Calendar No. 541

107TH CONGRESS *2d Session* | SENATE | REPORT 107–233

MOTHERS AND NEWBORNS HEALTH INSURANCE ACT OF 2002

AUGUST 1, 2002.—Ordered to be printed

Mr. BAUCUS, from the Committee on Finance, submitted the following

R E P O R T

[To accompany S. 724]

The Committee on Finance, to which was referred the bill (S. 724) to amend title XXI of the Social Security Act to provide for coverage of pregnancy-related assistance for targeted low-income pregnant women, reports favorably thereon and refers the bill to the full Senate with a recommendation that the bill pass.

I. BACKGROUND

Lack of health insurance is a significant barrier to receiving prenatal care, and contributes greatly to America's high levels of infant and maternal mortality. With 4.3 million uninsured mothers living below 200 percent of the Federal poverty level, the United States currently ranks 21st in the world in infant mortality and 26th in maternal mortality. These are the worst rates of any developed nation.

In recent years, the United States has made significant progress toward extending health insurance coverage to children in low-income families. Unfortunately, the mothers of these children remain at high risk of going uninsured. Mothers in low-income families account for nearly three of every four uninsured mothers in the country. These women often lack access to affordable, employer-based health insurance coverage and are excluded from public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP).

While a majority of states provide health insurance coverage through Medicaid or SCHIP to children in families up to 200 percent of the Federal poverty level, or about $24,000 for a family of two, the same level of coverage generally does not apply to their

mothers. Current law only requires states to cover pregnant women under Medicaid if they are under 133 percent of poverty, which is approximately $16,000 per year for a family of two. States also have the option to extend this coverage up to 185 percent of poverty, or about $22,000 a year, for that same family. Pregnant women are not eligible to receive coverage under SCHIP, unless a state is granted a Section 1115 waiver of current law to do so.

There is no valid policy rationale for the existing disparities in health insurance coverage between mothers and their children. Current law essentially dictates that low-income children receive health insurance coverage only after their mothers have gone through nine months of pregnancy without crucial prenatal coverage. This disparity in coverage levels exposes both mothers and children to unnecessary health risks. Moreover, it is not cost-effective. Recent studies have shown that infants born to mothers receiving late or no prenatal care are more likely to face complications—which can result in hospitalization, expensive medical treatments, and increased costs to public programs. Closing the gap in coverage between mothers and their children will improve the health of both, while reducing costs for taxpayers.

II. DESCRIPTION OF THE BILL

The legislation reported by the Finance Committee consists of the following provisions:

Section 1. Short title

Section 2. State option to expand or add coverage of certain pregnant women under Medicaid and SCHIP

(a) Medicaid

PRESENT LAW

States are required to provide Medicaid coverage to pregnant women with no other children who have family income up to 133 percent of the Federal poverty level (FPL), and have the option to extend such coverage to pregnant women with no other children who have family income above 133 percent FPL up to 185 percent FPL. Both of these eligibility categories are commonly referred to as "poverty-related pregnant women." These pregnant women are entitled only to pregnancy-related services (e.g., prenatal, delivery and postpartum care up to 60 days after delivery). States may increase the effective income level above these standards by modifying applicable income and resource methodologies. In addition, states may seek waivers of program rules to extend Medicaid to pregnant women at higher income levels.

The State Children's Health Insurance Program (SCHIP) allows states to cover uninsured children under age 19 in families with income above applicable Medicaid financial standards. States may choose from among three benefit options when designing their SCHIP programs. They may expand Medicaid, create a new separate state program that must meet minimum benefit requirements, or devise a combination of both approaches. Among the many services available under SCHIP are prenatal care and hospital services. Pregnant women ages 19 and above are eligible for SCHIP only through special waivers of program rules, or when employer-spon-

sored family coverage subsidized by SCHIP includes adults in families with eligible children.

The Federal share of Medicaid costs is equal to the Federal medical assistance percentage (FMAP) of those costs. The FMAP is determined annually according to a formula designed to pay a higher Federal matching rate to states with lower per capita incomes relative to the national average. The law establishes a minimum FMAP of 50 percent and a maximum FMAP of 83 percent. Under SCHIP, an enhanced FMAP (E-FMAP) is available. The E-FMAP is defined as the FMAP under Medicaid increased by 30 percent of the number of percentage points by which the FMAP for the state is less than 100 percent. E-FMAP ranges from 65 percent to 85 percent (the statutory upper limit).

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below applicable Medicaid income standards, until a formal determination of eligibility is made. Payments made on behalf of Medicaid children during periods of presumptive eligibility are matched at the regular Medicaid FMAP, but are paid out of state SCHIP allotments.

Federal funds for SCHIP were appropriated in the original enacting statute for FY1998 through FY2007. From each year's appropriation, a state is allotted an amount as determined by a formula set in law. Expenditures associated with presumptive eligibility for children under Medicaid are counted against a state's SCHIP allotment.

EXPLANATION OF PROVISION

The bill allows states meeting two conditions to cover under Medicaid additional pregnant women (up to 60 days postpartum) with no other children in families with income exceeding 185 percent FPL, up to the SCHIP income level for children in effect as of January 1, 2002. The two conditions include: (1) the state must cover under Medicaid and SCHIP such pregnant women in lower income families before or in addition to pregnant women in higher income families, and (2) the state must apply an income level to the new group of pregnant women that is no lower than the effective income level in place for pregnant women already covered under the state Medicaid plan as of January 1, 2002.

For states expanding coverage to additional pregnant women with incomes exceeding 185 percent FPL, the SCHIP enhanced FMAP applies and all payments are counted against the state's SCHIP allotment.

Finally, the bill eliminates the requirement that expenditures associated with presumptive eligibility for children under Medicaid be counted against a state's SCHIP allotment.

REASONS FOR CHANGE

The Committee bill includes provisions based on S. 724, introduced by Senator Breaux, and S. 1016, introduced by Senator Bingaman, to extend Medicaid and SCHIP coverage to pregnant women. The provisions attempt to restore balance in eligibility levels between mothers and their children by allowing states to cover pregnant women in these programs up to the income eligibility level available for their children. The provision offers an incentive

to states to raise income eligibility levels for pregnant women by providing the enhanced SCHIP matching rate to states that expand coverage above the current limit of 185 percent of poverty.

(b) SCHIP

PRESENT LAW

In general, SCHIP allows states to cover uninsured children under age 19 in families with incomes that are either: (1) above the state's Medicaid financial eligibility standard but less than 200 percent of the federal poverty level, or (2) in states with Medicaid income levels for children already at or above 200 percent FPL, within 50 percentage points over the state's Medicaid income eligibility limit for children in effect on March 31, 1997.

Generally, states cover SCHIP-eligible kids by either enrolling them into Medicaid expansion programs, or into separate state health insurance plans that meet specific standards for benefits and cost-sharing, or through a combination of both.

States covering SCHIP-eligible children through Medicaid must provide the full range of mandatory Medicaid benefits, including maternity care, and all optional services specified in their state Medicaid plans. Coverage for pregnant women under Medicaid is limited to services related to the pregnancy (e.g., prenatal, delivery, and postpartum care up to 60 days after delivery); complications of pregnancy; and family planning services. Alternatively, states operating separate state insurance plans may choose any one of three other benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other health benefits plan that the Secretary determines will provide appropriate coverage for the targeted population of uninsured children. These three additional benefit options may include maternity care. However, apart from requiring coverage of inpatient and outpatient hospital services, and physicians' surgical and medical services, there is no specific language in the federal statute that requires provision of prenatal, delivery and postpartum services with these non-Medicaid benefit plan options.

The SCHIP program does not include pregnancy status among its eligibility criteria, and does not cover individuals over age 18. There are two circumstances under which uninsured pregnant women over 18 years would be eligible for SCHIP. First, SCHIP has a "family coverage option" that allows states to provide coverage under a group health plan that may include maternity care to adult females in eligible families. States may cover entire families including parents if the purchase of family coverage is cost effective when compared with the cost of covering only the targeted low-income children in the families involved, and would not substitute for other health insurance coverage. Alternatively, states may apply for waivers of program rules to extend coverage to adults such as parents and pregnant women.

Cost sharing refers to the out-of-pocket payments made by beneficiaries of a health insurance plan. States that chose to implement SCHIP as a Medicaid expansion must follow the nominal cost sharing rules of the Medicaid program. Under separate state programs, total annual aggregate cost-sharing (including premiums, enrollment fees, deductibles, copayments, coinsurance, and other similar

charges) for any family may not exceed 5 percent of total income in a year. Preventive services are exempt from cost-sharing.

For each fiscal year, the states and the District of Columbia are allotted a proportion of the total amount of Federal SCHIP dollars available. From that amount, Federal matching funds are disbursed quarterly to each state by a formula set in statute. The original authorizing legislation for SCHIP requires that 0.25 percent of the program's total authorization be set-aside for five territories. This total is distributed among these territories based on specific percentages defined in statute.

EXPLANATION OF PROVISION

The Committee bill allows states to cover additional pregnant women under SCHIP. The SCHIP expansion group includes pregnant women with family income above the state's Medicaid financial eligibility standard for pregnant women in effect on January 1, 2002, up to the income eligibility for SCHIP children in effect as of January 1, 2002. The provision also requires states to meet the following conditions before they are permitted to expand their eligibility. First, the state must have already expanded Medicaid eligibility for pregnant women up to at least 185 percent FPL. Second, the same two conditions required of states choosing to expand coverage to pregnant women under Medicaid must also be met: (1) the state must cover under Medicaid and SCHIP pregnant women in lower income families before or in addition to pregnant women in higher income families, and (2) the state must apply an income level to the new group of pregnant women that is no lower than the effective income level in place for pregnant women covered under the state Medicaid plan as of January 1, 2002. Coverage for pregnant women is limited to services related to the pregnancy (e.g., prenatal, delivery, and postpartum care up to 60 days after delivery); complications of pregnancy; and family planning services.

The provision prohibits: (1) excluding pregnancy-related services based on a preexisting condition; (2) imposing a waiting period for the purpose of minimizing substitution; and (3) cost sharing for pregnancy-related services.

Children born to women receiving pregnancy-related services under SCHIP Medicaid expansions or separate state plans are automatically enrolled in such program at the time of birth and remain eligible for such assistance until the child attains 1 year of age. Unless the state issues a separate eligibility number for the child, such child retains the medical assistance eligibility identification number of the mother during this eligibility period.

For each of fiscal years 2003 through 2006, the Committee's provision adds an additional appropriation, in the amount of $200 million, out of funds not otherwise appropriated from the Treasury. A total of 98.95 percent of such funds are distributed among the states in the same manner as SCHIP funds are distributed under current law. The remaining funds are distributed among the territories also in the same manner as defined in current law. Funds added to the SCHIP program may be used for child health assistance for targeted low-income children, as well as for pregnancy-related assistance for pregnant women. Funds are available to states that expand coverage to pregnant woman under title XXI (SCHIP), or title XIX (Medicaid) beyond those covered as of January 1, 2002.

Additional funds are not available to the states before October 1, 2002.

REASONS FOR CHANGE

Current Federal law enables low-income pregnant women to receive coverage under SCHIP through age 18, but it does not provide such coverage to women ages 19 and above. While states have the ability to add SCHIP coverage for pregnant women over age 18 through Section 1115 waivers, states find this process to be both time-consuming and administratively burdensome. The Committee bill allows states to cover pregnant women under SCHIP regardless of age and gives states the flexibility to expand coverage to pregnant women through the simpler state plan amendment process. The committee bill also eliminates the disparity in coverage levels between pregnant women and infants that has been created through SCHIP, enabling both mothers and their newborn children to immediately receive health coverage under the program.

(c)(1) Other amendments to Medicaid: Eligibility of a newborn

PRESENT LAW

A child born to a woman eligible for and receiving medical assistance under a Medicaid state plan on the date of the child's birth, is deemed to have applied for, and to have been found eligible for such assistance. The child remains eligible for such assistance until that child attains 1 year of age as long as the child is a member of the woman's household, and the woman remains (or would remain if pregnant) eligible for Medicaid.

EXPLANATION OF PROVISION

For a child born to a woman eligible for and receiving medical assistance under a Medicaid state plan on the date of the child's birth, the Committee's bill removes current law requirements that the child remain a member of the woman's household; and the woman continues to be eligible (or would remain eligible if pregnant) for Medicaid.

REASONS FOR CHANGE

The Committee bill ensures that children born to women enrolled in Medicaid or SCHIP are immediately enrolled in the program for which they are eligible, regardless of the eligibility status of the mother. The provision prevents newborns eligible for SCHIP from being subject to enrollment waiting periods that may apply to other, older children eligible for the program and helps ensure that infants receive appropriate health care in their first year of life.

(c)(2) Other amendments to Medicaid: Application of qualified entities to presumptive eligibility for pregnant women under Medicaid

PRESENT LAW

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards, until a final formal determina-

tion of eligibility is made. Entities qualified to make presumptive eligibility determinations include Medicaid providers, agencies that determine eligibility for Head Start, subsidized child care, or the Special Supplemental Food Program for Women, Infants and Children (WIC). BIPA 2000 added several entities to the list of those qualified to make Medicaid presumptive eligibility determinations. These include agencies that determine eligibility for Medicaid or the State Children's Health Insurance Program (SCHIP); certain elementary and secondary schools; state or tribal child support enforcement agencies; certain organizations providing food and shelter to the homeless; entities involved in enrollment under Medicaid, TANF, SCHIP, or that determine eligibility for federally funded housing assistance; or any other entity deemed by a state, as approved by the Secretary of HHS.

EXPLANATION OF PROVISION

For purposes of presumptive eligibility determinations, the Committee bill clarifies that qualified providers be included under qualified entities as defined in current law. The bill further clarifies that qualified entities be permitted to make presumptive eligibility determinations for pregnant women in addition to children.

REASON FOR CHANGE

Given the established value of early prenatal care for ensuring the health of both mother and child, it is important to clarify and extend presumptive eligibility rules to pregnant women.

(d) Effective date

Section 2 of the Committee bill applies to items and services furnished on or after October 1, 2002, regardless of whether implementing regulations have been issued.

Section 3. Review of State agency blindness and disability determinations

PRESENT LAW

State agencies are required to conduct blindness and disability determinations to establish an individual's eligibility for: (1) Title II, (Federal Old-Age, Survivors, and Disability Insurance (OASDI) benefits); and (2) Title XVI (Supplemental Security Income, (SSI)). Disability determinations are made in accordance with disability criteria defined in statute as well as standards promulgated under regulations or other guidance.

Under current law, the Commissioner of Social Security is required to review the state agency's Title II initial blindness and disability determinations in advance of awarding payment to individuals determined eligible under such requirements. This requirement for review is met when: (1) at least 50 percent of all such determinations have been reviewed, or (2) other such determinations have been reviewed as necessary to ensure a high level of accuracy.

EXPLANATION OF PROVISION

After a 1-year phase-in, the bill aligns the initial review requirements for Title XVI with those currently required under Title II. As under Title II, the Commissioner of Social Security is required

to review initial Title XVI SSI blindness and disability determinations made by state agencies in advance awarding payments. For FY2003, the SSI review is required for 25 percent of all state-determined allowances. In FY2004 and thereafter, review is required for at least 50 percent of state-determined allowances. To the extent feasible, the Committee's bill requires the Commissioner to select for review, determinations that are most likely to be incorrect.

REASON FOR CHANGE

The Committee bill includes a requirement that determinations in the SSI program be reviewed to improve program integrity.

EFFECTIVE DATE

Section 3 of the Committee bill is effective at the time of enactment of such Act.

III. REGULATORY IMPACT STATEMENT AND RELATED MATTERS

A. Regulatory Impact

In accordance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee makes the following statement concerning the regulatory impact of the Mothers and Newborns Health Insurance Act of 2002.

IMPACT ON INDIVIDUALS AND BUSINESSES

Section 2(a) creates a state option for states to cover additional pregnant women under Medicaid. Because the provision merely creates an option for states to consider, it does not impose any additional paperwork or regulatory burdens on individuals or businesses.

Section 2(b) creates a state option for states to cover additional pregnant women under the State Children's Health Insurance Program (SCHIP), and it appropriates additional funds for the SCHIP allotment of states that chose to take up the option. Because the provision merely creates an option for states to consider enacting, it does not impose any additional paperwork or regulatory burdens on individuals or businesses.

For a child born to a woman receiving Medicaid on the date of the child's birth, Section 2(c)(1) removes current law requirements that the child remain eligible only as long as the child is a member of the woman's household and the woman remains eligible for Medicaid. Because it removes requirements for eligibility for infants, the provision reduces paperwork and regulatory burdens on individuals, and does not impose additional paperwork or regulatory burdens on businesses.

Section 2(c)(2) clarifies that qualified providers are qualified entities for purposes of determining presumptive eligibility for children for Medicaid. It also allows qualified entities to make presumptive determinations of eligibility for pregnant women. This provision reduces the paperwork and regulatory burdens on qualified providers and qualified entities, and it does not impose additional paperwork and regulatory burdens on other businesses or individuals.

IMPACT ON PERSONAL PRIVACY

The Committee bill permits states to provide health coverage through Medicaid or SCHIP to pregnant women who are not presently eligible. To establish their eligibility for coverage in states that take up the new options, pregnant women may be required to provide information regarding their income, their assets, and their medical condition, but they would not be required to provide any more information than presently eligible pregnant women would have to provide. Infants who were born to mothers eligible for and receiving Medicaid would have to provide less information about household and income to maintain their Medicaid coverage for one year. Finally, because the law clarifies that certain private entities may make presumptive eligibility determinations, it would give children and pregnant women the option to obtain eligibility by sharing income, asset, and medical condition information with private and public entities. However, no child or pregnant woman would be required to share the information.

B. UNFUNDED MANDATES STATEMENT

Due to time constraints, the Congressional Budget Office estimate was not included in the report. When received by the Committee, it will appear in the Congressional Record at a later time.

IV. BUDGET EFFECTS

Due to time constraints, the Congressional Budget Office estimate was not included in the report. When received by the Committee, it will appear in the Congressional Record at a later time.

V. VOTES

On July 11, 2002, a substitute for S. 724, entitled, the "Mothers and Newborns Health Insurance Act of 2002," was ordered favorably reported by a voice vote. A quorum was present.

No amendments were offered.

VI. CHANGES IN EXISTING LAW

In compliance with paragraph 12 of the rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no changes is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVI—GRANTS TO STATES FOR AID TO THE AGED, BLIND, OR DISABLED

* * * * * * *

ADMINISTRATION

SEC. 1633. (a) Subject to subsection (b), the Commissioner of Social Security may make such administrative and other arrangements (including arrangements for the determination of blindness

and disability under section 1614(a)(2) and (3) in the same manner and subject to the same conditions as provided with respect to disability determinations under section 221) as may be necessary or appropriate to carry out the Commissioner's functions under this title.

* * * * * * *

(e)(1) The Commissioner of Social Security shall review determinations, made by State agencies pursuant to subsection (a) in connection with applications for benefits under this title on the basis of blindness or disability, that individuals who have attained 18 years of age are blind or disabled as of a specified onset date. The Commissioner of Social Security shall review such a determination before any action is taken to implement the determination.

(2)(A) In carrying out paragraph (1), the Commissioner of Social Security shall review—

(i) at least 25 percent of all determinations referred to in paragraph (1) that are made in fiscal year 2003; and

(ii) at least 50 percent of all such determinations that are made in fiscal year 2004 or thereafter.

(B) In carrying out subparagraph (A), the Commissioner of Social Security shall, to the extent feasible, select for review the determinations which the Commissioner of Social Security identifies as being the most likely to be incorrect.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

* * * * * * *

(e)(1)(A) * * *

* * * * * * *

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year **[**so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance**]**. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).

* * * * * * *

(l)(1) Individuals described in this paragraph are—

(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

(B) infants under one year of age,

(C) children who have attained one year of age but have not attained 6 years of age, and

(D) children born after September 30, 1983 (or, at the option of a State, after any earlier date), who have attained 6 years of age but have not attained 19 years of age,

who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent *(or such higher percent as the State may elect for purposes of expenditures for medical assistance for pregnant women described in section 1905(u)(4)(A))* of the income official poverty line (as defined by the Office of Management and Budget and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

* * * * * * *

DEFINITIIONS

SEC. 1905. * * *

(b) Subject to section 1933(d), the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expenditures under section 1923) described in subsection (u)(2)(A) [or subsection (u)(3)], *(u)(3), or (u)(4)* for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 2104, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b), for purpose of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent and (4) the

Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII).

* * * * * * *

(u)(1) The conditions described in this paragraph for a State plan are as follows:

(A) The State is complying with the requirement of section 2105(d)(1).

(B) The Plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b).

(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional target low-income children described in subparagraph (B).

(B) For purposes of this paragraph, the term "optional targeted low-income child" means a targeted low-income child as defined in section 2110(b)(1) (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this title) who would not qualify for medical assistance under the State plan under this title as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(1)(D)).

(3) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1902(l)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this title based on such State plan as in effect as of March 31, 1997.

(4) For purposes of the fourth sentence of subsection (b) and section 2105(a), the expenditures described in this paragraph are the following:

(A) CERTAIN PREGNANT WOMEN.—If the conditions described in subparagraph (B) are met, expenditures for medical assistance for pregnant women described in subsection (n) or under section 1902(l)(1)(A) in a family the income of which exceeds 185 percent of the poverty line, but does not exceed the income eligibility level established under title XXI for a targeted low-income child.

(B) CONDITIONS.—The conditions described in this subparagraph are the following:

(i) The State plans under this title and title XXI do not provide coverage for pregnant women described in subparagraph (A) with higher family income without covering such pregnant women with a lower family income.

(ii) The State does not apply an effective income level for pregnant women that is lower than the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) that has been specified under the State plan under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902, as of January 1, 2002, to be eligible for medical assistance as a pregnant woman.

(C) DEFINITION OF POVERTY LINE.—In this subsection, the term "poverty line" has the meaning given such term in section 2110(c)(5).

[(4)**]***(5)* The limitations on payment under subsections (f) and (g) of section 1108 shall not apply to Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 2105(b).

* * * * * * *

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

SEC. 1920. (a) A State plan approved under section 1902 may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

(b) For purposes of this section—

(1) the term "presumptive eligibility period" means, with respect to a pregnant woman, the period that—

* * * * * * *

(2) the term "qualified provider" means any provider that—

(A) is eligible for payments under a State plan approved under this subchapter,

(B) provides services of the type described in subparagraph (A) or (B) of section 1396d(a)(2) of this title or in section 1396b(a)(9) of this title,

(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

(D)(i) receives funds under—

(I) section 330 or 330A of the Public Health Service Act

(II) title V of this Act, or

(III) title V of the Indian Health Care Improvement Act;

(ii) participates in a program established under—

(I) section 17 of the Child Nutrition Act of 1966, or

(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973,

(iii) participates in a State perinatal program; or

(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638).

The term "qualified provider" includes a qualified entity as defined in section 1920A(b)(3).

* * * * * * *

TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH

SEC. 2102. (a) GENERAL BACKGROUND AND DESCRIPTION.—A State child health plan shall include a description, consistent with the requirements of this title, of—

* * * * * * *

(b) GENERAL DESCRIPTION OF ELIGIBILITY STANDARDS AND METHODOLOGY.—

(1) ELIGIBILITY STANDARDS.—

(A) IN GENERAL.—The plan shall include a description of the standard used to determine the eligibility of targeted low-income children for child health assistance under the plan. such standards may include (to the extent consistent with this title) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

(B) LIMITATIONS ON ELIGIBILITY STANDARDS.—Such eligibility standards—

(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income**[**, and **]***;*

(ii) may not deny eligibility based on a child having a preexisting medical condition**[**.**]***; and*

(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income pregnant woman.

COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE

SEC. 2103. (a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE.—The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 2101(a) shall consist, consistent with subsection (c)(5), of any of the following:

* * * * * * *

(e) COST-SHARING.—

(1) DESCRIPTION; GENERAL CONDITIONS.—

(A) DESCRIPTION.—A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

(B) PROTECTION FOR LOWER INCOME CHILDREN.—The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income.

(2) NO COST SHARING ON BENEFITS FOR PREVENTIVE SERVICES *OR PREGNANCY-RELATED SERVICES*.—The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the cat-

egory of services described in subsection (c)(1)(D) *or for pregnancy-related services.*

* * * * * * *

ALLOTMENTS

SEC. 2104. (a) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing allotments to States under this section, *subject to subsection (d),* there is appropriated, out of any money in the Treasury not otherwise appropriated—

* * * * * * *

(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—Subject to paragraph (4) *and subsection (d)*, of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) (determined without regard to paragraph (4) thereof) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of—

* * * * * * *

(c) ALLOTMENTS TO TERRITORIES.—

(1) IN GENERAL.—Of the amount available for allotment under subsection (d) for a fiscal year subject to subsection (d), the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

* * * * * * *

(d) ADDITIONAL ALLOTMENTS FOR PROVIDING COVERAGE OF PREGNANT WOMEN.—

(1) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing additional allotments to States under this title, there is appropriated, out of any money in the Treasury not otherwise appropriated, for each of fiscal years 2003 through 2006, $200,000,000.

(2) STATE AND TERRITORIAL ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraphs (3) and (4), of the amount available for the additional allotments under paragraph (1) for a fiscal year, the Secretary shall allot to each State with a State child health plan approved under this title—

(A) in the case of such a State other than a commonwealth or territory described in subparagraph (B), the same proportion as the proportion of the State's allotment under subsection (b) (determined without regard to subsection (f)) to the total amount of the allotments under subsection (b) for such States eligible for an allotment under this paragraph for such fiscal year; and

(B) in the case of a commonwealth or territory described in subsection (c)(3), the same proportion as the proportion of the commonwealth's or territory's allotment under sub-

section (c) (determined without regard to subsection (f)) to the total amount of the allotments under subsection (c) for commonwealths and territories eligible for an allotment under this paragraph for such fiscal year.

(3) USE OF ADDITIONAL ALLOTMENT.—Additional allotments provided under this subsection are not available for amounts expended before October 1, 2002. Such amounts are available for amounts expended on or after such date for child health assistance for targeted low-income children, as well as for pregnancy-related assistance for targeted low-income pregnant women.

(4) NO PAYMENTS UNLESS ELECTION TO EXPAND COVERAGE OF PREGNANT WOMEN.—No payments may be made to a State under this title from an allotment provided under this subsection unless the State provides pregnancy-related assistance for targeted low-income pregnant women under this title, or provides medical assistance for pregnant women under title XIX, whose family income exceeds the effective income level applicable under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902 to a family of the size involved as of January 1, 2002.

PAYMENTS TO STATES

SEC. 2105. (a) PAYMENTS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104, an amount for each quarter equal to the enhanced FMAP [(or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)))] of expenditures in the quarter—

(A) for child health assistance under the plan for targeted low-income children in the form of providing medical assistance for which payment is made on the basis of an enhanced FMAP under the fourth sentence of section 1905(b);

[(B) for the provision of medical assistance on behalf of a child during a presumptive eligibility period under section 1920A;]

(B) for the provision of medical assistance that is attributable to expenditures described in section 1905(u)(4)(A);

* * * * * * *

SEC. 2111. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN.

(a) OPTIONAL COVERAGE.—Notwithstanding any other provision of this title, a State may provide for coverage, through an amendment to its State child health plan under section 2102, of pregnancy-related assistance for targeted low-income pregnant women in accordance with this section, but only if—

(1) the State has established an income eligibility level for pregnant women under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902 that is at least 185 percent of the income official poverty line; and

(2) the State meets the conditions described in section 1905(u)(4)(B).

(b) DEFINITIONS.—For purposes of this title:

(1) PREGNANCY-RELATED ASSISTANCE.—The term "pregnancy-related assistance" has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income pregnant women, except that the assistance shall be limited to services related to pregnancy (which include prenatal, delivery, and postpartum services and services described in section 1905(a)(4)(C)) and to other conditions that may complicate pregnancy.

(2) TARGETED LOW-INCOME PREGNANT WOMAN.—The term "targeted low-income pregnant woman" means a woman—

(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

(B) whose family income exceeds the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) that has been specified under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902, as of January 1, 2002, to be eligible for medical assistance as a pregnant woman under title XIX but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and

(C) who satisfies the requirement of paragraphs (1)(A), (1)(C), (2), and (3) of section 2110(b).

(c) REFERENCES TO TERMS AND SPECIAL RULES.—In the case of, and with respect to, a State providing for coverage of pregnancy-related assistance to targeted low-income pregnant women under subsection (a), the following special rules apply:

(1) Any reference in this title (other than in subsection (b)) to a targeted low-income child is deemed to include a reference to a targeted low-income pregnant woman.

(2) Any such reference to child health assistance with respect to such women is deemed a reference to pregnancy-related assistance.

(3) Any such reference to a child is deemed a reference to a woman during pregnancy and the period described in subsection (b)(2)(A).

(4) In applying section 2102(b)(3)(B), any reference to children found through screening to be eligible for medical assistance under the State medicaid plan under title XIX is deemed a reference to pregnant women.

(5) There shall be no exclusion of benefits for services described in subsection (b)(1) based on any preexisting condition and no waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) shall apply.

(6) Subsection (a) of section 2103 (relating to required scope of health insurance coverage) shall not apply insofar as a State limits coverage to services described in subsection (b)(1) and the reference to such section in section 2105(a)(1)(C) is deemed not to require, in such case, compliance with the requirements of section 2103(a).

(7) In applying section 2103(e)(3)(B) in the case of a pregnant woman provided coverage under this section, the limitation on

total annual aggregate cost-sharing shall be applied to such pregnant woman.

(8) The reference in section 2107(e)(1)(D) to section 1920A (relating to presumptive eligibility for children) is deemed a reference to section 1920 (relating to presumptive eligibility for pregnant women).

(d) AUTOMATIC ENROLLMENT FOR CHILDREN BORN TO WOMEN RECEIVING PREGNANCY-RELATED ASSISTANCE.—If a child is born to a targeted low-income pregnant woman who was receiving pregnancy-related assistance under this section on the date of the child's birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under title XIX and to have been found eligible for such assistance under such title, as appropriate, on the date of such birth and to remain eligible for such assistance until the child attains 1 year of age. During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the child health or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).

○