "to improve and strengthen the initial core child health care quality measures" and authorizes grants and contracts to develop and disseminate evidence-based quality care measures for children's health.

The bill requires states to report annually on state-specific health quality measures adopted by their Medicaid and/or SCHIP plans and authorizes up to 10 grants for demonstration projects related to improved children's health care and the promotion of health information technology. The bill also authorizes (subject to appropriation) $25 million for a demonstration project to reduce childhood obesity by awarding grants to eligible local governments, educational or public health institutions, or community-based organizations.

The bill establishes a program to develop a model electronic health record for Medicaid and SCHIP beneficiaries and authorizes a study on pediatric health quality measures. These and the other quality programs addressed above would be funded through mandatory appropriations totaling $45 million per fiscal year.

Lastly, the bill applies certain quality provisions to the managed care organizations with whom states contract to provide SCHIP benefits—including marketing restrictions, required disclosures to beneficiaries, and access and quality standards both for the managed care organizations and the state agencies overseeing them. The bill also requires a Government Accountability Office (GAO) study on whether the rates paid to SCHIP managed care plans are actuarially sound.

Enhanced Benefits The bill requires state SCHIP plans to have access to dental benefits, and mandates that those dental plans resemble a) coverage provided to children under the Federal Employee Health Benefit Program (FEHBP), b) "a dental benefits plan that is offered and generally available to state employees," or c) the largest commercially-available dental plan in the state based on the number of covered lives. States would also be permitted to offer "wrap-around" SCHIP dental benefits packages to supplement children's employer-sponsored coverage.

The bill includes language requiring mental health parity in state SCHIP benefits, specifically that "financial requirements and treatment limitations applicable to such...benefits" are no more restrictive than those applied to medical and surgical benefits covered by the plan and establishes a prospective payment system for federally qualified health centers receiving Medicaid reimbursements. The bill also

requires that states impose a grace period of at least 30 days on beneficiaries for non-payment of any applicable premiums due before terminating the beneficiaries' coverage; under current law, such premiums generally only apply to individuals with family incomes above 150% FPL.

Other Provisions The bill includes language stating that "nothing in this Act allows federal payment for individuals who are not legal residents." However, as noted above, the bill provisions allow states to verify SCHIP eligibility without document verification and provide no financial penalties to states enrolling illegal aliens until those errors (which in the case of "Express Lane" applications will be derived from sample audits, not scrutiny of each application) exceed 3%—and these penalties may be waived in the Secretary's sole discretion.

The bill establishes a new Medicaid Payment and Access Commission (MACPAC), similar to the Medicare Payment Advisory Commission (MedPAC), and requires the new Commission to submit two annual reports to Congress. The bill requires the Commission to examine both payment policies for the two programs as well as the program's impact on "access to covered items and services," including creation of an "early warning system" designed to draw attention to any "problems that threaten access to care" for beneficiaries. Some Members may be concerned that this provision first would establish a new federal bureaucracy, and second that both its membership—which will include consumer and related advocacy groups—and its stated purpose on maintaining access will result in a primary focus on expanding the scope and reach of federal Medicaid spending, rather than restoring the program's fiscal integrity and improving its quality of care.

The bill includes language prohibiting the Department of Health and Human Services from approving any new state Health Opportunity Account demonstrations under the program established in DRA. Some Members may be concerned that the prohibition on this innovative—and entirely voluntary—program for beneficiaries may hinder beneficiaries' ability to choose the health plan that best meets their needs.

The bill would disregard any "significantly disproportionate employer pension or insurance fund contribution" when calculating a state's *per capita* income for purposes of establishing the federal Medicaid matching percentage for that state. According to CMS, only one state would benefit from this provision—Michigan. The bill would also increase Disproportionate Share Hospital (DSH) allotments for Tennessee and Hawaii and would clarify the treatment of a regional medical center in such a manner that the Congressional Budget Office, in its score of the bill, identified the provision as specifically benefiting the Memphis Regional Medical Center. Some Members therefore may view these provisions as constituting authorizing earmarks.

Tobacco Tax Increase; Pay-Fors The bill would increase by 62 cents—from 39 cents to $1.01—the federal per-pack tobacco tax and place similar increases on cigars, cigarette papers and tubes, and smokeless and pipe tobacco products. Some Members may be concerned that an increase in the tobacco tax, which is highly regressive, would place an undue and unnecessary burden on working families during an economic downturn and could encourage the production of counterfeit cigarettes by criminal organizations and other entities.

Lastly, the bill increases the percentage of payment of certain corporate estimated taxes in the last fiscal quarter of 2013 by 0.5%, and reduces the next applicable estimated tax payment in the first fiscal quarter of 2014 by a similar amount.

COST

A final CBO score of the Senate amendments was not available at press time. However, according to the Congressional Budget Office, the original House-passed bill would increase direct spending by a total of $39.4 billion between Fiscal Year 2009 and Fiscal Year 2014, and $73.3 billion over the FY09-FY19 period. Most of the spending in the first five years of the budget window ($34.3 billion) would be derived from

the SCHIP expansion; and Medicaid spending in the latter five years would rise, as the score notes that children enrolled in SCHIP would be shifted to the Medicaid program upon SCHIP's expiration. However, both the Medicaid and SCHIP scores are contingent upon provisions in the bill cutting SCHIP spending from $17.4 billion in Fiscal Year 2013 to $5.7 billion in Fiscal Year 2014. To the extent that Members believe this 66% reduction in SCHIP expenses will not take place, they may be concerned that the funding "cliff" is a budgetary gimmick designed to mask the true costs of the bill's expansion of health care benefits.

The Joint Committee on Taxation estimates that the increase in tobacco taxes would generate $38.8 billion through Fiscal Year 2014, and $72 billion from Fiscal Years 2009-2018. The bill also increases revenues by $1.6 billion through Fiscal Year 2018 as a result of individuals dropping private health insurance in order to enroll in the SCHIP program, as employees with group health insurance would have less of their income sheltered from payroll and income taxes.

The JCT score on the tobacco tax notes that the tax provisions would generate $7.2 billion in FY10 (the first full year the tax increase would take effect), but only $6.4 billion in Fiscal Year 2019—a decrease of more than 10%. Some Members may be concerned that expansions of the SCHIP program would rely on a declining source of revenue.

STAFF CONTACT

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