EXECUTIVE MEETING

THE CHILDREN'S HEALTH INSURANCE REAUTHORIZATION ACT OF 2007

THURSDAY, JULY 19, 2007

U.S. Senate,

Committee on Finance,

Washington, DC.

The meeting was convened, pursuant to notice, at 9:05 a.m., in room 215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Salazar, Grassley, Hatch, Lott, Snowe, Kyl, Smith, Bunning, Crapo, Roberts, and Ensign.

Also present: Russ Sullivan, Democratic Staff Director; Bill Dauster, Deputy Chief Counsel Kolan Davis, Republic Staff Director and Chief Counsel: ~~Dean Zerbe, Tax Counsel and Senior Counsel to the Chairman;~~ Carla Martin, Chief Clerk; Mark Blair, Deputy Clerk.

Also present: Peter Orszag, Director, Congressional Budget Office; Alice Weiss, Health Counsel; David Schwartz, Health Counsel; Becky Schipp, Health Policy Advisor; Rodney Whitlock, Health Policy Advisor; and Thomas Barthold, Acting Chief of Staff, Joint Committee on Taxation.

I N D E X

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. The committee will come to order.

We are here to consider an original bill entitled "The Children's Health Insurance Program Reauthorization Act of 2007", and we're here at this hour because a Senator has anonymously exercised his rights, under the Standing Rules of the Senate, to object to this committee meeting while the Senate is in session.

Under the rules of the Senate, the Senator certainly has that right. But to avoid such disruption again today, we will move expeditiously to conclude action before noon. There is an old political adage: "When you don't have the votes, you talk." Well, when you have the votes, you vote, and we are here today to vote.

And so I will dispense with my incredibly eloquent opening statement. [Laughter]. And I urge my colleagues, who are even more eloquent, to also dispense with their even more eloquent opening statements. Without objection, all Senators' statements will be printed in the record.

If we have completed action before noon, that is clearly a wonderful opportunity for Senators to show their eloquence and their passion on this issue.

Shortly, I will recognize Senator Grassley for an remarks he may choose to make, and thereafter if Senators insist on making statements, they may do so at that point. But I will limit all statements to four minutes, and I will be very strict with that because we have to move on.

To paraphrase President Lincoln, the world will little note nor long remember what we say here today, but I hope that it could take notice of what we do. So, let us get down to work.

Senator Grassley?

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator Grassley. It is very important that we reauthorize this program. Too many children in America do not have health care coverage. Those numbers will be reduced by 2.7 million, and I think it does it in a cost-effective way and in a targeted way.

The package focus SCHIP dollars on children, where it was intended. the compromise proposal ends enhanced match for adults. We have fixed the funding formula. We have compromised on the total spending of this program.

Some say we should spent another $50 billion; some say we should keep spending, for the reauthorization, around $5 billion. That is not realistic. In fact, that would not even be enough to keep the program running as we know it now.

So I encourage everyone to take their wants and desires for SCHIP reauthorization and bring them to a place that we ought to visit more often: a place called reality. You can want $50 billion. You can want a $5 billion bill. But this bipartisan Chairman's mark represents the best of the possible.

Finally, I would mention an opportunity that we are missing here. Senator Wyden and some Republican Senators

want to make changes in the Tax Code to help tens of millions of Americans who do not have health insurance instead of just helping a few million kids through SCHIP. That is good policy.

But what we are doing here is what can be done, and what needs to be done, because this reauthorization has to be done by September 30. So, I believe we are doing what can be done.

I am not finding fault with other people that have other ideas. I agree with most of that policy. But we need to move on now and have another crack at the other good ideas that are floated in this committee, and by people outside of this committee.

The Chairman. Thank you, Senator, very much.

I would now recognize other Senators who wish to make opening statements. But, in recognition of their very hard work on this legislation, I will first recognize Senators Hatch and Rockefeller. Again, I would urge all Senators to stay within four minutes, or under, if possible.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator Hatch. Well, Mr. Chairman, this is a classic compromise. I will put my statement in the record. I know that it has caused a lot of heartburn for a lot of people on both sides, but I want to commend, especially you and Senator Grassley and Senator Rockefeller for the hard work that you have done on this.

I wish we could solve these problems cheaper, and I wish we could solve them even in a better way. But this bill goes a long way towards doing what I think is right for our children in this society, especially the children of the working poor.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

[The prepared statement of Senator Hatch appears in the appendix.]

The Chairman. I just want everyone to know how helpful you have been. You have been really working very hard to find the right compromise here, and I just compliment you very, very much, Senator, for all of your very hard work.

Senator Hatch. Thank you.

The Chairman. senator Conrad?

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator Conrad. I have examined my statement, and it is not particularly eloquent so I will not even give it. I just want to say, I think the four of you, Senator Baucus as our Chairman, Senator Grassley as the Ranking Member, Senator Hatch, and Senator Rockefeller, deserve the thanks of all of us, because we know how many hours you have put into this effort. It is a job well done, and we thank you for the extraordinary time and energy You have put into it.

The Chairman. Thank you, Senator.

[The prepared statement of Senator Conrad appears in the appendix.]

The Chairman. Other Senators who wish to speak? Senator Roberts?

OPENING STATEMENT OF HON. TRENT LOTT, A U.S. SENATOR FROM MISSISSIPPI

Senator Lott. Mr. Chairman, I will be brief. And while I have a number of concerns wit this legislation and will have some amendments, I think that we certainly should be able to finish it by noon.

I think 9:00 is a nice time to have a meeting, actually. I think everybody is in the frame of mind to try to point out the problems here and discuss what is being proposed and move on.

But this is a classic case, I think, of where a well-intentioned effort that goes back to the 1990s--and Senator Hatch was intimately involved in that, and others, to try to make sure that low-income, poverty children got health care. That was the intent. It was not easy on the floor.

I remember, there were some pretty strong feelings by Senator Kennedy, Senator Graham, and others. But we got it done. I voted for it because I thought it was targeted in an area where really there did not need to be some coverage made available.

But over a period of time, there have been problems with it growing. I must say right up front that the administration has contributed to this mightily by all

the waivers they have given, including adults and raising it up to, I think, as much as 400 percent of poverty.

They have contributed to the program basically growing. But now, what we are doing here is an explosion. Quite often we say, my goodness, if we do not find some reasonable compromise it will only be a $60 or $70 billion program, or it will be $100 to $130 billion.

I mean, this is billions we are talking about. There are a number of problems with it. I understand that one of the problems, the pay-go problem, maybe has been addressed in the mark, and I will be interested in hearing that.

I do think we need to know, is this a $41 billion increase over the $25 billion base rate line? Is it $35 billion? Who is going to be covered? It looks to me like adults are going to be on the program. Not just pregnant mothers, but parents.

Also, in those States that have the waiver, other adults will be able to get on the program. Now, if that has been clarified I would be very interested in hearing that.

But, again, I was thinking that we were going to come to something that would make sure we covered the children that are now covered and allow for some mild to moderate increase. I had no idea that it would jump by

$35 billion.

Show them this chart here of what we are talking about here. One of the slights of hand to try to get the $60 billion program, is we basically have the increases coming, and then in the sixth year, supposedly, we will either address it, come up with a way to pay for the tremendous increase, or we are going to have 75 percent of the kids knocked off the program. You are talking about a massive increase here.

A point was made by Senator Kerry about, well, look, should we decide what we want to cover and then pay for it and do not worry about the money? I guess I understand that position, but $35 billion, or $50 billion, or $60 billion? I do not know where the House is. I guess they are somewhere $60 to $100 billion above the $35 billion.

And then there is the matter of the pay-fors. Sixty-one cents a pack increase in the cigarette tax and cigar tax would go from 5 cents to $10. None of that is going to be enough because the revenue that will be coming in from that proposal will be declining.

And then what? Does anybody really think we are going to cut the program back at that point? So I just think there are tons of problems with the way this has been developed. I do not have any doubt about the

sincerity of the effort by all those involved, Senators Rockefeller, Grassley, Hatch and Baucus.

But I think we have major problems here and I would like to get a result. By the way, I think the effort that Senator Wyden has been working on is eventually where we need to go. I know my time has expired, but I will pick back up when I get to my amendments.

Thank you, Senator Baucus.

The Chairman. Thank you very much.

[The prepared statement of Senator Roberts appears in the appendix.]

The Chairman. Senator Wyden?

STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator Wyden. Mr. Chairman, I will be very brief. I am going to strongly support this effort today. It seems to me the four of you have better targeted children. It is obscene that millions of kids go to bed at night without decent health care.

The fact of the matter is, you all have actually rolled this program back in the direction it ought to go. It is going to be better targeting for children, and that is absolutely essential.

I also think that there is a real hope now for Democrats and Republicans, if we can get CHIP reauthorized and get CHIP reauthorized promptly, to move on to the broader effort. There is no question that the tax rules on health care are a mess. I think there is bipartisan agreement on that.

Senator Bennett and I have produced the first bipartisan health reform bill in 13 years before the Senate. Other Senators have good ideas. If we can get SCHIP reauthorized and reauthorized quickly, that will give us a chance, under the leadership of Chairman Baucus and Senator Grassley to move on.

Finally, I do hope that as part of this we can look at amendments that cost no additional money. I will be

offering one to attack the problem of Type II diabetes and the problem with kids and diabetes. This is going to engulf the entire Federal budget. I mean, it is staggering, what we are seeing with children. We have developed a way to attack it with no additional expenditures.

So, Mr. Chairman, my thanks to you and Senator Grassley. I look forward to supporting this effort and then seeing what we can do under your leadership to move forward with a broader effort.

The Chairman. Thank you, Senator.

[The prepared statement of Senator Wyden appears in the appendix.]

The Chairman. Senator Kyl?

OPENING STATEMENT OF HON. JON KYL, A U.S. SENATOR FROM ARIZONA

Senator Kyl. Thank you, Mr. Chairman. I associate myself with Senator Lott's remarks and would begin by pointing out the fact that the question here is not about reauthorizing SCHIP. The question is how we do it.

I would like to have the second chart that Senator Lott talked about displayed for you all again, because I do not think that this kind of gimmickry does this committee proud. That is all you can call this. We just make an assumption in the year 2012 that we are not going to have to pay for what is in the bill.

And, yes, you can do it to meet the budget point of order by calling the fifth year a non-year and doing a one-year appropriation so you do not have to carry that spending out throughout the remaining 10 years. But the reality is, you have got a hole between the red line that goes up to the top and says $34 billion, but CBO estimates it is really $41 billion. There is a $41 billion deficit.

You talk about the donut hole in the Part D Medicare? I do not know what you call the shape of that particular four-sided thing. Maybe it is not a hole. But it is a funding hole. We are either going to have to

cut benefits or raise taxes because the current legislation does not provide for the payment of that. It is a gimmick. We cannot be proud of that.

If Congress does not flat-line this proposal, then the bill's total costs will exceed over $100 billion over 10 years. What are the risks? Obviously Congress puts the financial burden on others, the tobacco tax, which cannot possibly pay for it, or causes us to modify the program.

The other reforms, I think, are ludicrous. To allow the coverage of families earning $82,600 a year, these are not poor kids that go to bed at night without health coverage. This bill permits that.

The distinguished Chairman of the Budget Committee, a member of this committee, has pointed out there is no "A" in SCHIP, but adults are permitted to be covered under this. This is all the result of compromise, I recognize, but it is bad policy.

Then in this classic bait-and-switch, we know from CBO that for every 100 children who enroll in SCHIP there is a corresponding reduction in private coverage of between 25 and 50 children.

So this crowd-out effect--and I will have an amendment to deal with that--really means that we are not expanding coverage to as many people as we think we are.

We are just taking them off of private insurance.

CBO estimates that over 2 million people will go off private coverage under this legislation. Is that something we can be proud of?

Mr. Chairman, I appreciate the efforts of all of the people who have worked hard on this, but it does not mean that they have it right. I think this committee in particular, which everybody else in the Senate looks to to be honest and objective and thorough, they want to count on the product of this committee.

We cannot say to them, this is all legitimate, folks, trust us. We have to acknowledge that this is full of gimmicks and bad policy, I guess because we had to make compromises. Count me out of the compromise, Mr. Chairman.

The Chairman. Thank you, Senator. You have been pretty eloquent, as have your predecessors. But there are all very honest, objective, thorough responses to all those points, which we will get to in good time.

[The prepared statement of Senator Kyl appears in the appendix.]

The Chairman. All right. Who is next? Senator Salazar.

OPENING STATEMENT OF KEN SALAZAR, A U.S. SENATOR FROM COLORADO

Senator Salazar. Chairman Baucus and other members of the committee, I appreciate the work that you have done. I think at the end of the day there are three points I would just like to make.

One, is that what you have done here by working together is developed a program that is going to cover 3.3 million more children in America that need health care, and I think we cannot lose sight of the fact that these are kids that are in need. It ought to be a very important family value that we ought to be pushing forward.

Two, Senator Grassley's comments, I think, are very appropriate. That is, we have to be realistic and live in the world of reality. Though this may not be as much as some of us would have wanted, I think you ended up with a $35 billion program here that I think is very worthwhile of our support.

And, three, I think Senator Wyden's comments are appropriate. I think, partially in response to you, Senator Kyl, it seems to me if we have a five-year program that we are dealing with here with respect to the reauthorization of SCHIP, that it ought to give us the

opportunity as well to deal with the much broader issue of health care, whether it is Senator Wyden's approach or some other approach, because this is an issue that I do not think is going to go away.

We in the Congress are going to have to deal with it. Hopefully during the next several years we will be able to put our hands around it in a more comprehensive way.

Thank you very much, Mr. Chairman. I have a statement for the record that is much more eloquent than that.

The Chairman. Thank you.

[The prepared statement of Senator Salazar appears in the appendix.]

The Chairman. Senator Crapo?

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator Crapo. Thank you very much, Mr. Chairman. I think it is evident from the comments that we have heard already, the issue here is not whether we are going to take the necessary action to cover children who are in poverty and who need health care. The question is how. There is a huge debate over what type of health care delivery system our Nation should have.

I am one of those who is working with Senator Wyden and a number of others to focus on insurance solutions, because I truly believe that market-oriented insurance solutions are the direction that will be best for our Nation.

As this compromise has taken shape, frankly, those solutions have not had much representation in this compromise. There is a little bit in here that helps, but very little. That being said, I recognize the work that the four leaders on this compromise have been recognize as having made.

The proposal before us in the form of this compromise is far better than the original proposal that we began with that we are working on, and it represents significant movement in the proper direction. Because of

that, I will be supporting the compromise today in the committee.

When the bill moves to the floor, I will also be supporting efforts to try to fix it more. We will see, as it moves forward on the floor, whether we can actually make this into a bill that should make it to the President's desk.

I truly believe that in the end, a lot of the concerns that have been raised by Senator Lott and Senator Kyl will have to be addressed. We do need to recognize the general direction that our Nation needs to go in terms of focusing on health care solutions that involve market-oriented insurance solutions where we are not just focused on trying to reach out and pick out one member of the family who will be deserving of support, but where we find a way to insure the family and make sure that those in this country who are uninsured, whether they are children or adults, have health care coverage. There are ways to do that.

I am concerned that some of the provisions in this approach that we have before us actually, as has been said, move people out of an insurance solution, and that is going the wrong direction.

So as I said, I believe there are a lot of reforms that were agreed to in this compromise that are moving

the ball in the right direction. I believe that there has been a really good-faith effort to try to so by those who put the compromise together, and that is why I am willing to help move it forward. But there is a lot more work that needs to be done on this legislation, and I look forward to that effort as well.

The Chairman. Thank you, Senator, very much.

[The prepared statement of Senator Salazar appears in the appendix.]

The Chairman. I see Senator Rockefeller has arrived. If you wish to make a statement, that would be wonderful. While he is thinking about what he wants to say, let me just commend you, Senator, for your very hard work. We would not be here today but for you. You have done a great job. Thank you.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER, IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator Rockefeller. Well, so have a lot of people, and all the people sitting behind us in particular. All I want to say is that I cannot imagine coming to something of this sort and not following through on it.

There is something about making children healthy which is not just about humanity towards children, but it is about the future of our country. It takes in every single idealistic thought that you can possibly bring.

It is a commitment that we have made, it is a commitment that we have not fulfilled, but it is a commitment we can fulfill. We have gone through unbelievable compromises to do it, and I hope very much that we come out of this successfully. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

Senator Stabenow?

OPENING STATEMENT OF HON. DEBBIE STABENOW, A U.S. SENATOR FROM MICHIGAN

Senator Stabenow. Thank you, Mr. Chairman. As other members have done, I want to thank you very much for bringing this to this point today, Mr. Chairman and Ranking Member Grassley, and certainly Senator Rockefeller and Senator Hatch.

This really is a bipartisan compromise in the truest sense of the word. It is really what happens when people of good faith get together and work hard towards a very important goal. I am very appreciative of all the hard work.

And it is a compromise. For those of us on the Budget Committee that worked very hard to put a larger number into the budget of $50 billion over five years, it is a compromise.

For those of us who are in States where, in good faith, the administration gave waivers to broaden the program, this is a compromise. This is a compromise in every sense of the word.

It is one that I support because the bigger goal is the most important thing, which is to provide more children, particularly over 78 percent whose parents are working in low-income jobs, the opportunity to have

health care. We are the greatest country in the world. If we cannot do that, I wonder what we can do.

Mr. Chairman, I also want to thank you for accepting some language that Senator Snowe and I suggested on testing the use of electronic medical records as we go forward. It is important as we look at health IT to be able to provide the kind of records that allow us to address quality and look at how we find, enroll, and treat children.

I also want to just say, I have to say editorially to my good friend from Mississippi talking about cost, everything we do here is about values and priorities. Without getting into all the debate we have had in the last week as it relates to the war in Iraq, we are spending almost $12 billion a month now--a month. This bill provides $7 billion in a year. It is paid for, the war is not.

I do not think, when we look at what the American people are asking us to do, $7 billion a year to make sure that parents, most of whom are working, have the population to have their children be able to go to the doctor and get the health care they need, is too much.

So with that, Mr. Chairman, I just want to thank you again. I think this is legislating in the best possible way of people coming together of good faith on both sides

of the aisle, and I congratulate everyone.

The Chairman. Are there any other statements?

Senator Schumer. Mr. Chairman?

The Chairman. The Senator from New York.

OPENING STATEMENT OF HON. CHARLES E. SCHUMER, A U.S. SENATOR FROM NEW YORK

Senator Schumer. I will be very brief, Mr. Chairman, and ask unanimous consent my whole statement be put in the record.

The Chairman. It will.

Senator Schumer. Just two quick points. One, the CHIP program has worked extremely well in my State. In seven years, it has reduced the number of uninsured children by 40 percent, which shows that this does work, and can work.

Today, almost 400,000 children in New York are enrolled, thousands more need coverage. I want to say, the Chairman's mark goes a long way to filling the rest of the gap and does very well for a successful program like ours to continue with success, and I thank all four of you for that.

Second, I have filed a couple of amendments on diabetes, particularly focusing on prevention. It is absurd that we will pay for the long interim treatment-removing a limb or whatever--and we will not pay for the early nutrition programs that really can stop diabetes when it begins, and I hope we will focus on that.

Thank you, Mr. Chairman.

[The prepared statement of Senator Schumer appears in the appendix.]

The Chairman. Senator Ensign?

OPENING STATEMENT OF HON. JOHN ENSIGN, A U.S. SENATOR FROM NEVADA

Senator Ensign. Thank you, Mr. Chairman. I appreciate all the work that has gone into this piece of legislation and very much think that the folks involved with this legislation have very good intentions.

The health care system, the way that it works in this country right now--the health care financing system would be a better way to put it--is a very inefficient system and it has a lot of perverse incentives in it.

The people who receive the care because somebody else is paying for the care is not nearly as involved in health care decisions as they should be. When we have a situation where market forces -- the incentive there to, one, make better decisions based on quality and cost are not part of the decision-making process, we end up with a less efficient system. People do not think it is analogous or that you can compare veterinary medicine to human medicine.

I have a lot of experience in veterinary medicine. But it is where people who, for their animals, are paying the costs more immediately, they are much more involved in the health care decision with their pets than humans are with their own health care decisions. I think that

we should be looking at ways to make a more consumer-oriented health care system.

The more we take people out of the decision-making process when it comes to costs, the further we go down the road of developing perverse incentives. That is why I think that the direction that the SCHIP program has gone is the opposite direction that we should be going.

Providing the coverage is a good idea because treating people in the emergency rooms who do not have coverage, we all know is a bad thing to do. So, getting people in that direction toward coverage is the right thing to do. We all think that is the compassionate thing to do.

But I think more in a free market type of approach where they are responsible more, where there are incentives to look at the type of insurance that they have and where that type of insurance will bring them more into the accountability loop, is the direction we should be going. I believe in a more comprehensive approach than this bill does, and would like to see us work toward that direction.

When we come to the floor we will be offering some amendments dealing with more comprehensive reform. In the long run, I believe that it is cheaper. Not only do we end up with a better health care system and a better

health care financing system, but it does it in a way that I think will provide better quality at less cost, with less money going to the bureaucracy of health care and more money going to patient care.

So, thank you, Mr. Chairman. I appreciate the efforts of this bill.

The Chairman. Any other Senators? Senator Cantwell?

OPENING STATEMENT OF HON. MARIA CANTWELL, A U.S. SENATOR FROM WASHINGTON

Senator Cantwell. If I could just add a statement for the record, I would appreciate it. If I could just offer my thanks to you and to Senator Grassley for your hard work and many hours. We would not be here without your leadership.

It is a tremendous step forward that this compromise is here, and I certainly want to thank Senator Rockefeller and Senator Hatch. I know that there were many, many hours of meetings over a long period of time, and I want to thank staff for also working to get us to this point. It is a big step forward.

The Chairman. Thank you, Senator.

[The prepared statement of Senator Cantwell appears in the appendix.]

The Chairman. Senator Lincoln?

OPENING STATEMENT OF HON. BLANCHE L. LINCOLN, A U.S. SENATOR FROM ARKANSAS

Senator Lincoln. Mr. Chairman, I would like to add my thanks, and certainly accolades, to you, to Senator Grassley, Senator Hatch, and Senator Rockefeller for the time you have invested in this, and just to say how grateful I am that we have set this as a priority in this committee.

I think we can all agree that providing health care for our children is something that we would all want to see for anyone, but it is also an investment, Mr. Chairman. I hope that we continue to look at it as an investment: in our Nation's most precious resource, in the future leadership of this country, in lower cost of health care as our children age.

But I think just personally, as a mom who has sat on the playground with another mother who was so panicky because her child had been injured and she was afraid what it was going to cost her to get the ambulance to get her child to the medical care that he needed, because she knew she was uninsured, she knew he was uninsured. It is just a frightening thing.

And so I am very, very, very grateful to you for sticking it out, and for all of you all for working

so hard to get us to this point. I look forward to working with you in that same bipartisan to get this bill all the way through because I think our children really do deserve it.

Thank you.

The Chairman. Well, thank you, Senator. Thank you very much.

I see no other Senators seeking recognition. I thank Senators for attending. A quorum for conducting business is now present.

There is a modification before the committee. The mark is so modified.

The next order of business would be a walk through the modification. Ms. Weiss, if you could very briefly describe the main features of the modification. Also, because this is a bipartisan bill, I will then ask Ms. Schipp to add whatever she may want to add as well.

Ms. Weiss?

Ms. Weiss. Thank you, Mr. Chairman. The modifications to the Chairman's mark make 11 changes to the mark. First, there is a provision providing increased funding for the territories for information systems.

This accepts part of Senator Schumer's amendment and amends Section 104 of the mark to allow territories to

get additional Medicaid funds at the enhanced match rate of 90 percent for start-up costs, and 75 percent for operation of Medicaid management information systems.

These are for claim processing and citizenship documentation, Social Security number verification systems. These funds would be outside of the territory's annual cap on spending.

Second, there is a delay in the effective date of the CHIP contingency fund created in the bill. This amends Section 108 of the mark, to delay by one year the effective date of the CHIP contingency fund to alleviate shortfalls and provide relief during disasters.

Third, there is a technical correction regarding the availability of funds of the unspent fiscal year 2006 funds. This amends Section 109 of the mark to correct a technical error, to ensure that unspent CHIP allotments that States have at the beginning of fiscal year 2008 can be retained by States, subject to the rule limiting carry-over funds in fiscal year 2008 to 50 percent of the 2008 allotment.

The correction clarifies that fiscal year 2006 unspent allotments can be retained by the States in fiscal year 2008, subject to this limit.

Fourth, there is a technical correction regarding the amounts provided for outreach grants. This

amendments Section 201 of the mark to clarify that $100 million will be provided for outreach and enrollment grants created under such section.

Fifth, there is a new Express Lane State Option demonstration program that is added, and this accepts a modified version of Senator Bingaman's amendment, Amendment 3, which was offered with Senator Kerry, Senator Lincoln, and Senator Salazar to create a new Express Lane demonstration program option for States.

It creates a new Section 203 to establish a $49 million, 3-year demonstration program for up to 10 States to implement an Express Lane Outreach and Enrollment demonstration.

It also creates a new Section 204 to authorize certain information disclosures to simplify health coverage determinations.

Sixth, there is a technical correction regarding new citizenship documentation options for States, and this accepts part of an amendment offered by Senators Bingaman and Kerry, Amendment 2.

It amends Section 301 of the mark to clarify that individuals whose Social Security number and identity do not generate a positive match by the Social Security Administration would have the right to seek a correction to the invalid match with the Social Security

Administration before the State may require them to present documentary evidence of citizenship under the Medicaid rules established under the Deficit Reduction Act of 2005.

Seventh, there is an additional pooling option for State premium assistance programs. This accepts part of an amendment offered by Senator Smith, Amendment 55, and it amends Section 401 of the mark to allow States that establish a premium assistance program the option to set up a purchasing pool for employers with less than 250 employees that have at least one CHIP-eligible employee. The State would have to offer at least two coverage options for this pool.

Eighth, there are child health quality improvement activities that are added, and these adopt three changes to the quality provisions laid out in Section 501 of the mark.

First, the modifications adopt Senator Lincoln's amendment, Amendment 25, offered with Senators Snowe, Kerry, and Salazar, which amend Section 501A of the mark to require the Secretary to identify existing core health quality measures for children that measure whether services that States provide promote healthy birth and prevent and treat premature birth.

Second, the modifications adopt Senator Stabenow's

amendment, Amendment 34, to amend Section 501D by adding an electronic health record demonstration program to the list of permissible grants the Secretary of HHS can make to up to 10 States, and child health providers to demonstrate promising ideas improving the quality of children's health care delivered by Medicaid and CHIP.

Third, the modifications adopt Senator Snowe's amendment, Amendment 46, to add a new Section 501E, establishing a childhood obesity demonstration program to develop a comprehensive and systematic model for reducing childhood obesity. The program is authorized at $25 million over five years.

Ninth, the modifications adopt mental health parity requirements. This adopts Senator Kerry and Senator Smith's amendment, Amendment 12, offered with Senators Bingaman, Wyden, and Lincoln to create a new Section 607 to require stand-alone CHIP programs to provide parity in mental health services that are provided.

It bars discriminatory limits on mental health care and CHIP programs by directing States that offer mental health services to apply the same financial requirements or treatment limits that apply to mental health or substance abuse services to limits that apply to other medical services.

Tenth, there is a new provision providing dental

health grants. This adopts a modified version of amendments offered by Senators Bingaman and Snowe, Amendments 47 and 48, to create a new Section 608 of the mark to provide $200 million in new Federal grant funding for States to improve the availability of dental services and strengthen dental coverage for children covered under CHIP. States that receive these grants would have to maintain prior levels of spending for dental services.

Eleventh, there would be a citizenship documentation delay of the provisions by one year. This adopts a modified version of Senator Smith's amendment, Amendment 54, to amend Section 801 of the mark to delay the effective date of the citizenship documentation provisions in Section 301 of the mark by one year.

The Chairman. Thank you, Ms. Weiss.

I see Senator Snowe has arrived. Before I get to Ms. Schipp, I will give Senator Snowe an opportunity to make a statement, if you choose.

OPENING STATEMENT OF HON. OLYMPIA SNOWE, A U.S. SENATOR FROM MAINE

Senator Snowe. Thank you. Thank you, Mr. Chairman. I want to thank you, Senator Grassley, Senator Rockefeller, and Senator Hatch or forging this compromise on such a critical issue of insuring children and building upon a program that has worked exceptionally well with the Federal and State partnership.

I know that this is the art of possible, not what is preferable for each of us, but clearly I think it bridged the gap on so many critical issues, and I think most importantly raising the poverty level income in order to capture more children who have no health insurance in this country that will now bring in an additional 3.3 million children.

I know certainly Senator Rockefeller and I would have preferred to go further on some of these issues based on legislation we introduced, but I think that this is a great step forward and I want to thank everybody for working together to ensure that this vital program gets reauthorized.

I think a strong statement--and vote--by this committee will help build the momentum on the floor. Hopefully there will not be any efforts to impede the

progress of this legislation on the floor or a veto by the President. So, thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

Ms. Schipp, for your additions.

Ms. Schipp. Thank you, Mr. Chairman. I have nothing to add to Ms. Weiss' characterization of the mod to the mark. Thank you.

The Chairman. Thank you.

Are there questions from members that you wish to ask of the staff?

Senator Kyl. Mr. Chairman?

The Chairman. Senator Kyl?

Senator Kyl. Thank you, Mr. Chairman. I have a few questions, if I could.

Can anybody on the staff tell me what the cost of the legislation is per year, per child?

Ms. Weiss. Senator, I believe that may be a question that is better directed to Director Orszag, who is at the table with us.

Senator Kyl. Sir?

Dr. Orszag. We estimate that the average Federal spending for all newly insured children under the mark would be approximately $2,300 in 2012. That is per reduction in uninsured children. If you look per beneficiary, per new beneficiary the cost would be

roughly $1,500 per child.

Senator Kyl. Excuse me. You said newly insured would be $2,300.

Dr. Orszag. In 2012.

Senator Kyl. Right. Is there a big difference in the first five years, from 2008 to 2012?

Dr. Orszag. There should not be a significant difference. There are various changes that take effect over time. And, of course, overall health care cost growth also increases over time.

Senator Kyl. Are the overall health care costs calculated in this number?

Dr. Orszag. Yes.

Senator Kyl. So the number is somewhere around $2,300 for the newly insured per year, and as of the year 2012 you estimate it to be $2,300?

Dr. Orszag. Yes. Again, that is evaluating the cost basically on the basis of the 4 million reduction in the number of uninsured children. If you measure it relative to the slightly more than 6 million new beneficiaries under the program, it would be about $1,500 in 2012.

Senator Kyl. No. This is the amount of the Federal expenditure per child.

Dr. Orszag. That is correct.

Senator Lott. But there is also a State cost, too, is there not?

Dr. Orszag. That is also correct. This is the Federal spending.

Senator Kyl. So if there is a crowding out effect, then the number would actually be lower, is that what you are saying, from the private insurance?

Dr. Orszag. The $2,300 effectively incorporates any crowd-out or shifting from private insurance to public coverage. The $1,500 basically excludes that effect, so that is effectively the difference between the two numbers.

Senator Kyl. Right. But there is a crowding out effect, right?

Dr. Orszag. There is a crowding out effect. Any attempt to reduce the number of uninsured children in the United States through a voluntary system of incentives will involve some shifting from current insurance.

Senator Kyl. All right. Do you know what the cost per adult is?

Dr. Orszag. Yes. The cost per adult is slightly higher. It is somewhere in the range of $2,700 to $3,400 in 2012, depending on whether you are looking at parents or childless adults.

Senator Kyl. All right. Which is which?

Dr. Orszag. The Federal spending per parent is roughly $2,700 in 2012, and the Federal spending per childless adult is roughly $3,400 in 2012.

Senator Kyl. All right.

Dr. Orszag. I should quickly emphasize, that is not the impact of the policy intervention. That is basically from the existing program.

Senator Kyl. Yes. It is the continuation of the existing program. So, $3,400 per year for childless adults.

How many children do you estimate would lose SCHIP coverage from 2013 through 2017 the way that the bill is constructed right now?

Dr. Orszag. We have estimated, relative to our baseline, what the effects would be. And let me just quickly look those up for you. Just one second. Sorry.

The Chairman. Senator, your time is ticking away here. You have eight seconds left.

Dr. Orszag. The bottom line. I can tell you in exact numbers. There would be a small reduction relative to the baseline in SCHIP enrollees compared to our baseline and an increase in Medicaid beneficiaries.

Senator Kyl. Excuse me just a second. Mr. Chairman, these are very important questions. We are going to spend over $100 billion over 10 years. I think

we can take a couple of minutes to try to understand some things.

The Chairman. Maybe we can get back to it. We will get back to you, Senator. You will be recognized again.

Senator Kyl. Mr. Chairman, might I just make a quick point? First of all, I did not understand the answer. Second, I have got a Judiciary Committee mark-up at 10:00. I do appreciate your calling on me first so I could get a couple of these questions out of the way. If I do not have the opportunity to complete the questions, then when I get back I would like to have an opportunity to ask the remainder of my questions.

The Chairman. We will see if we can find time before 10:00.

Senator Smith?

Senator Kyl. Would you please state the answer again? I am sorry. I did not understand what you said.

Dr. Orszag. I do have the numbers now. Under baseline assumptions, we project a certain amount of SCHIP and Medicaid spending. Under those assumptions, SCHIP enrollment, given the policy that would be adopted here, would decrease by 0.7 million children in 2017.

Medicaid enrollment of non-disabled children would increase by 3.6 million relative to our baseline. The

reason is that there would be shifting from the SCHIP program back onto Medicaid with the funding levels that would be embodied in the mark in 2017.

The Chairman. Senator Smith, questions?

Senator Smith. No questions, Mr. Chairman.

The Chairman. Oh. You have a statement?

Senator Smith. But I will put my statement in the record in the interest of time. Thank you and the Ranking Member for a good work product.

The Chairman. Okay. Thank you. Thank you very much, Senator.

[The prepared statement of Senator Smith appears in the appendix.]

The Chairman. Senator Conrad?

Senator Conrad. Mr. Chairman, I would like to direct my questions at Dr. Orszag. The question has been raised by some of our colleagues about the coverage of adults. I have always thought that did not fit with this program because this is children's health care coverage. But we all know this administration has granted waivers to cover adults.

It is my understanding that the mark moves away from that in a series of ways, and I would like to know if these understandings are correct. First, the mark stops all new waivers from being approved. Is that correct?

Dr. Orszag. That is correct.

Senator Conrad. By 2009, States would receive reduced reimbursements for childless adults they currently cover. Is that correct?

Dr. Orszag. I believe that is correct.

Senator Conrad. And by 2010, no childless adults will be on the CHIP program.

Dr. Orszag. That is correct, although there would be some opportunity for coverage under Medicaid.

Senator Conrad. Under Medicaid, but not under this program.

Dr. Orszag. Correct.

Senator Conrad. The mark also takes steps, as I understand it, to stop States from covering parents as well, does it not?

Dr. Orszag. Yes. There is a reduced match embodied in the mark.

Senator Conrad. Well, look. We have been handed a mess by this administration. They gave a whole series of waivers here, and now this takes steps to change that, and that is a fact.

The second thing I would like to ask, is does this mark, as currently constituted, comply with pay-go?

Dr. Orszag. Again, that would be a question for your committee, the Budget Committee, to evaluate. If

you look at the 5-year and 10-year expenditures and revenue raisers, they are balanced on an on-budget basis.

Senator Conrad. Our committee conclusion is that it does comply with pay-go on both a 6- and 11-year basis, as required under the rule.

The other point I want to make with respect to the dip at the end, because we are faced with a requirement -- this is a five-year reauthorization. this is not a 10-year program, it is 5 years. It is fully paid for over that period with the offset that is proposed. Is that not the case? Is it not paid for with the proposed offset over the five-year period?

Dr. Orszag. That is correct.

Senator Conrad. So I think all of us understand, I think on a bipartisan basis, we are not going to be able to continue with this current health care system beyond that five-year window, in any event. This system cries out--cries out--for reform.

Senator Wyden and Senator Bennett have tabled a proposal that I think is very serious with respect to reform. It is bipartisan. A number of us have tried to be supportive of it. I think this is another incentive, if you will, to help change the system.

I thank the Chair.

The Chairman. Thank you, Senator.

Are there other questions?

Senator Lott. Mr. Chairman?

The Chairman. Senator Lott.

Senator Lott. Let me make sure I understand what you were saying about the adults. The answer was that adults now on the program because of the waivers would be phased off. But is it not that the childless adults now under the program would be taken off but adults with children and pregnant women would be able to stay on the program? Is that not correct?

Dr. Orszag. Pregnant women would, and parents would with a reduced match rate associated with them.

Senator Lott. Say that last part again.

The Chairman. Reduced match rate.

Dr. Orszag. There would be a reduced match rate for parents under SCHIP as a result of this mark.

Senator Lott. But parents, adults, would still be able to stay on the program, correct?

Dr. Orszag. Still would be adults on the program. Correct.

Senator Lott. I was listening to Senator Conrad, because I know he does pay attention to the fact that he was uncomfortable about the adults being on the program. I do think it is a tragedy how these waivers have been granted. I do know that he looks at the budget numbers.

The pay-go question. Obviously there has been an attempt to address it in the last few days, and continuing we have to do that.

But here is the problem. Yes, it may be five years, but who among us really believes that after five years there is going to be this big drop-off? We are building up the momentum as it goes up in that fifth year, or each year it goes up to where it is going to be, what, $13 billion, $18 billion a year, and it keeps going. We are not going to, after five years, cut it.

Now, the argument might be, well, we may have an overhaul by then. We may have Washington bureaucratic-run health care for everybody by then so we will not have to worry about it. So, I think there is a lot of disingenuousness about what we have here.

Show us that second chart that shows the kind of thing we are dealing with. I just do not think it is honest to think that we are going to build this up. And people say, oh, it is just $35 billion. It is $60 billion. It is $35 billion, plus the current $25 billion, so it is $60 billion at least.

It is going to continue to go up. And I understand that the final cost is certainly much more than the $2,300 per child, because when you factor in the shifting off of private insurance, shifting over to Medicaid, the

State involvement is significantly more than $2,300 per child or person.

But this is just not realistic to build it up the way it is proposed to be built up, and then expect that, 1) it will just crater; or 2) that we are going to come up with double the money in the years ahead.

I just think we have gotten away from the core mission, which was well-intentioned and good, to target this to low -- and when you are talking about giving free health care to children and parents, a family of three, $60,000, $70,000, $80,000, I do not know. Maybe in some States that is low income, but that is upper income in my State.

I just think there are all kinds of budget problems and we are just not being realistic if we do not look at it in the first five, which I think is a huge problem, and then in the next five which is just going to be totally unattainable.

But I appreciate the opportunity, Mr. Chairman, to make some points.

The Chairman. Are there any other questions?

Senator Bingaman. Mr. Chairman, could I just ask a question of Peter Orszag?

The Chairman. Senator Bingaman.

Senator Bingaman. I know there has been a lot of

talk here about childless adults and coverage there. My impression is that we are substantially reducing coverage for non-pregnant adults as part of the Chairman's mark. And comparing the mark to a simple extension of current law, how does spending on non-pregnant adults compare?

Dr. Orszag. It declines under the mark. In particular, if you evaluate the baseline, plus filling the existing shortfall, we estimate that spending on non-pregnant adults would be $4.9 billion over the next five years; under the mark, it is $3.8 billion under the SCHIP program. So, that is a reduction of slightly more than $1 billion.

Senator Bingaman. All right. Thank you.

The Chairman. If I might follow up on that, Dr. Orszag. Is it not true that under each of the categories of adults--that is, childless adults, parents, and pregnant women--under the mark that there would be a reduction in the number of either dollars spent or adults covered?

Dr. Orszag. There would be a reduction for childless adults and parents. I'm not sure about pregnant women. I believe there may be an increase there.

The Chairman. But under pregnant women, is it not also true that the reimbursement rate is at a much lower

rate compared with the SCHIP reimbursement rate for the last years?

Dr. Orszag. I will defer to your staff.

The Chairman. All right. Maybe I am incorrect on that.

Ms. Weiss. Senator, the reimbursement rate for pregnant women would be on par with children, so the same enhanced match rate that is available for children would be available for pregnant women.

The Chairman. Could I ask you, Dr. Orszag, about crowd-outs?

Dr. Orszag. Yes, sir.

The Chairman. Is it not true, though, that this bill deals with that question about as efficiently as one can, that is, compared with crowd-out under tax credits, there is more crowd-out if we provide the same coverage for kids under the tax credit system versus the crowd-out that would occur under this? How efficiently is this mark designed in order to minimize crowd-out?

Dr. Orszag. Senator, CBO has not done a formal analysis of that, but I have spoken to various academic researchers and the CBO staff on precisely that question. In the absence of a mandate, a mandatory system on employers, individuals, or States, so in a voluntary system where you are trying to provide an incentive to

reduce the number of uninsured children, I think this approach is pretty much as efficient as you can possibly get per new dollar spent to get a reduction of roughly $4 million uninsured children.

The Chairman. And why is that? Why is it about as efficient as one can get?

Dr. Orszag. The incentive fund is designed in a particularly efficient way, for two reasons, to address this problem. The first one is that it provides a payment per child only for new Medicaid, as opposed to new SCHIP, children.

That is helpful in minimizing crowd-out because Medicaid kids tend to be lower income, and our estimates suggest that crowd-out is less of an issue for lower income children because they are less likely to have the option of private coverage. So by tilting towards Medicaid, that is beneficial.

The second important efficiency aspect of this is that the payments are graduated on the incentive fund, so you are not spending a lot of money on random variation or random noise that would happen otherwise just for whatever reason. The combination of those two is a relatively efficient outcome.

The Chairman. Compared with tax credits.

Dr. Orszag. And the shortcoming in a tax credit

approach is that you tend to buy out the base of existing coverage. Even if you look 100 to 200 percent of poverty, for example, something like 2 to 3 times as many children have private coverage as are uninsured, and so you often wind up spending a lot of money spilling over into currently insured children for every uninsured child that you pick up.

The Chairman. So if I hear you correctly, if we would approach coverage through tax credits there would probably be more crowd-out?

Dr. Orszag. It would depend on the details, but again I would come back to suggesting that, broadly speaking, this is probably about as efficient as you are going to get in order to get this much of a reduction in uninsured children.

The Chairman. Thank you.

Any other questions?

Senator Rockefeller. Mr. Chairman?

The Chairman. Senator Rockefeller?

Senator Rockefeller. Dr. Orszag, going back to what was previously being discussed about adults, cannot one say that if we cut out adults altogether from CHIP, that means that children lose health care?

Dr. Orszag. Yes. In our analysis, restricting eligibility to parents does have an effect on take-up

among children, in part because when you pick up the parent you are more likely to pick up the child also. It is not one-for-one, though, so for every three or four parents you lose, you might lose one or two kids, for example.

Senator Rockefeller. Thank you.

Senator Conrad. Mr. Chairman?

The Chairman. Senator Conrad?

Senator Conrad. Just a final question, if I could. We have seen the chart held up by the other side about the five-year sunset of some of the costs of SCHIP. I just compare it to what was done with the tax cuts. The tax cuts were sunset, not partially, but completely.

And when you compare the cost of the tax cuts over the same period to SCHIP, here is what you find. The tax cuts expire under current law. That creates the gap that you see here between the $421 billion. That is the amount of the cost by 2017 for that year alone.

And here is the comparison to SCHIP. SCHIP is that tiny sliver at the bottom. So if we want to be direct with people about people writing law around here to kind of hide the cost, what was done on the tax cuts absolutely dwarfs what has been done here.

Is that not the case, Dr. Orszag, that if one were to compare the gap here on the tax cuts to the gap in

SCHIP that the real chasm is the difference between the tax cuts that were sunset and the cost that is uncovered there compared to SCHIP?

Dr. Orszag. I think there is no question that extending the 2001 and 2003 tax legislation has a larger budget impact than extending the 2011 or 2012.

Senator Conrad. And dramatically so, as this chart depicts.

The final point I would make, and most importantly, does anybody here not believe that we have got to reform the health care system in the next five years? We are on a collision course here that we have to grapple with collectively.

And it is not going to be, I do not believe, a government-directed system, as Senator Lott indicated. I think it is much more likely to be the kind of proposal that Senator Wyden and Senator Bennett have come up with on a bipartisan basis. I think Senator Crapo may have some interest in it; I certainly do.

We have got a system here that does not add up. This SCHIP thing proves it. It is another confirmation that we have got an overall health care system that is utterly unsustainable. That is a fact. What this is doing is providing a patch so that kids in this country, at least some millions of kids, have coverage that is

desperately needed. That is a good investment for this country.

The Chairman. All right. Senator Roberts?

Senator Roberts. Thank you, Mr. Chairman.

You can take the chart down.

Senator Conrad. Would you like to borrow it?

Senator Roberts. No. Well, yes. I would like to take "tax cuts" and put "tax relief", and I would like to show that the deficit is coming down, not going up, and I will show that chart one day in 2010.

There are 406,090 childless adults on this program, according to the numbers that I have. I know that the Chairman and the Ranking Member--the distinguished Ranking Member and former Chairman--wrote a letter to the President asking whether the administration would continue granting waivers about two weeks ago when we were involved in all this. I think Wisconsin came on board.

As a matter of fact, it is 406,091. They missed some fellow who was hunting up in Wisconsin. [Laughter]. Now, have you received any notice back from the administration that this business of CMS waivers is going to cease and desist?

Senator Grassley. No, it is not.

Senator Roberts. Well, you sent the letter about,

what, two weeks ago?

Senator Grassley. And made direct conversation with people in the Cabinet long before the letter went.

Senator Roberts. So if we do not pass some form of this bill that hopefully is acceptable to a majority of the committee, this process will continue. And it is not going to be 406,000, it is probably going to be 506,000 very quickly. Is that correct?

Senator Grassley. That is correct.

Senator Roberts. I thank you. I will make my full statement a part of the record at this point. I want to thank everybody that everybody else has thanked. [Laughter].

[The prepared statement of Senator Roberts appears in the appendix.]

The Chairman. Thank you, Senator. That prompts another issue here for either Dr. Orszag or Ms. Weiss, whatever. Does this bill--following up just to confirm what the Senator said--prohibit future waivers?

Ms. Weiss. Yes, Senator, it would prohibit future waivers for adults.

The Chairman. For adults.

Ms. Weiss. Non-pregnant adults.

The Chairman. For non-pregnant adults. All right.

How many States currently have waivers?

Ms. Weiss. There are 5 States that have waivers for childless adults, 11 States that have waivers for parents, and 5 States that have waivers for pregnant women.

The Chairman. So with respect to the remarks of the Senator from Mississippi, which States would then continue to have childless adults, or parents, or whatnot? Will they be all States in the Nation or would they be States that currently have waivers?

Ms. Weiss. States that currently have waivers would continue. Only those States with parent waivers would continue, but the childless adult waivers would cease after fiscal year 2009.

The Chairman. And again, there are no new waivers?

Ms. Weiss. No new waivers.

The Chairman. All right. Thank you.

Senator Grassley. And further, to emphasize, because I think you can get the impression that except for pregnant women all 50 States -- existing policy. Waivers could be granted for the other 34 States eventually under existing policy.

So if you want real reform of what has gone wrong with this program in the last 10 years, and particularly under this administration, we have got to change the policy, pass this bill, and get rid of the waivers or you

are going to have more adults on.

Ms. Weiss. Senator, I would clarify, there are 39 States that will never have an opportunity to have parents covered.

Senator Grassley. And do not have now.

Ms. Weiss. Yes.

Senator Grassley. There are not 50 States with adults on today, as people might be led to believe.

Senator Snowe. Mr. Chairman?

The Chairman. The Senator from Maine.

Senator Snowe. Yes. Just in response to the overall issue of the cost of health insurance and the cost of this program, I understand everybody's concerns about the dimensions of the price tag associated with it. But I think it should give us a dose of reality of what the average American is facing, the average working family.

I mean, these are individuals who are struggling every day to provide some measure of health insurance to their families. These are people who are working. Half of all individuals earning less than $40,000 have had their employer drop their health insurance. Less than $40,000. There has been a 9 percent drop over the last 10 years.

It just demonstrates the drastic picture that

families are facing and confronting. And when we talk about the cost of this program and how it is escalating, well, I would remind you that as well the States across this country are assuming the tremendous burden as well.

I mean, they are picking up where we leave off because they recognize it and they confront people every day. In the State of Maine, the average cost for health insurance is more than $12,000 for a family of four. An individual policy is more than $4,000.

So I think we have a primary obligation, if we are going to complain about the cost of this program, and I think that it is time to address the issue of health insurance and the 47 million who are uninsured.

And by the way, 60 percent of those are small businesses, their families, and their employees. These are working Americans, people of modest means. So I hope we are not just dealing with a momentary reality because we are marking up a bill here today.

It is what Americans are facing on a daily basis who are struggling to have to make the choice as to whether or not their child is sick enough to even go to the doctor's. And I do not think that is a choice any family or any parent should have to make.

So while we complain about the cost of this program, and obviously we should be very concerned, and making

sure that we are spending every dollar appropriately, we had better be reminded of the larger picture here and what it represents. This is a manifestation of a tremendous problem.

It is one of the greatest single domestic challenges that we face, and we are ignoring it. I have been trying to get health insurance for small businesses. I have been trying to do that for the last four years, and all working, average Americans. They cannot understand why the best insurance policy they can buy is one that has catastrophic coverage with $10,000 or $15,000 deductibles.

So, I commend the States for taking the actions they do because they are on the front lines every day. We come in here, we mark up this bill, and we go on and say, gee, this is terrible. It is costing the Federal Government too much. Yes, it is. It really is.

It is staggering to think that to cover an additional $3.3 million children, it is costing an additional $35 billion. But that is just the collective impact of what families are facing across this country. So I hope that somehow this will galvanize the Senate and the House to do something and to grapple with this question.

The Chairman. Any other questions? Senator

Ensign?

Senator Ensign. I want to address what was said about the adults and the waivers. How many adults currently would come off of the program October 1. Do you know that number?

Ms. Weiss. October 1 of 2007?

Senator Ensign. 2007.

Ms. Weiss. All adults that are currently on the program would remain on the program as of October 1, 2007.

Senator Ensign. You are positive on that?

Ms. Weiss. I believe so.

Senator Ensign. All right. I was told that half of them would be coming off.

Does this bill allow Illinois and Wisconsin to put their adults back on SCHIP and get an enhanced match for them?

Ms. Schipp. Senator, we understand that CMS is in the process, potentially, of transitioning States whose waivers are expiring over the next few years into a Medicaid waiver. You are correct that Illinois, which covers about 200,000 parents and 1,500 childless adults, potentially would have those adults transitioned off.

Ms. Weiss. However, we have at this time no confirmation of any change in waiver policy given the

recent approval of a parent waiver.

Senator Ensign. Right. But does this bill allow them to put the adults back on SCHIP and get an enhanced match for them, for Illinois and Wisconsin?

Ms. Schipp. Senator, if this bill was enacted prior to the expiration of the waiver, yes, sir.

Senator Ensign. All right.

The other question that I have, and Senator Conrad has talked about honest budgeting. The reason I think some people have brought this up, a 5-year program, but yet the tax is out for 10 years -- and by the way, I would have wanted to have the taxes permanent.

I would have voted for the 10-year and beyond on the taxes and shown that, because I think that the budget -- and I have always had a problem with the way budgets are done around here because many of us were arguing that tax cuts would actually increase revenues in the United States when you cut the tax rates, which is exactly what we have seen, the increase in tax rates. That is why the deficit has been coming down, because we certainly have not cut spending around this place. It has to be coming from someplace, and that is because we have a better economy.

But that is not the point I want to get to. The point I want to get to is, in this program, have you

seen, when we have spending programs like this in place, when we have numbers of people, has anybody at this table ever seen us, when we have a sunsetted program, actually have something sunset?

In other words, we have a cliff here where they are assuming in the out years that none of these people are going to be there. Has anybody ever seen that actually happen in reality? [No response].

Do any of you think that this will happen? What is set in the mark, does anybody think that these people are all going to go away and they are not going to cost us in the out years of this program?

Ms. Schipp. Senator, the mark contemplates a five-year reauthorization of the State Children's Health Insurance Program.

Senator Ensign. Do you think that the cost that is -- and let me address this to you. Do you think that the cost that has been scored in this program is truly going to happen?

The Chairman. I have to stop you there, Senator. That is not really for the staff to answer. You are asking a hypothetical question of staff. Staff is here to give professional answers to what is in the bill.

Senator Ensign. But Mr. Chairman -- Mr. Chairman --

The Chairman. It is not fair to ask staff to hypothesize about the future, what is or is not going to happen. That is up to us, Senator, what legislation we want enacted.

Senator Ensign. Correct. But staff has been around here long enough to watch us, to understand that we do not cut off programs.

The Chairman. We are. We are cutting and stopping waivers here. We are cutting off lots here in this bill.

Senator Ensign. But this program, nobody expects this is going to stop, is the bottom line. So to be honest, we should put in the full cost of this program so we can be honest with the American people.

If you are going to have pay-go apply in the way that it is supposed to apply, if it is going to be honest, it should apply in this case and it does not apply in this case.

Senator Conrad. Mr. Chairman? Mr. Chairman?

The Chairman. Senator Conrad, then Senator Rockefeller.

Senator Conrad. Senator Ensign raised my name. I would just say back to him, look, this is a five-year reauthorization. That is it. It is done. The only way it is going to get extended is by further congressional action. What will the rules be at that time? None of us

can say. None of this staff can say.

Will pay-go be in place at that time? I hope so because pay-go at least will require that it will be paid for if it is extended, just as we are paying for a five-year extension now. That is honest budgeting. That is what we should do.

I personally believe, in this five-year period--at least I hope fervently--that we reform the health care system in the country because the truth about the explosion of cost is the explosion of health care costs in America.

Dr. Orszag just did a report for us that demonstrates that conclusively. I must say it educated me because I thought the explosion was largely the demographic problem. Turns out, it is not. The biggest part of the health care explosion is underlying health care costs, and that is what is exploding the costs of this program. We are going to have to deal with it.

The Chairman. Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, it is 10:15. We have been discussing a lot of subjects here. At least a third of our discussion has had to do with children, our business here. [Laughter]. Our business here this morning is to do coverage of children if it is the will of the committee.

I strongly suggest that we stop trying to -- I was actually thinking of asking Dr. Orszag, how many bolts are there in the U.S.S. Carter, but I thought that did not have anything to do with children either. I suggest that we get to amendments and get on with the business of children.

The Chairman. Senator, I think that is a good idea. Unless Senators really wish to ask questions at this point, I will open the mark up for amendments..

Do any Senators have any amendments they wish to offer?

Senator Wyden. Mr. Chairman?

The Chairman. Senator Wyden.

Senator Wyden. Thank you, Mr. Chairman. I have a substitute for my Amendment 27 to deal with juvenile diabetes.

Mr. Chairman, I will just start the explanation in the interest of time. This amendment does not add any additional spending. On top of it, it goes to a very important point that I think the Senator from Nevada has been talking about and I happen to share a view on, and that is personal responsibility and how we are going to go about changing behavior in American health care.

What this does, is it deals with kids and the issue of Type II diabetes, which is just exploding as a health

care problem in our country. A recent study by a major providing of prescription drugs looked at prescription claims for millions of kids aged 5 to 19 and found a four-year doubling in those taking medication typically used to treat or prevent Type II diabetes.

Colleagues were talking about a doubling of prescription claims for Type II diabetes in kids over just the last four years. I think the Senator from Nevada and I would both agree that a lot of this involves getting parents to work on healthy eating and exercise for kids. What my amendment proposes is that we use existing funds--no additional spending--from the incentive pool so that we could have voluntary programs--no mandates, with existing funds--to attack an area of children's health care that goes to behavior and personal responsibility that in my view is going to engulf American health care if we do not deal with it. So I am very hopeful that we can pass it.

I have had a chance to talk to Dr. Orszag briefly about it. It involves no mandates, existing spending, the discretion of the States to try these programs that I believe on the local level--not from Washington, DC, on the local level--can really work in terms of addressing juvenile diabetes and what I think every Senator would agree is an epidemic.

The Chairman. Senator, I think you have got a good idea, but there are a couple of objections. It is my thought, my hope, my expectation we can work this out among staffs before we include it in this mark-up today. So I was just wondering if perhaps the Senator could withdraw with that understanding so we could work all that out.

Senator Wyden. Mr. Chairman, I would be happy to continue to work with colleagues on this.

The Chairman. Thank you. I thank you.

Are there other amendments?

Senator Kyl. Mr. Chairman?

The Chairman. Senator Kyl?

Senator Kyl. Thank you, Mr. Chairman. I would like to call my Amendment #1. The short title is "Preventing the Erosion of Private Health Insurance."

The description is very brief. Prior to the effective date of the Act, CBO must certify that the bill will not result in a crowd-out effect, in other words, a reduction in private coverage due to SCHIP of greater than 20 percent.

Mr. Chairman, let me briefly describe the amendment. In its May 2007 report, the Congressional Budget Office estimates "for every 100 children who enroll as a result of SCHIP there is a corresponding reduction in private

coverage of between 25 and 50 children."

It goes on to state, "The potential for SCHIP to displace employer-sponsored coverage is greater than it was for the expansion of management because the children eligible for SCHIP are from families with higher income and greater access to private coverage."

Finally, Mr. Chairman, CBO notes that no studies have estimated the extent to which SCHIP reduces private coverage among parents, so the available estimates probably under-estimate the total reduction in private coverage associated with the introduction of SCHIP.

Put simply, the more individuals you put in SCHIP the more you crowd out of private coverage. That is not good, we all agree. But that is what the bill does. In many respects it is not just an SCHIP reauthorization, it is an SCHIP expansion.

First, as we know, the bill allows States to enroll children from higher income families, the very families who have greater access to private coverage. And, of course, it does allow States with existing waivers--existing waivers--to continue enrolling additional parents.

Now, CBO estimates that over 2 million people will go off private coverage under the bill. Half of this bill's reduction in the uninsured comes from taking

people off coverage, in effect.

So for newly-eligible SCHIP populations, CBO shows a one-for-one replacement, meaning that for each 600,000 newly insured individuals, 600,000 individuals go off their private coverage.

Now, this is all CBO, folks. This is not good. This cannot be what we intended. And what makes matters worse, is once the bill removes people from private coverage and enrolls them in SCHIP, the bill's funding hole after the fifth year will result in the loss of SCHIP coverage for millions of children.

In other words, we are bringing people onto SCHIP, taking them out of private coverage, and then after the fifth year, leaving them holding the bag. They no longer have private coverage. They can be led to expect that we are going to insure them, sure. Senator Conrad is right, it is only a five-year bill.

But is this a bait-and-switch where we pull people out of private insurance, put them on a Federal program that they think is going to continue to provide them benefits, and then after the fifth year we say, sorry, no more benefits? No. Of course we are going to provide benefits.

ut we are going to have the same kind of problem we do with physicians in SGR today, where there is a huge

hole and each year we have to come figure out a way to fill that hole. But the bottom line is, there is a bad relationship here.

Mr. Chairman, I heard Dr. Orszag speak glowingly of the efficiency rate pursuant to your question that it only crowds out 2 million individuals between 25 and 50 percent, which seems to me to show just what a low standard we have here in terms of an effective program. It may look good compared to tax credit programs, which I do not support, but it does not meet a cost-benefit rationale.

In any event, what my amendment ensures is that this crowding out effect will not happen at least more than 20 percent. That is bad enough, so it requires the Budget Office to certify that there will not be a crowd-out effect of more than 20 percent.

I guess I would just complete my statement by saying this. If people are right in saying, oh, for some reason we disagree with CBO and we do not think that this crowding effect will occur, well, my amendment cannot do any harm.

But if you think that a 20 percent threshold would come into play, the bill obviously represents bad policy that we need to rethink. Either way, the discipline of my amendment, I think, is very worthwhile.

Senator Lott. Will you yield, Senator Kyl?

The Chairman. Is there further discussion?

Senator Lott. If Senator Kyl would yield.

The Chairman. His time has expired, virtually.

Senator Lott. Well, we have got 19 seconds.

The Chairman. All right. Let us go with 19.

Senator Lott. If we are going to punch a clock here.

The Chairman. Yes, we are.

Senator Lott. The chart we had, I just want to point out, is one from CBO, July 18, 2007. The number here circled is the one that shows that there would be, in effect, a one-for-one crowding out from private insurance as they go into SCHIP. Is that correct, Dr. Orszag?

Dr. Orszag. The way I would describe it is that, for the expansion populations, roughly half of the new beneficiaries would be coming from private coverage. So I would not describe it as the one-for-one, but rather of which two new people on the program in that expansion population, there would be one coming from private coverage.

Senator Lott. Thank you.

The Chairman. Thank you.

Is there further discussion on the amendment?

Senator Grassley?

Senator Grassley. Yes. Well, first of all, in 1997 when this program was adopted CBO told us that there would be a 40 percent crowd-out rate. We should do all we can not to have crowd-out. But we still have this 40 percent rate, so the practical effect is that this is not a viable option.

While I respect the Kyl amendment and would like to work with him to reduce the crowd-out rate, such a 20 percent figure is not feasible. The effect would be to stop the reauthorization of SCHIP. And I do not believe that that is his intent, but that would be the effect of it.

We have also taken steps to minimize crowd-out by expanding options for SCHIP to pay for private coverage, and the incentive fund is targeted only at the lowest income children where the crowd-out rate is the very lowest.

The higher up the income ladder you go, the more crowd-out you have. So we are trying to focus this where we can help the most kids to get into the program, and by doing that at the level where you have the least crowd-out. So, I oppose the amendment.

Senator Kyl. Mr. Chairman, might I just respond to that last point Senator Grassley makes?

The Chairman. All right.

Senator Kyl. What that argues for is stopping this expansion of the coverage to the higher income people, because I think Senator Grassley is exactly right, that is where the largest effect of the crowd-out occurs.

The Chairman. Senator Bingaman?

Senator Bingaman. Mr. Chairman, I was just trying to recollect, when we were talking about Medicare Part D, my impression was the crowd-out rate in that circumstance was something like 75 percent and nobody was complaining bitterly about it here at that time. Am I correct on that, Dr. Orszag? Is it in that range?

Dr. Orszag. I do not want to embrace a particular number, but there certainly was significant shifting from existing coverage into Part D.

The Chairman. I might also add and just remind us that we designed this to be sufficiently as slim as we can to reduce crowd-out. There is always going to be crowd-out. There is crowd-out, as has been mentioned, back in 1997.

CBO at the that time suggested even a 40 percent crowd-out back then. I have not heard a lot of complaints in the last 10 years about the crowd-out under that program. The crowd-out here is going to be a lot less than 40 percent.

In addition, I think it is important to remind ourselves that this bill also has previous assistance provisions in it to encourage private coverage as opposed to the coverage under this CHIP program.

And, I might add that about 39 States use private health insurance companies today to administer CHIP, and States have deductibles. States have co-pays under this program. The health insurance industry is very integrally involved in respect to the crowd-out issue.

It is, again, because those States have chosen to use private health insurance companies with co-pays in many cases, with deductibles in many cases, to administer the program. The goal here is to help kids. We cannot lose sight of that. Let us keep our eye on the ball here. The goal here is to help kids as efficiently as we possibly can.

We again designed this in a way to accomplish that objective, by eliminating the waivers, cutting back on coverage under those waivers. Even today, with parents and adults who are covered, 91 percent of the beneficiaries under the CHIP program today are children in families under 200 percent of poverty. This is a 100, 200 percent of poverty program.

When all is said and done, when this bill passes that percentage is going to be higher than 91 percent

because we are cutting back on adults, parents, and so forth. So, it is good. We are increasing the number of kids that will be covered.

A lot more kids are going to be covered under this. I think it is also important to remind us that if we kept the current program as is, we will lose a lot of kids. We will lose, go backwards, backwards to the nature of I think about 800,000 kids that will be dropped off the program.

So to just stay where we are and not drop kids, and also to add more low-income kids. Again, this is sort of Senator Snowe's point. We are trying to help provide insurance coverage in the main, administered by the private health insurance industry, for low-income kids, that is, families whose incomes are not as low as Medicaid, but whose incomes are not high enough to get health insurance. That is the goal here.

Senator Kyl, just to close on your amendment.

Senator Kyl. Just closing argument.

The Chairman. And I would hope, before he closes, to urge Senators to vote not in favor of this amendment, to oppose the Kyl amendment.

Senator Kyl. I think I gathered that from your comments. [Laughter]. But just to make sure, I think that several of you made my argument for me, which is

that you are always going to have crowd-out. I think the argument that it is less than 40 percent is incorrect, as Dr. Orszag pointed out. Fifty percent is too high a crowd-out. I think 20 percent may be acceptable.

What we are doing if we oppose my amendment is to just acknowledge that we are going to have between 25 and 50 percent crowd-out effect, and that is fine with us because we cannot do any better. We have the most efficient way to avoid that result. If that is the way that this program works, we ought to find a different way for the program to work.

The Chairman. Just to make sure we have accurate representation from Dr. Orszag, Dr. Orszag, can you address the percentage of crowd-out that CBO anticipates?

Dr. Orszag. Yes, Mr. Baucus. The 50 percent number that I cited in response to Mr. Lott was with regard to expansion populations, which are only part of overall coverage effects under the mark. If you look overall for the change in coverage overall from the mark, the crowd-out rate is below 40 percent.

The Chairman. Thank you.

Senator Kyl. Well, Mr. Chairman, might I just ask then, is this what your 2007 May report said: "For every 100 children who enroll as a result of SCHIP, there is a corresponding reduction in private coverage of between 25

and 50 children"? In other words, 25 to 50 percent. Is that what you wrote or what CBO wrote?

Dr. Orszag. Yes.

Senator Kyl. Thank you.

Dr. Orszag. I believe I even wrote that.

The Chairman. The question is called on the amendment. All those in favor, say aye.

[A chorus of ayes].

The Chairman. Those opposed, no.

[A chorus of nays].

Senator Kyl. Roll call vote, please.

The Chairman. A roll call has been requested. The Clerk will call the roll.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Bingaman?

Senator Bingaman. No.

The Clerk. Mr. Kerry?

The Chairman. No by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. No.

The Clerk. Mr. Wyden?

Senator Wyden. No.

The Clerk. Mr. Schumer?
The Chairman. No by proxy.
The Clerk. Ms. Stabenow?
Senator Stabenow. No.
The Clerk. Ms. Cantwell?
Senator Cantwell. No.
The Clerk. Mr. Salazar?
Senator Salazar. No.
The Clerk. Mr. Grassley?
Senator Grassley. No.
The Clerk. Mr. Hatch?
Senator Grassley. No by proxy.
The Clerk. Mr. Lott?
Senator Lott. Aye.
The Clerk. Ms. Snowe?
Senator Snowe. No.
The Clerk. Mr. Kyl?
Senator Kyl. Aye.
The Clerk. Mr. Smith?
Senator Smith. No.
The Clerk. Mr. Bunning?
The Chairman. Yes by proxy.
The Clerk. Mr. Crapo?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Roberts?

Senator Roberts. No.

The Clerk. Mr. Ensign?

Senator Ensign. Aye.

The Clerk. Mr. Chairman?

The Chairman. No. The Clerk will announce the results.

The Clerk. Mr. Chairman, the tally is 5 ayes, 16 nays.

The Chairman. The nays have it. The amendment fails.

Are there any further amendments?

Senator Bingaman. Mr. Chairman?

The Chairman. Senator Bingaman?

Senator Bingaman. Mr. Chairman, I had three amendments I wanted to just talk about, three of the ones I have offered. I have offered several more than that. But I do not plan to ask for a vote on any of these, but I would like to just discuss them, and any thoughts you have related to them, I would be anxious to hear.

First, on Amendment #8, I believe, listed on the list that has been passed out, this relates to the Medicare savings program, this QI-1 program. My concern here is that, as I understand it, this program is scheduled to expire September 30th, just as the SCHIP program is scheduled to expire September 30th.

If we allow it to expire, it will result in seniors being forced to pay over $1,200 in additional costs in 2008 just in order to receive their Medicare Part B benefit.

In addition, because the receipt of QI-1 or QI qualifies for individuals for the full low-income subsidy under Part D, expiration of the program will cost beneficiaries many thousands of dollars more.

The amendment that we have filed on this subject would raise the threshold to 135 percent of poverty and would add an indexing for inflation to the assets test for this Medicare savings program.

I would just ask if you or Senator Grassley, either one of you, has thoughts as to how we avoid the QI program from expiring here at the end of September. I know this may not be the right place to try to get that problem fixed, but time is running and we are going to be under great pressure to solve this problem.

The Chairman. Senator, I appreciate what you are trying to do here and I commend you for it. Some Medicare Part B folks need a little help, frankly. I do expect us to take up Medicare later this year. Under the time constraints we are working under now, I just do not know that we can work it out now. But later on --

Senator Bingaman. But you think prior to the

expiration at the end of September?

The Chairman. Prior to the expiration in September we will certainly work to find a way to deal with it, but it is not without controversy. Some Senators have some difficulty with what the Senator is trying to accomplish. But, nevertheless, I agree with the approach taken by the Senator and I hope that prior to the expiration that we will find a solution here and work with you.

Senator Bingaman. Well, I thank you very much for your comment on that. I know this is an issue that you feel strongly about as well.

Let me also mention on this childless adult program, everyone has been speaking about what a terrible thing it is that we are providing coverage to childless adults. I think it would be very unfortunate if we do not allow States adequate time to transition the people who are currently covered under this SCHIP program into other programs, so I filed an amendment, along with Senator Stabenow, to extend that transition period one more year.

I will not call that for a vote at this point, but I hope we can work toward that result. My State is one that has a great many childless adults covered and we did that because frankly we were not permitted to cover children at the time this program went into place because we had already stepped up and covered the children.

So it is a little bit of a catch-22 that we enact a program and say States that have already done what they should have done to cover children cannot benefit from it, and so we will give them a waiver.

This administration, of course, gave us a waiver to cover childless adults. Now we are saying we are going to cut that off so you cannot cover them either. So I hope that before we conclude action on this bill we are able to extend that for one more year.

Senator Lott. How long do you have under the bill?

Senator Bingaman. I think, what, until 2009. Is that right?

Ms. Weiss. Senator, you would have one year of CHIP coverage for transition, and after that you would have a set-aside block grant for all those individuals covered in FY 2008.

The Chairman. At a reduced rate.

Ms. Weiss. At a reduced rate, at the Medicaid match rate.

Senator Bingaman. And I would prefer if we could have a two-year transition under where they could stay on SCHIP for two years. That still does not take us the full length of the waiver that the Bush administration has granted us, but it helps. So at any rate, that will be a subject that I hope we can revisit at some point.

The only other one is Item #7. This, again, is not directly specific to this SCHIP legislation. I understand that. But in January the administration issued a Medicaid rule that severely limits the ability of public providers to receive Medicaid payments and makes a lot of other changes in the Medicaid program.

Sixty-five of us here in the Senate went on record in opposition to this rule in disregard of what I believe is pretty clear congressional intent. CMS issued the final rule on May 25 of this year, the same day the President signed the one-year moratorium provision that is in law.

This is not something I understand to be addressed as part of the SCHIP bill, but I do think that this committee needs to act soon to further extend that moratorium. So I would hope we could do that also at some point here between now and the time we conclude action on health care legislation in the next few months.

The Chairman. Thank you, Senator. As we all know, the world is somewhat run by deadlines. All these are piling up so we will have to deal with them later on this year, and we will. Thank you.

Senator Smith?

Senator Smith. Mr. Chairman, as I said at the beginning, I really do appreciate the delicate balance

you and Senator Grassley are walking in terms of this bipartisan compromise. I think you have done excellent work. There are many amendments that people have come to me and asked me to support which, in normal circumstances, I would.

But believing that the focus needs to remain on children, I am going to follow the leadership that you two gentlemen are providing and trusting that there will be another opportunity to take up many of these ideas. And so in the spirit of that, I would bring up Amendment 56, my Amendment #3, offer it, and withdraw it.

But let me just briefly describe what it refers to. First of all, let me add, with Senator Snowe's permission, her co-sponsorship of it. As many of you know, the Supplemental Security Income, SSI, has a seven-year time limit to it in terms of the receipt or the eligibility of refugees to this country.

The SSI clock ticks differently than the naturalization process, and sometimes folks who are elderly, disabled, but here legitimately, simply are victimized by the bureaucracy that ticks according to different clocks.

This would simply extend their eligibility for two years. This is something we need to do. But because I do not want to upset this focus on children and getting

this done, at least in the fashion that it has been formed, I simply speak of this, the need to do this, and withdraw it.

The Chairman. Thank you, Senator. I might say, and I do not know if the Senator said this--I know he knows--this has passed the House just recently.

Senator Smith. I failed to mention that, but that is another reason why we need to address it in due course.

The Chairman. Right. I am hoping, maybe we can get this up by unanimous consent and passed. But I thank you.

Senator Lott. Mr. Chairman?

The Chairman. Senator Lott?

Senator Lott. I do have an amendment. Are you alternating back and forth on amendments?

The Chairman. Whatever. Senator Stabenow, go ahead.

Senator Stabenow. Thank you, Mr. Chairman.

First, a comment on the amendment that Senator Bingaman spoke about that he and I are offering related to adults. I, too, want to keep the adults on children.

Unfortunately, in the bill we treat different adults differently, and I am hopeful that we might work something out in terms of possibly expanding, giving

States another transition year as it relates to childless adults. I appreciate very much that we are transitioning away from that. But for many of our States this will involve actual cuts, so I hope we can work together on that.

The Chairman. Thank you, Senator.

Senator Lott?

Senator Stabenow. If I might offer an amendment.

The Chairman. Oh. Sorry.

Senator Stabenow. Yes.

The Chairman. Go ahead.

Senator Stabenow. I have an amendment that I will offer, actually, and withdraw, Mr. Chairman. But it is co-sponsored by Senators Salazar, Bingaman, Wyden, Kerry, and Lincoln. The reason I am withdrawing it at this point, is we do not have a CBO score. It is Amendment 33, that creates a definition for school-based health centers.

One of the ways to reach children with preventative or primary care is through our schools. The National Assembly of School-Based Centers believes that the cost of the amendment is under $30 million. We do not yet have a score, but it does basically define what a health center is for purposes of reimbursement so that we can have the opportunity through schools to reach more

children.

I am looking forward, Mr. Chairman, to working with you and the staff on the floor, and with CBO so that we might be able to get a score to be able to address what is a low-cost, effective way of reaching children with primary health care.

Senator Lott. Mr. Chairman?

The Chairman. Thank you, Senator.

Senator Lott?

Senator Lott. Thank you, Mr. Chairman.

I do have an amendment. It is identified as Lott Amendment #1. What is the number on the list? Lott Amendment #1. The amendment would apply the provisions of Section 106 of the Chairman's mark for non-pregnant, childless adults to all non-pregnant adults.

The amendment would strike provisions of Section 301 of the Chairman's mark with respect to verification of decoration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.

To state it simply and straightforwardly, it would refocus SCHIP resources where they belong, on kids. The Chairman's mark would allow SCHIP funds to be used to cover adults. The amendment would change that. It would remove adults from SCHIP and apply the savings to the very people we all say we want to help, and that is kids.

The amendment would increase the child tax credit to $1,080 next year and it would put the money in the hands of hardworking families and allow them to buy groceries, clothing, dental, health care, whatever they need for their own children.

So I really do think we ought to try to make sure we keep the "C" in the SCHIP program for children. Instead of spending money on the Children's Health Insurance Program to cover adults, let us give that money back to the kids. I think this goes to the heart of what the program originally intended and it would put the money back over into a program that has been broadly supported by the Child Tax Credit. I would urge a "yes" vote.

Senator Lincoln. Mr. Chairman?

The Chairman. Senator, I might say at the outset, I do not think this amendment is germane. In fact, I know it is not germane. We can have further discussion on it, but because it is non-germane I will rule this amendment non-germane.

Senator Lott. Well, let me just inquire about that. Are you saying then that any amendment would have to just deal only with the excise tax, the cigarette tax area for it to be to germane?

The Chairman. With respect to taxes, that is correct. Senator Grassley and I have worked out the mark

together. The parameters of the mark are Medicaid issues, excise taxes, but not non-excise taxes.

Senator Lott. I suspected you might do that. I realize that purity is not something we want to get too overwrought about around here. I remember supporting the Wyden amendment on rural schools, which was clearly non-germane but was not so ruled and was allowed.

But I know the Chairman invoke the germaneness rule when they want to, and they do not when they do not. But I am trying to make the point here that this is something that really we should be doing. I do think that the tax credit is a good program, and I do think we still have a problem.

The goal here, of course, unspoken, is, look, it is supposed to be about low-income children, then it is about all children, then it is about adults. This is where we are all heading. We are going to give everybody Washington bureaucracy health coverage through what was the SCHIP program. That is what is really at stake here, and we all know it.

I agree with Senator Snowe. I do not understand why we did not do the association health plans last year when we had a chance. There is a case where we can let people come together in different groups and provide care to their workers, low-income entry level moms who need that

help. We did not do that. I think a lot of the problem in health care -- look, we do have a problem. We are going to have to address it: accessibility, affordability.

It is big in all of our States, but we are attacking it on the other end. We are saying, all right, we have got a big problem with health care costs. Oh, by the way, the government will just pay for it. The problem is, what is causing the health care cost increases? There are a lot of problems here and we are doing nothing about that. But at any rate, I wanted to make that point.

I have four amendments that are in this category that would take the money that would be going for adults in the SCHIP program and move it over into programs that would really be aimed at helping children, but those four, at least, would be ruled non-germane.

Senator Lincoln. Mr. Chairman?

The Chairman. Senator Lincoln?

Senator Lincoln. Mr. Chairman, I understand the germaneness issue and certainly appreciate it, and think it is absolutely correct, so I would certainly not support the amendment in light of the incredible negotiation and balance that you and the Ranking Member have created here.

But I would like to say to Senator Lott, I am delighted to hear his passion over the Child Tax Credit. Senator Snowe and I have felt passionate about this issue for a long time and would encourage him to work with us as we move forward, because we have gone to bat many, many times on the Child Tax Credit and realize its importance and the importance of making it refundable, and a whole host of other things.

Senator Lott. And we have raised it.

Senator Lincoln. I am excited that he is excited, so I hope he will work with us in the future as Senator Snowe and I continue to work on that issue.

The Chairman. Does the Senator insist in offering his amendment?

Senator Lott. I think the point is made and I will not pursue a recorded vote. But I would like to go ahead and offer the only other amendment I will offer, in recognition of where we really are.

You know, Mr. Chairman, look. I know you are trying to find a way to appear to be paying --

The Chairman. Might the Senator identify his amendment? Which amendment are you talking about?

Senator Lott. Yes. This is Amendment #6.

The Chairman. All right. Thank you.

Senator Lott. That would refocus the SCHIP

resources to children and take the savings by reducing the adults and apply those savings to the so-called cigar tax.

Now, I am not a guy that smokes cigars a whole lot, mainly because I do not like the way they smell, cannot afford them. And I know you were just trying to find a way to fill the gap with not having enough money. But, all right. We are going to take it.

Nobody else will touch this issue, but I am going to because I am concerned about the people who are going to wind up being hit with this 61-cent-a-pack tax increase, and the fact that the revenue we expect to get will not materialize.

But the one that is really curious is to take the cigarette tax from 5 cents a cigar to $10, a 20,000 percent increase, a 53 percent tax on cigars. It would dwarf the tax on cigarettes, alcohol, and a whole range of other excise taxes. How do we explain that or justify that, or do we even care?

So I guess what happened is, instead of trying to come up with some realistic tax you just said, look, we will need X amount more, we will add a $10 tax per cigar and take care of the problem. How do you explain that and justify it?

The Chairman. Well, we increased tobacco taxes

proportionately. You take 61 cents for cigarettes and you apply that to other tobaccos, small cigars, big cigars and all kinds of different cigarette products, or products in the nature of cigarettes and cigars, and you apply that increase proportionately, then the cap, that is, the excise cap cannot be higher than the cap, but the cap increase proportionately computes to be $10.

Senator Lott. So for a pack of cigarettes it is 61 cents, but for one cigar it is $10?

The Chairman. Yes. Some cigars. If you apply the tax -- and the tax is a percentage tax. Some cigars are very expensive. There are certain parts of the world where one can get very expensive cigars.

Senator Lott. Are you talking about illegal Cuban cigars or something? [Laughter].

The Chairman. I am just talking about cigars. So that $10 cap on a very expensive cigar would not be terribly onerous. But the underlying philosophy and rationale is --

Senator Lott. Well, maybe you know what the price of cigars would be. But what would be the price of a cigar if you have got a $10 tax, plus the underlying cost? What do cigars cost? I do not even know.

The Chairman. I do not smoke cigars.

Senator Lott. What, 20 bucks?

The Chairman. Sorry?

Senator Lott. Is one cigar going to cost 20 bucks after the cost and the tax?

The Chairman. No, no, no. Again, it depends upon the price of the cigars.

Senator Lott. So the tax is even more than the cost of a cigar?

The Chairman. The tax is a complicated formula that is applied to cigars. It is a percentage. That is why we felt the best solution would be a proportion increase. It is true, for very, very expensive cigars, there would be a cap. But the cap is still $10. It could not be higher than $10.

Senator Lott. I think we ought to just shoot people who presume to smoke cigars in our presence and get it over with. [Laughter]. It is ridiculous. I do not smoke them. But the ridiculousness of this just shows you what one of the many problems are with this bill.

I withdraw the amendment, but I had to offer it to make the point of how outrageous some of this is, and it is not going to happen. At some point this is going to be taken out, reduced, whatever. Then what? Then the cost of the program, which is at least $35 billion on top of the $25 billion, is not going to be covered.

Senator Grassley. I would not worry about it. People who pay that much for cigars are smoking something else before they smoke the cigars anyway. [Laughter].

Senator Lott. Well, why do we not tax that? [Laughter]. At least it is an illegal product.

The Chairman. Are there further amendments?

Senator Ensign. Mr. Chairman?

The Chairman. Yes, Senator Ensign?

Senator Ensign. I would like to call up Amendment Ensign #7, Amendment #68.

The Chairman. 68. All right.

Senator Ensign. What this amendment does, very, very simply, is on the qualified employer-sponsored coverage reference in Section 401 of the bill, this amendment says that it "shall include a high-deductible health plan purchased in conjunction with the health savings account, as defined in the Internal Revenue Code."

It does not mandate that somebody is going to get a health savings account, it just says that the premium support shall allow it. In other words, if somebody wants to get a higher deductible policy with a health savings account, the premium support would allow the purchase of that. That is all this amendment does. Because right now they are not allowed.

From what I understand, they are not allowed to purchase with the premium support under the SCHIP program. If a State is using the private health insurance, for instance, they are not allowed to do a high deductible policy combined with a health savings account.

Many of us believe that the health savings account is the consumer-driven type of health care that we need with more accountability in the system. This just allows people of lower income, if they want to take that and make more and better health care decisions for their family, they would be allowed to do that. That is the purpose of this amendment.

The Chairman. Is there further discussion?

[No response].

The Chairman. I would have to oppose this amendment. The purpose of the SCHIP program is to make health care accessible to children from lower income families. A high-deductible plan, I think, does not meet this goal. Low-income families, certainly low-income parent families, cannot afford to pay for a health savings account. At some other time it may be appropriate to address HSAs, but not make that an option or further complication, frankly, in this program.

Senator Ensign. Well, Mr. Chairman, if a low-

income family cannot afford it, then they would choose not to get it. This does not force it on them, this just allows the freedom of choice.

This allows them to make the decision instead of the government mandating the decision. This broadens the choices that they can make if there is a low-income family that wants to choose this. This just says that they would be allowed to choose it. It does not force them to choose it, it just would make it allowable to be paid for under the premium support.

So if you say that low-income people cannot afford it, why do you not allow low-income people to make that decision for themselves instead of the government making that decision for them?

The Chairman. All those in favor of the amendment, say aye.

[A chorus of ayes].

The Chairman. Those opposed, no.

[A chorus of nays].

The Chairman. The nays have it.

Senator Ensign. Roll call.

The Chairman. A roll call has been requested.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

The Chairman. No by proxy.
The Clerk. Mr. Bingaman?
Senator Bingaman. No.
The Clerk. Mr. Kerry?
Senator Kerry. No.
The Clerk. Mrs. Lincoln?
The Chairman. No by proxy.
The Clerk. Mr. Wyden?
Senator Wyden. No.
The Clerk. Mr. Schumer?
The Chairman. No by proxy.
The Clerk. Ms. Stabenow?
Senator Stabenow. No.
The Clerk. Ms. Cantwell?
Senator Cantwell. No.
The Clerk. Mr. Salazar?
Senator Salazar. No.
The Clerk. Mr. Grassley?
Senator Grassley. No.
The Clerk. Mr. Hatch?
Senator Grassley. No by proxy.
The Clerk. Mr. Lott?
Senator Lott. Aye.
The Clerk. Ms. Snowe?
Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Crapo?

Senator Crapo. Aye.

The Clerk. Mr. Roberts?

Senator Roberts. No.

The Clerk. Mr. Ensign?

Senator Ensign. Aye.

The Clerk. Mr. Chairman?

The Chairman. I vote no. I see Senator Lincoln is here.

Senator Lincoln. No in person. [Laughter].

The Chairman. The Clerk will announce the results of the vote.

The Clerk. Mr. Chairman, the tally is 5 ayes, 16 nays.

The Chairman. The nays have it. The amendment fails.

Are there further amendments?

Senator Rockefeller. Mr. Chairman?

The Chairman. Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, I want to point out to my colleagues on both sides that there is an interesting thing happening here. We have got a deadline. We have got one hour left. There is an instinct on the part of a lot of people not to bring amendments to a vote, but to be able to talk about it because it is something they feel very strongly about. That is incredibly laudable and understandable.

But I think that we 60 minutes in order to do our work up here and turn out a good product, and I strongly advise that we adhere to that and people exercise the discipline. All you have to do is look up there.

Senator Salazar. Mr. Chairman?

The Chairman. Senator Salazar?

Senator Salazar. I will be brief on our amendment, but I call up Amendment #36, as modified. As it is being circulated, I would thank Senators Roberts, Stabenow, and Bingaman for their leadership and support of this amendment.

What it does, is it equalizes a formula that we use to reimburse community health centers. There are currently community health centers in 16 States, including Arizona, Colorado, Kansas, Michigan, Montana, North Dakota, Utah, and West Virginia, and what it does is it corrects the reimbursement formula so that we do

not have the disparity between those States that have community health centers and they are serving CHIP children and those in other States. So it is an equalizer amendment and I appreciate Senator Roberts' bipartisan leadership on this amendment. I would ask for a vote on it.

The Chairman. Is there further discussion?

[No response].

The Chairman. I commend you, Senator. You have worked hard on this amendment with other Senators. It is bipartisan. I think it is laudable, a good idea, and I urge the members to accept the amendment.

All those in favor of the amendment, indicate by saying aye.

[A chorus of ayes].

The Chairman. Those opposed, no.

[No response].

The Chairman. The ayes have it. The amendment is agreed to.

Senator Salazar. Mr. Chairman? Just keeping in mind Senator Rockefeller's statement here about us being short, I just want to say there is another amendment that I would offer and withdraw, and that is Amendment #35 regarding the nurse home visitation program.

As we fund all of these different kinds of programs

here at the Federal level, it seems to me what we need to do is to make sure we are funding those programs that are scientific in nature that have been evaluated to actually work.

I think we fund a lot of programs that do not work. This is one program that does, in fact, work. It now operates in 22 different States. The results in terms of what it does at home to young children is just incredible.

So, I would hope that as we move forward that I could work with you and with Senator Grassley in a bipartisan way to get this amendment adopted. But I offer and withdraw Amendment $35.

The Chairman. Thank you, Senator.

Are there other amendments?

Senator Kerry. Mr. Chairman?

The Chairman. Senator Kerry?

Senator Kerry. Mr. Chairman, I appreciate what Senator Rockefeller has said. Let me, first of all, thank you and Senator Grassley for accepting the amendment on mental health parity that Senator Smith and I introduced. We appreciate that.

The discipline I will show is to save the committee a prolonged debate and not ask for a vote on either of the two amendments, but I do want to say something about

both of them.

We passed a budget in the U.S. Senate for $50 billion over five years for children's health insurance. I think what you have achieved is impressive. I understand the delicate balance of the committee, so I am not going to ask some colleagues who I know support the $50 billion to vote against their conscience here in the committee because we want to get this bill out onto the floor. But I reserve the right to do that on the floor.

Here is the rationale. I know, Senator Lott, you mentioned something about my philosophy about covering these kids. I am sorry I was not here. I was at a Pentagon briefing on Iraq. But I do want to comment on it.

Six million of the uninsured kids are already eligible, or 9 million or so are already eligible for SCHIP or Medicaid. Of the 6 million, 4 million are Medicaid eligible.

Now, the CHIP program, which was bipartisan passed and supported by people who tried to cover the poorest of the poor, ought to be able to do that. This compromise, which has been, frankly, the best deal that some of the folks on our side can get in some prolonged negotiations, but it has been forced to accept that only 1.8 million of those kids on Medicaid are going to get picked up.

So we are not covering all of the poorest of the poor in this effort. And while the Chairman's mark results in a total yield of 3.3 newly insured children, 2.7 million of whom are eligible but not yet enrolled, that is only roughly half of the 6 million eligible but unenrolled.

Now, the negotiators have put a careful incentive to give the States an ability to draw more people onto Medicaid where they are Medicaid and they get more Medicaid covered. But I think, frankly, we could do more.

I have to say to my colleagues on the committee, when you balance it, there are a lot of things in the Finance Committee that we have passed in both spending and tax relief, and some things we failed to reform, that have to be measured against this choice about Medicaid eligible children.

For instance, if the Alternative Minimum Tax relief is extended for 2007, the tax cuts for those with incomes over $1 million a year will cost us $43 billion for 2007 alone. That is a choice this committee is making, and I believe it ought to make a different choice.

I do not think people earning $1 million or more a year ought to be walking away with $43 billion worth of tax relief at the expense of those Medicaid children. It

is just a fundamental choice.

The gas guzzler loophole is costing American consumers $10 billion annually. It excludes SUVs, minivans and pick-ups from paying a tax on excessive fuel use, despite the fact that tax applied to gas-guzzling cars has effectively reduced the numbers of those gas guzzlers. That is a policy choice.

We approved extension and expansion of Section 29 tax credits for coal bed methane production. That is a $5 billion set-aside for a form of energy production that is scarring western lands, threatening scarce water supplies, not to mention benefitting some of the country's biggest energy companies and most profitable companies: Phillips Petroleum, Texaco, USX, to name a few. That is a policy choice and that is the choice that is being made here.

If we do not reform Medicare Advantage, a program which I think most of us support, we are going to over-pay private plans by $50 billion over the next five years. That is $10 billion a year compared to $3 billion a year to cover every single child under Medicaid.

So I am going to bring this amendment to the floor of the Senate and we are going to have this debate, because I think it is an appropriate debate to have. I think there are a lot of other choices. I have barely

scratched the surface of the choices that we make with respect to tax expenditures and benefits that are parceled out here.

So it is hard to understand. I know --

The Chairman. I might say, Senator, your time has expired.

Senator Kerry. My time has expired? I have the same argument or similar argument with respect to legal immigrant children. Legal immigrant children. I reserve it for the floor. I will withdraw both amendments without a vote.

The Chairman. Other amendments?

Senator Bunning?

Senator Bunning. Thank you. My amendment is Bunning Amendment #1 in regards to the health insurance program. It would strike the provision allowing an exemption. The money --

The Chairman. I am sorry, Senator. Which amendment is yours?

Senator Bunning. One.

The Chairman. Number one?

Senator Bunning. Number one.

The Chairman. Thank you.

Senator Bunning. I will just get into it. I do not have to read the amendment.

I have heard a lot of talk about how this bill puts the focus for SCHIP back on children. My amendment gives everyone a chance to do just that.

Under the Chairman's mark, States that want to cover kids above 300 percent of poverty will get their Medicaid match rate, not their higher SCHIP matching rate. Three hundred percent of Federal poverty is about $62,000 for a family of four.

In fact, it is $62,000. The bill also includes a provision to grandfather in States that have already gotten approval from HHS to go above the 300 percent. Along with States that have simply passed a State law to let them ask for HHS for this additional coverage, I think that all States should play by the same rules.

That is why my amendment would eliminate this exemption and require any State covering children above 300 percent of poverty be paid their Medicaid matching rate. States can cover these children, but must do so at their Medicaid rate.

There will obviously be some small savings from this. My amendment would take this savings and provide additional money to the outreach and enrollment grants. You have an option: more money for outreach and enrollment efforts or more money for covering children in families that most of us probably do not consider poor,

those making $62,000 and up, to $2,600 a year for a family of four.

The Chairman. One of the Senators who is most directly concerned with this amendment who is on the committee is not now present. He is on his way. That would be Senator Schumer from New York.

Senator Bunning. Yes. His is at 400 percent.

The Chairman. Yes. Let me say, pending his arrival, that we have tried to respond generally to the concerns of Senators to keep this program for kids, and for low-income kids, by providing for the 300 percent rule, namely, States that do go up to 300 percent get their reimbursement at the lower Medicaid match rate.

I think it is important to remind ourselves that the 200 percent, 300 percent of poverty, whatever it is, is a national figure that applies nationwide. The trouble is, every State is different. Some States are high cost of living States, much higher than some others.

Senator Bunning. Yes. But 200 percent of poverty is what Kentucky keeps its rate at.

The Chairman. Yes. Well, I do not want to comment on the income levels of people in Kentucky. But I do know that there are some States that have very high living costs, much higher, say, than my State in Montana.

Senator Bunning. But this is a national program, I

assume.

The Chairman. Yes. Right. And there are certain States who played by the rules. They were under the law as it has been in the last five years. I do not know whether these States got waivers or not. Maybe the staff could tell me whether the States that are above 300 percent got waivers or not. Did they?

Ms. Weiss. There are a number of waiver States with income levels at 300 percent that got waivers. There are some States above 300 percent that got that way with using a State Plan Amendment with a block of income disregard.

The Chairman. All right.

I wonder, could the Senator withdraw his amendment pending the arrival of Senator Schumer so we can take other amendments up and then come back to you?P

Senator Bunning. Certainly. I will hold it.

The Chairman. All right. Let us do that. Senator Schumer is not here yet. Thank you.

Senator Lincoln?

Senator Lincoln. Thank you, Mr. Chairman. First of all, again, I want to thank you and Senator Grassley for working with us, particularly on the amendment I had with the premature babies and premature quality issue, for accepting that.

I also want to thank the Chairman for working with us on the Medicaid AMP, which was my first amendment, #24. Then I also wanted to speak on my third amendment, which was #26.

Twenty-six was just to provide a sense of the Senate that vision care would be something we could work towards including, knowing how important that vision care is for children, recognizing early on the need for vision care so that children can learn properly and really work hard to reach their full potential. I will not offer the amendment, but would like to express certainly my interest in that issue.

Also, thanking the Chairman, the Ranking Member, and others for working hard to accept the mental parity and the dental coverage especially. Knowing that food insecurity is an enormous issue among children, we cannot deal with food insecurity if children's teeth are rotten and they cannot eat.

So, they lack nourishment for multiple reasons, whether it is access to food, but more importantly if they are not getting dental care and they are suffering from decaying teeth, then none of the other works. I mean, they cannot learn, they cannot eat the nutritious foods that they need because they are in pain. So, I am grateful for that.

The last one that I would speak on, Mr. Chairman, was the pharmacy Medicaid AMP fix. I am also very grateful to Senator Roberts and Senator Salazar, who I offered this amendment with. I will certainly withdraw the amendment, but would just like to speak on it for a few moments if I may, certainly respecting Senator Rockefeller's suggestions that we keep it to brief comments.

We have offered this amendment because we are deeply concerned that the CMS rule regarding prescription drug pharmacy reimbursement in the Medicaid program will threaten the existence of retail pharmacies and severely restrict the ability of millions of Medicaid beneficiaries to access prescription drugs from those pharmacies.

I want to thank the Chairman for his work on this issue. We certainly know that, under the Deficit Reduction Act of 2005, that Congress intended for CMS to promulgate a rule that would more clearly define the average manufacturer price. The definition should closely approximate the cost incurred by our retail pharmacies to purchase drugs.

But rather than providing that clarity or any accurate reflect of what retail pharmacy drug costs are, the rule threatens retail pharmacies and the

beneficiaries' access to critical medication, particularly in rural areas.

So my hope is that we can continue to work on this issue. It is really important for access, particularly for Medicaid, in rural areas. But certainly reinforcing our small pharmacies in rural America means prescription drug access for children, for Medicaid beneficiaries, and everybody else is going to be there if we are fair, and I think reasonable, with how that is calculated.

Under the amendment that we have presented here, the Federal upper reimbursement would be calculated using the weighted, rather than the lowest, average of the most recent AMPs for the multi-source drugs available to retail community pharmacists.

So I appreciate the Chairman working with us on this, and especially appreciate Senator Roberts and Senator Salazar on this issue, recognizing that our retail pharmacists in rural America are very important and we want to continue to work on this issue.

The Chairman. Thank you, Senator. You worked mightily to try to correct a big problem here with retail pharmacists on this AMP issue, along with Senator Roberts, Senator Salazar, others, and myself. I intend to introduce legislation later this year, along with you and others, to address it because it is a big issue.

It is a problem, frankly. It just an unfair issue. I think CMS is very unfair in the way it is promulgating its rules in this area. So, thank you very much. We will work with you.

Senator Lincoln. Thank you.

Senator Kyl. Mr. Chairman?

The Chairman. Senator Kyl?

Senator Kyl. Thank you, Mr. Chairman. Again, I want to apologize. I have got a mark-up in Judiciary. And if you think this stuff is complicated, start getting into the nuts and bolts of patent reform. That is really exciting stuff.

The Chairman. I do not want to.

Senator Kyl. No. I did not either.

This is my Amendment #2, and it is the short title, "Protecting Children's Health Coverage". The description is this: prior to the effective date of the Act, the Congressional Budget Office must certify that the bill would not result in reduced enrolled or a change in covered benefits from fiscal year 2013 through fiscal year 2017.

Now, we have all said we support the reauthorization of SCHIP for low-income children. That is exactly the purpose of this amendment, to ensure that that coverage is not diminished as a result of this reauthorization.

We have seen from the chart that has been displayed a couple of times that in 2013, SCHIP funding falls off of a cliff and all that people have to rely on after that is our good intentions.

So, in fact, it is so much so that it is inconceivable that States would continue funding their programs and provide this coverage for low-income children.

There are only two things that can happen. Number one, we are either going to have to impose some kind of a new tax to raise the money needed to sustain the program, or millions of children are going to lose SCHIP coverage.

I do not think we can just rely upon some feel-good notion that somehow or another between now and then we are all going to come together and sing Kum Ba Ya and totally reform the system and magically come up with all the money so we do not have to worry about what happens after five years. We have to worry about what happens after five years a lot around here.

I wondered exactly what the cost would be, how much money it would require to continue funding SCHIP in the last five years. So we asked CBO to estimate the cost of using the rate of growth in spending from 2011 to 2012. Here is the answer: CBO estimates that $41 billion is needed to sustain the program over the fiscal years 2013-

through-2017 period of time.

That means that this bill contains a $41 billion hole. If you fill the hole, it brings the grand total to $112 billion over 10 years. That is what we are committing to here. Make no mistake about it, $112 billion over 10 years. Not my numbers, CBO's numbers.

This is unsustainable. We do not pretend to sustain it in the bill. We only sustain it for five years. We are buying a very expansive--not just expensive--SCHIP policy here and we are making commitments to people.

Here is my concern. We should not be making a promise that we know we cannot keep, or we do not have at least some plan to figure out how to keep. People will rely on us, and in the future I doubt that we will want to cut the benefits. What my amendment ensures is that we will not cut the benefits.

Now, am I just dreaming a problem up here? Look at the SGR problem. We are all familiar with the SGR problem. We know it is going to come at us every year. Why? Because we created the same kind of cliff. We did not have the ability to address the long-term costs of reimbursing physicians, so we do it each year in a cursory manner, one year at a time.

It solves the short-term problem but it makes the big hole there even bigger each year. This year is no

exception. Physicians will face a 10 percent payment cut in 2008 unless we act. We know we have to act, so we will. But each year we continue this sort of game.

By the way, I do not think we figured out yet how we are going to do it this year. I submit that this bill puts SCHIP on the same kind of trajectory that SGR is, setting up a giant SCHIP payment cliff in 2013. Why would we dig ourselves a bigger hole than we already have with SGR?

So again, let me just reiterate that I support the SCHIP reauthorization but I do not support a promise to people that we have no earthly idea of how we are going to keep, except that somehow we will figure something out. That is not keeping faith with people.

So, my amendment is very clear. Prior to the effective date of the Act, CBO certifies that the bill will not reduce SCHIP enrollment or a change in covered benefits from those years. If they cannot make that certification, then we are making a promise we cannot keep.

A final point.

The Chairman. The Senator's time has expired.

Senator Kyl. Might I just make this final point? I am sorry, Mr. Chairman. The distinguished Chairman of the Budget Committee has made the point a couple times,

well, this is only a five-year budget.

The Chairman recalls well many hours of discussions we had when we tried to reform the inheritance tax, the death tax. We always had to look at that 10-year number, what is it going to cost over 10 years.

We cannot just use the 10-year number when it suits our purposes and then jettison it when it is inconvenient. It is required and we need to know what the 10-year cost is and be consistent in planning to meet the costs of a program that is going to go on for more than one year.

The Chairman. I appreciate that, Senator. Let me just get this straight. You mean, the Senator is concerned about reduced enrollment?

Senator Kyl. I am concerned about Congress making a promise. You know, we are down to 14 percent approval rating now. That is half of the President's. That ought to cause us to look at ourselves and say, are we maybe not keeping faith with the American people? Are they seeing something in us that they are not too keen on? One of the problems is making promises that we know we cannot keep.

The Chairman. Well, I would like to vote on the amendment, frankly.

Senator Stabenow. Mr. Chairman?

The Chairman. Very briefly.

Senator Stabenow. If I might, just briefly. I have been colleagues speak about this five-year window.

The Chairman. We have 40 minutes. I might say to the Senator, we have 40 minutes left and there are other amendments that will be coming up, so we have to be very, very careful with our time here.

Senator Stabenow. I would just indicate that we have a five-year farm bill, we have a five-year higher education bill. I hope we will have the same discussions as we approach other five-year authorizations.

Senator Kyl. I am going to have a five-year death tax reform bill then, Mr. Chairman. You and I can do that together.

The Chairman. The question is on the amendment. All those in favor of the amendment, say aye.

Senator Kyl. Mr. Chairman, could we have a roll call vote, please?

The Chairman. A roll call is requested. The Clerk will call the roll.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

The Chairman. No by proxy.

The Clerk. Mr. Bingaman?

The Chairman. No by proxy.
The Clerk. Mr. Kerry?
The Chairman. No by proxy.
The Clerk. Mrs. Lincoln?
Senator Lincoln. No.
The Clerk. Mr. Wyden?
Senator Wyden. No.
The Clerk. Mr. Schumer?
The Chairman. No by proxy.
The Clerk. Ms. Stabenow?
Senator Stabenow. No.
The Clerk. Ms. Cantwell?
Senator Cantwell. No.
The Clerk. Mr. Salazar?
Senator Salazar. No.
The Clerk. Mr. Grassley?
Senator Grassley. No.
The Clerk. Mr. Hatch?
Senator Grassley. No by proxy.
The Clerk. Mr. Lott?
Senator Lott. Aye.
The Clerk. Ms. Snowe?
Senator Snowe. No.
The Clerk. Mr. Kyl?
Senator Kyl. Aye.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

Senator Bunning. Aye.

The Clerk. Mr. Crapo?

Senator Crapo. Aye.

The Clerk. Mr. Roberts?

Senator Roberts. No.

The Clerk. Mr. Ensign?

Senator Ensign. Aye.

The Clerk. Mr. Chairman?

The Chairman. No. The Clerk will announce the results of the vote.

The Clerk. Mr. Chairman, the tally is 5 yeas, 16 nays.

The Chairman. The nays have it. The amendment is not agreed to.

Are there further amendments?

Senator Wyden. Mr. Chairman?

The Chairman. Senator Wyden?

Senator Wyden. Just so I can clarify mine on the substitute Amendment #27, I want to thank, particularly Senator Rockefeller and Senator Hatch, and all who have worked with us. I think the critical question for the Director is, I just want to make sure that there is no

additional cost in this amendment. Do you have the substitute? It is the one entitled "State Discretion to Use Payments From the Incentive Pool." Our reading is that that would mean --

The Chairman. Senator, would you indicate which amendment it is that you are referring to?

Senator Wyden. Yes. It is the substitute amendment for 27, my original amendment. It was the one that I discussed earlier and was able to show Director Orszag, Senator Rockefeller, and Senator Baucus and Grassley. All have been very gracious with respect to their time.

This would, by my reading, give us the opportunity to do that Senator Ensign is talking about, which is get more personal responsibility into the system, involve parents, schools, and children, to get healthy eating and exercise programs, and with no additional spending. But I think it is important to be able to make some final judgments here.

Director Orszag, would that be your reading, that there is no additional spending in that version?

Dr. Orszag. Under that original version of the amendment where States are given the option to use some of the incentive payments for this type of program, that is correct, there is no additional spending that is

entailed.

Senator Wyden. All right. Well, colleagues, I would hope that we could approve this now that the Director of CBO has indicated no additional spending.

I do not have to tell anybody on this committee that Type II diabetes in kids is soaring into the stratosphere. It is going to engulf the entire system. We have done a lot of good work here, but here is a chance to attack a problem with the very ideas that Senator Ensign is talking about and do it in a bipartisan way, consistent with sensible reforms for the future. I would hope my colleagues could support it now that Director Orszag has said it does not cost additional money.

Mr. Chairman, thank you.

The Chairman. Thank you, Senator. This amendment still has not been worked out. I cannot speak for all Senators, but there are some here who still are not in favor of it. I said we would try to work it out--we spoke earlier about it--but we are not quite there. I would urge the Senator to again not push it. We are a lot closer, but we are not quite there yet.

Senator Wyden. In light of the good work the Chairman, Senator Rockefeller, and others have done, I will be glad to withdraw. I thank colleagues for their

kind comments about broader reform. These are the kinds of changes we ought to make.

My only reason for bringing it up at this point was because I think there was a question among some colleagues about whether this would cost any money. So now that Director Orszag has told us that, I will hold off.

The Chairman. Thank you, Senator.

Any further amendments?

Senator Snowe. Mr. Chairman?

The Chairman. Senator Snowe?

Senator Snowe. Thank you, Mr. Chairman. I am not going to offer this amendment but I do think that the issue is critical enough to raise, and that is regarding dental benefits as part of this overall reauthorization.

Senator Bingaman and I had drafted various amendments with respect to this benefit, and I know we have been in discussions with you, Mr. Chairman, and your staff, and Senator Grassley's, and others here on the committee.

I hope that we can rectify this problem on the floor. I do intend to offer an amendment on the floor, and we have the offsets. But I realize that I am not going to get the support in the committee at this point.

I do want to thank you, Mr. Chairman, for including

a demonstration grant of $200 million to be provided for States to provide some assistance, but I do think it is a crucial benefit to children's health care and their well-being. So I hope that we can do more in this regard.

I would at least like to have included a dental wrap-around benefit that would have been part of the private health insurance plans that are already used by the States, as the Chairman indicated, and to provide a wrap-around benefit that would have cost $300 million, which I think is a major step in the right direction, in addition to providing an overall benefit.

The total would have been, I think, a little more than $1 billion, including even additional mental health benefits. I want to thank Senator Smith for the health parity benefit that was inserted in this legislation. But I think we have to recognize that proper dental care is absolutely essential.

I mean, more than half the children by the age of nine have cavities. Tooth decay is more than five times as common as asthma. For every child who lacks health insurance, 2.6 children lack dental health insurance. So, this is really an overall critical issue. I do intend to follow up and build upon what you have offered here in the committee, Mr. Chairman, on the floor.

The Chairman. Well, Senator, I thank you and hop

that you do, because I also think that we need to have more dental coverage, dental assistance for low-income kids.

When I talk to people in Montana--dentists, especially--it is just very clear to me how much we can help kids by having dental coverage and how much we can prevent future illnesses and future problems which are expensive and painful for kids if we have dental coverage.

I very much agree with you. I would like to have included more in this mark. I applaud your efforts to try to include more dental coverage. I think it is extremely important. We will see what we can work out.

Senator Rockefeller?

Senator Rockefeller. I agree with the Chairman and Senator Snowe. I mean, this is absolutely basic. Mental, dental is basic. It was totally potent, powerful, right. But it drives the cost up.

If it, therefore, causes the bill to lose either in committee or on the floor, then it does not do much good to have a benefit in which nobody can take advantage of. It is better to have the bill. But I totally agree with you, and I look forward to working with you.

The Chairman. Senator Bunning, I see Senator Schumer is here if you want to resurrect your amendment.

Senator Bunning. Well, maybe Senator Schumer would like to comment about my amendment. I do not want to take your time, your precious time.

The Chairman. All right.

Senator, do you wish to comment?

Senator Schumer. Yes, I do.

Senator Bunning. Good.

Senator Schumer. I would like to oppose the amendment. And, first, I appreciate the committee. We had Chairman Bernanke in the Banking Committee, and I preceded Senator Bunning on that, questioning him.

I want to say that I totally disagree with this amendment. It is very easy if you are from one State to single out two other States, and both New York and New Jersey have done a tremendous job to cover children. It has been a very successful program and I do not think we should be penalized because it is successful.

The other problem we always face in New York is our cost of living, and New Jersey, and a few other States. Our cost of living is much higher than in other places. Making $30,000 may put you above average income in my States--I do not know the numbers in Kentucky--but it puts you way below in New York, where the cost of housing, the cost of food, the cost of everything else is much higher.

So to be able to provide health care for your children, it is not an across-the-board number uniformly because costs are so much higher.

So, I want to encourage my colleagues to oppose this amendment, not stop in the tracks two very, very laudable and successful programs that have stayed within the strictures of CHIP. I want to thank my colleagues for waiting for me.

The Chairman. You bet.

Senator Bunning. Well, let me comment on it. Since this is a national program and we are covering 50 States, each individual State could, in fact, have a different level of coverage, whether it be 400, or 300, or whatever it might be. New York presently does not have 300. It is in the mark that you would get your 300 if the bill passes. Is that correct or incorrect, Chuck?

Senator Schumer. I do not believe that to be true.

Senator Bunning. It is 400 percent it is going up to in the mark.

Senator Schumer. Not in the mark, but in the waiver that the State has applied for.

Senator Bunning. Applied. You have not gotten your waiver yet.

Senator Schumer. Correct.

Senator Bunning. All right. Well, I think when we

are doing a national program it should be a national program and we should allow the State, if they want to, to cover what they want to cover. Since you have so many more dollars in New York than we do in Kentucky, we have held to the 200 percent of poverty level because that covers an awful lot of people in Kentucky, where it might not cover a lot of people in New York.

Senator Schumer. To me, sir, to be fair, you would look at standard of living, not an objective number. If a standard of living of $30,000 in Kentucky is a lot higher than a standard of living of $30,000 in New York --

Senator Bunning. Well, I do not think it is.

Senator Schumer. It certainly is, without any question. I think that should be taken into account. In other words, if you looked at all people below $30,000, you might have 60 percent of the people in Kentucky and you might only have 40 percent of the people in New York, even though they are living exactly the same way at the 40th and 60th percentile. So I do not think it is fair to single out States that have higher costs of living.

Senator Bunning. I do not either.

Senator Schumer. Well, that is what you are trying to do.

Senator Bunning. I think you should be able to do

it if you want to do it.

Senator Schumer. All right. Well, you are putting us at a significant disadvantage because we have a higher cost of living in this amendment.

Senator Cantwell. Mr. Chairman? Mr. Chairman?

The Chairman. Senator Cantwell?

Senator Cantwell. If I could enter into the record, I have been asking my staff this question for some time just because I think it is important. We have data from Georgetown University's Children and Families Center, and I think it is very important. If you look at what the purchasing power is at 200 percent of poverty level, Milwaukee, Wisconsin is right at that line, 200 percent of poverty level, $33,200.

But if you are looking at other high-expense areas of the country, that same purchasing power, for example, in San Jose, California, a very expensive area, is $51,000, that same purchasing power.

So I do think what we are trying to do is to say that all cities of the country should be on a level playing field, whatever their purchasing power is, but recognize that that purchasing power is different.

For San Jose, that actually means 308 percent of the poverty line, but that is what it takes to get the same purchasing power. So while I do not have every city

here, I would like to enter that into the record.

The Chairman. It will be included.

Senator Cantwell. Hopefully we can get geographic data for our colleagues.

[The information appears in the appendix.]

Senator Ensign. Mr. Chairman

The Chairman. I was going to ask Senator Bunning to close. But very briefly here.

Senator Ensign. I will. Very briefly. The other thing that is not taken into account, though, when we are talking about Federal programs is wealthier areas, higher income areas also can afford more at the local and at the State level.

So if the State or the local area wants to put the money in, they do have more. They have a higher property tax base, they have higher, usually, business tax base. So you should not expect poor States to pay for richer States, and I think that that is the reason that this amendment is the right thing to do.

Senator Bunning. In closing, I am going to say that this bill targets our farmers in Kentucky.

The Chairman. It does?

Senator Bunning. Yes, it does. So, enough said.

The Chairman. All right. Thank you.

The question is on the amendment. All in favor --

Senator Hatch?

Senator Hatch. I have to admit, I agree with the Senator from Kentucky. Unfortunately, in putting this compromise together we had to draw the line and we had to be able to get enough people to support it. Frankly, I regret that I have to vote against it, but I commend the Senator from Kentucky for standing up the way he has.

The Chairman. The Clerk will call the roll.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

The Chairman. No by proxy.

The Clerk. Mr. Bingaman?

The Chairman. No by proxy.

The Clerk. Mr. Kerry?

The Chairman. No by proxy.

The Clerk. Mrs. Lincoln?

The Chairman. Pass. I do not know where Ms. Lincoln is.

Senator Lincoln. I am here.

The Chairman. There she is.

Senator Lincoln. No.

The Clerk. Mr. Wyden?

Senator Wyden. No.

The Clerk. Mr. Schumer?

Senator Schumer. No.

The Clerk. Ms. Stabenow?

Senator Stabenow. No.

The Clerk. Ms. Cantwell?

Senator Cantwell. No.

The Clerk. Mr. Salazar?

Senator Salazar. No.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

Senator Grassley. Yes, by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. Aye.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

Senator Bunning. Aye.

The Clerk. Mr. Crapo?

Senator Crapo. Aye.

The Clerk. Mr. Roberts?

Senator Roberts. Aye.

The Clerk. Mr. Ensign?

Senator Ensign. Aye.

The Clerk. Mr. Chairman?

The Chairman. No. The Clerk will announce the result.

The Clerk. Mr. Chairman, the tally is 6 ayes, 15 nays.

The Chairman. The nays have it and the amendment is not agreed to.

Senator Schumer. Mr. Chairman?

The Chairman. The Senator from New York.

Senator Schumer. I have an amendment. I have two I am not going to ask for a vote on, but I would just like to discuss them. That is, these two amendments relate to diabetes.

Now, first, I would like to thank the committee for putting an important part of my Amendment #4 in the bill, or in the mark, or in the manager's amendment, and I appreciate that. These are numbers 28 and 29 and they deal with diabetes.

We all know it is a major problem for kids and adults: 20.8 million children and adults in the U.S. are affected now, and it could go up to 50 million by 2025. It is a rapidly increasing disease. Eight hundred thousand adult New Yorkers, more than 1 in 8, have

diabetes. Every 21 seconds, someone is diagnosed with it.

Complications, of course, if you do not treat it early: blindness, kidney failure, heart disease, limb amputations. It is a major issue. The rate of amputation for people with diabetes is 10 times higher than for people without. And so I believe coverage for diabetes services is essential, and that is why I introduced legislation, S. 755, to provide screening tests, insulin, and key services like diabetes education and podiatric visits to Medicaid recipients. The number of children diagnosed has been growing steadily, and it is anomalous that Medicaid, all these other programs, private insurance, will pay for when you get it really bad and you are blind, you need a limb amputated, God forbid, but they will not pay for the early stuff, podiatric care, nutrition, things like that.

We do not do prevention in this country, we do not do enough of it, and diabetes is a glaring area where that happens. Only four States, for instance, provide screenings for at-risk children. So the two amendments I have, first, would add diabetes screenings and treatment to CHIP to help the kids who have it.

The second amendment would help identify Medicaid patients who have diabetes but do not know it, and would

make sure they receive appropriate treatment.

Now, I know that this is an issue that I know concerns you, Mr. Chairman, the Ranking, and Mr. Rockefeller. I am going to withdraw my amendments, but hope we could work towards this as we move ahead.

The Chairman. Thank you, Senator.

Senator Kyl, I think, has an amendment.

Senator Kyl. Thank you, Mr. Chairman. I appreciate your calling on me. I had two. They both relate to AMT. I will simply offer Amendment #4. I understand, is it correct, that the Chairman does not believe that this amendment in its current form would meet the relevancy test?

The Chairman. The Senator is correct. It is not germane. The amendment is not germane.

Senator Kyl. Not germane. Then I will withdraw it. But let me just discuss it briefly, because I think it points to a problem with the committee's agenda here.

This amendment would waive AMT penalties and interest. I think I do not need to describe it any further than that. The reason for wanting to offer this amendment is that we are acting on the SCHIP because it is going to expire in September, and we have all said we need to authorize or reauthorize the program before it expires.

But as those of us on this committee know, the AMT patch, the one-year fix currently that should be applicable, has already expired. It expired on December 31 of last year. So we are now more than half-way through a year where people have AMT liabilities and they are liable for interest and penalties if they do not meet the requirements of the law.

Because there are so many new people who are going to be added to the rolls, I think 15 million additional taxpayers estimated, there are a lot of folks who will not have done the things that they need to do under the Internal Revenue Code to avoid payment of penalties and interest unless we were to retroactively do something.

I guess my point is, this is a more immediate problem in some respects than the potential for the expiration of SCHIP in September, and I think we ought to be, therefore, addressing it.

The way that my amendment addresses it, Amendment #4, would be to simply shield the taxpayers from penalties and interest that might be assessed to them if Congress fails to, at a minimum, enact a patch for the year 2007.

I will not go into all the details. You all know how penalties and interest are assessed, how different taxpayers in different brackets can avoid them. I think

Joint Tax is right now trying to determine how many taxpayers might be hit with penalties and interest due to under payment if Congress fails to enact the patch. But this safe harbor could shelter everybody from that eventuality, and I think we ought to be working to do that.

My point is, there are far more people who have an interested in, and could be adversely affected by, our failure to act in this area. Not to denigrate what we are trying to do with reauthorization of SCHIP, but to point out to my colleagues that we have got to act, and we have got to act soon.

It represents just another problem in which we have got to somehow come up with and offset, because of the rule that we have self-imposed that says that we cannot maintain tax relief for the American people at current levels without coming up with another way to come up with revenues.

Senator Rockefeller. Mr. Chairman?

The Chairman. Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, I just want to point out that we now have 16 minutes left. My suggestion to the Chair, respectfully, would be for those who are going to insist on a vote, that those should be called upon first. Those who wish to talk about

amendments and then withdraw them should wait until those who want a vote and have so indicated have had their chance.

The Chairman. Does the Senator wish to withdraw his amendment?

Senator Kyl. I will.

The Chairman. Thank you.

I do not see any other Senators seeking to offer amendments. Therefore, if there are no further amendments I will entertain a motion that the committee report -- before I get to that, I guess, a little colloquy with Senator Wyden here. Senator Wyden, you were interested in offering an amendment. Which one was that?

Senator Wyden. Mr. Chairman, you have been very gracious, you and Senator Rockefeller, with your time. This is the amendment that would give us a chance to deal with what Senator Ensign is talking about in terms of changing behavior, attacking on a preventive basis juvenile diabetes, that Dr. Orszag said would not cost additional money. It would come from the incentive pool that is already give to States. My understanding is that there are some questions among the four of you, and I think --

The Chairman. Yes. That was the amendment. I

thought that was it. We will work with you when we get to the floor.

Senator Wyden. Because of the concern of you four and the desire to keep a bipartisan effort, I am going to hold off. I do want to tell colleagues, just in wrapping up, I am very appreciative of the comments that have been made about what Senator Bennett and I are trying to do.

There are others who have similar approaches. We can get at this broader question of health reform using government not to control everything, but to have a role. I thank you, Mr. Chairman, and I will hold off until the floor.

The Chairman. Thank you.

Senator Kyl. Mr. Chairman?

The Chairman. Senator Kyl?

Senator Kyl. Might I just ask you one question I had intended in the course of my AMT discussion?

The Chairman. Sure. Absolutely.

Senator Kyl. It is a very important subject for this committee. Could I inquire what the Chair's intention is? I know you have a bill to repeal it, which I have co-sponsored. But one way or another, we have to address this. I do not know what the timing of the committee is to do that.

The Chairman. Well, it will be this year, I will

tell you that, because we do not want anyone who does not now pay AMT on their 2006 income taxes to have to pay AMT on their 2007 taxes. But you are right, it is a big issue. It is one that has to be addressed. I do not know a Senator who does not want to address it.

Senator Kyl. Should we do that when we do SGR and estate tax reform?

The Chairman. There is a lot we have to do in this committee, but that certainly is high on the list. It is going to have to be done sometime this year. I actually thank the Senator for raising the issue, because it has got to be solved.

If there are no further amendments, I would entertain a motion that the committee report an original bill entitled "The Children's Health Insurance Program Reauthorization Act of 2007" to consist of the Chairman's mark, as modified.

Senator Grassley. I so move.

The Chairman. A roll call vote is automatic. If it is not automatic, I request it anyway. So, the Clerk will call the roll.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

The Chairman. Aye by proxy.

The Clerk. Mr. Bingaman?
The Chairman. Aye by proxy.
The Clerk. Mr. Kerry?
The Chairman. Aye by proxy.
The Clerk. Mrs. Lincoln?
Senator Lincoln. Aye.
The Clerk. Mr. Wyden?
Senator Wyden. Aye.
The Clerk. Mr. Schumer?
The Chairman. Aye by proxy.
The Clerk. Ms. Stabenow?
Senator Stabenow. Aye.
The Clerk. Ms. Cantwell?
Senator Cantwell. Aye.
The Clerk. Mr. Salazar?
Senator Salazar. Aye.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Hatch. Aye.
The Clerk. Mr. Lott?
Senator Grassley. No by proxy.
The Clerk. Ms. Snowe?
Senator Snowe. Aye.
The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Smith?

Senator Smith. Aye.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Crapo?

Senator Crapo. Aye.

The Clerk. Mr. Roberts?

Senator Roberts. Aye.

The Clerk. Mr. Ensign?

Senator Ensign. No.

The Clerk. Mr. Chairman?

The Chairman. Aye. The Clerk will announce the results.

The Clerk. Mr. Chairman, the tally of members present is 13 ayes, 3 nays. The final tally including proxies is 17 ayes, 4 nays.

The Chairman. The ayes have it. The bill is ordered reported.

Senator Bunning. Would you mind repeating that, please?

The Chairman. First, let us let Senator Kerry vote in person if he wishes to.

Senator Kerry. Aye.

The Clerk. Mr. Kerry votes aye.

Senator Bunning. Could the Clerk report again? I missed it.

The Chairman. Will the Clerk announce the results, please? Hold on. The Clerk will hold. Senators are coming to vote in person. Let them do so.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Chairman. Will the Clerk again tally and announce the results?

The Clerk. Mr. Chairman, the tally of members present is 15 ayes, 3 nays. The final tally, including proxies, is 17 ayes, 4 nays.

The Chairman. The ayes have it. The bill is ordered reported. I ask consent that staff have authority to make technical and conforming changes. Without objection, so ordered.

Once again, I thank all Senators for their cooperation. I especially want to thank all staffs, and also a special thanks to Senator Rockefeller and his staff, Senator Hatch and his, Senator Grassley, and all Senators. This has been a very productive and fruitful mark-up. I thank Senators for cooperating in the time we had to work with. Thank you very much.

[Whereupon, at 11:49 a.m. the meeting was concluded.]

UNITED STATES SENATE
COMMITTEE ON FINANCE

Max Baucus, Chairman

Thursday, July 19, 2007

215 Dirksen Senate Office Building

Agenda for Business Meeting

An original bill entitled "The Children's Health Insurance Reauthorization Act of 2007."

Description of the Chairman's Mark

The Children's Health Insurance Reauthorization Act of 2007

Scheduled for Markup
by the
Senate Committee on Finance
On July 17, 2007

Section 1. Short title; Amendments to Social Security Act; References; Table of Contents

Current Law

No provision

Explanation of Provision

This act may be cited as the "Children's Health Insurance Program (CHIP) Reauthorization Act of 2007." Unless otherwise noted, this act amends, or repeals provisions of the Social Security Act. When this act references: "CHIP" it is referring to the State Children's Health Insurance Program established under Title XXI; "MEDICAID" it is referring to the program for medical assistance established under Title XIX; "Secretary" it is referring to the Secretary of Health and Human Services.

Title I — Financing of CHIP

Section 101. Extension of CHIP

Current Law

Title XXI of the Social Security Act specifies the following national appropriation amounts in §2104(a) from FY1998 to FY2007 for SCHIP:

$4,295,000,000 in FY1998;
$4,275,000,000 in FY1999;
$4,275,000,000 in FY2000;
$4,275,000,000 in FY2001;
$3,150,000,000 in FY2002;
$3,150,000,000 in FY2003;
$3,150,000,000 in FY2004;
$4,050,000,000 in FY2005;
$4,050,000,000 in FY2006; and
$5,000,000,000 in FY2007.

These amounts are allotted to states, including the District of Columbia, except for (1) 0.25% of the total annual amount is allotted to the territories and commonwealths (hereafter referred to simply as "the territories"), and (2) from FY1998 to FY2002, $60 million was set aside annually for special diabetes grants (Public Health Service Act §330B and §330C), which are now funded by direct appropriations. The territories are also allotted the following appropriation amounts in §2104(c)(4)(B):

$32,000,000 in FY1999;
$34,200,000 in FY2000;
$34,200,000 in FY2001;
$25,200,000 in FY2002;

$25,200,000 in FY2003;
$25,200,000 in FY2004;
$32,400,000 in FY2005;
$32,400,000 in FY2006; and
$40,000,000 in FY2007.

Explanation of Provision

The following national appropriation amounts are specified for CHIP in §2104(a):
$9,125,000,000 in FY 2008;
$10,675,000,000 in FY 2009;
$11,850,000,000 in FY 2010;
$13,750,000,000 in FY 2011; and
$3,500,000,000 in FY 2012.

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

Current Law

The annual SCHIP appropriation available to states, including the District of Columbia, is the amount of the total appropriation remaining after amounts set aside for the territories and, for FY1998 to FY2002, the special diabetes grants. Each state's share, or percentage, of the available appropriation is determined by a formula using the state's "number of children," as adjusted for geographic variations in health costs and subject to certain floors and a ceiling.

Beginning with the FY2001 SCHIP allotment, the "number of children" is equal to (1) 50 percent of the number of children in the state who are low income (with "low income" defined as having family income below 200% of the federal poverty threshold), plus (2) 50 percent of the number of *uninsured* low-income children in the state. The source of data is the average of the number of such children, as reported and defined in the three most recent Annual Social and Economic (ASEC) Supplements (formerly known as the March supplements) to the Census Bureau's Current Population Survey (CPS) before the beginning of the calendar year in which the applicable fiscal year begins. For example, in determining the FY2007 allotments, the three most recent supplements available before January 1, 2006, were used. Thus, states' FY2007 allotments were based on the "number of children" using data that covered calendar years 2002, 2003 and 2004.

The adjustment for geographic variations in health costs is 85% of each state's variation from the national average in its average wages in the health services industry. The source of data is the average wages from mandatory reports filed quarterly by every employer on their unemployment insurance contributions and provided to the Department

of Labor's Bureau of Labor Statistics (BLS). A three-year average of these data is also required in the statute.

Each state's "number of children," as adjusted for geographic variation in health costs, is calculated as a percentage of the national total. This is the state's preliminary proportion of the available SCHIP appropriation, against which the floors and ceiling are compared.

Since the beginning of SCHIP, no state's share of the available appropriation could result in an allotment of less than $2 million. No state has ever been affected by this floor. Beginning with the FY2000 allotment, two additional floors also applied: (1) no state's share could be less than 90% of last year's share, and (2) no state's share could be less than 70% of its FY1999 share. (Each state's FY1999 share was identical to its FY1998 share, per P.L. 105-277.)

A ceiling has also applied beginning with the FY2000 allotment: No state's share can exceed 145% of its FY1999 share.

Once the floors and ceiling are applied to affected states to produce their adjusted proportion, the other states' shares are adjusted proportionally to use exactly 100% of the available appropriation. Each state's adjusted proportion multiplied by the appropriation available to states for a fiscal year results in each state's federal SCHIP allotment for that fiscal year.

Explanation of Provision

The annual CHIP funds available to states, including the District of Columbia — that is, the available national allotment — is the amount of the total appropriation remaining after amounts allotted to the territories.

For FY2008, a state's allotment is calculated as 110% of the greatest of the following four amounts: (1) the state's FY2007 federal CHIP spending multiplied by the annual adjustment; (2) the state's FY2007 federal CHIP allotment multiplied by the annual adjustment; (3) for states that were determined in FY2007 to have exhausted their own federal CHIP allotments (and therefore designated a shortfall state for FY2007), the state's FY2007 projected spending as of November 2006 (or as of May 2006, for a state whose May 2006 projection was $95 million to $96 million higher than its November 2006 projection) multiplied by the annual adjustment; and (4) the state's FY2008 federal CHIP projected spending as of August 2007 and certified by the state to the Secretary not later than September 30, 2007.

The annual adjustment for health care cost growth and child population growth is the product of (1) 1 plus the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for the fiscal year over the prior fiscal year, and (2) 1.01 plus the percentage increase in the child population (under age 19) in each

state as of July 1 of the fiscal year over the prior fiscal year's, based on the most timely and accurate published estimates from the Census Bureau.

For FY2009 to FY2012, a state's allotment is calculated as 110% of its projected spending for that year, as submitted to CMS no later than August 31 of the preceding fiscal year.

For FY2008, if the state allotments as calculated exceed the available national allotment, the allotments are reduced proportionally. For FY2009 to FY2012, if the state allotments as calculated exceed the available national allotment, then the available national allotment is distributed to each state according to its percentage calculated as the sum of the following four factors:

- Each state's projected federal CHIP expenditures for that fiscal year (as certified by the state to the Secretary no later than the August 31 of the preceding fiscal year), calculated as a percentage of the national total, multiplied by 75%;
- Each state's number of low-income children (based on the most timely and accurate published estimates from the Census Bureau), calculated as a percentage of the national total, multiplied by 12½%;
- Each state's projected federal CHIP expenditures for the preceding fiscal year (as certified by the state to the Secretary in November of the fiscal year), calculated as a percentage of the national total, multiplied by 7½%; and
- Each state's actual federal CHIP expenditures for the second preceding fiscal year, as determined by the Secretary, calculated as a percentage of the national total, multiplied by 5%.

If a state's projected CHIP expenditures for FY2009 to FY2012 are at least 10% more than the last year's allotment (excluding any reduction in states' allotments due to insufficient available national allotment) then, unless the state received approval in the prior year of a state plan amendment or waiver to expand CHIP coverage or the state received a payment from the CHIP Contingency Fund, the state must submit to the Secretary by August 31 before the fiscal year information relating to the factors that contributed to the need for the increase in the state's allotment, as well as any other information that the Secretary may require for the state to demonstrate the need for the increase in the state's allotment. The Secretary shall notify the state in writing within 60 days after receipt of the information that (1) the projected expenditures are approved or disapproved (and if disapproved, the reasons for disapproval); or (2) specified additional information is needed. If the Secretary disapproved the projected expenditures or determined additional information is needed, the Secretary shall provide the state with a reasonable opportunity to submit additional information to demonstrate the need for the increase in the State's allotment for the fiscal year. If a determination has not determined by September 30 whether the state has demonstrated the need for the increase in its allotment, the Secretary shall provide the state with a provisional allotment for the fiscal year equal to 110% of last year's allotment (excluding any reduction in states' allotments

due to insufficient available national allotment). Once the Secretary makes a determination, the Secretary may adjust the state's allotment (and the allotments of other states) accordingly, but not later than November 30 of the fiscal year.

For FY2008 allotment factors based on CHIP expenditures, the Secretary of Health and Human Services (HHS) shall use the most recent FY2007 expenditure data available to the Secretary before the start of FY2008. The Secretary may adjust the FY2008 allotments based on the actual expenditure data reported to CMS no later than November 30, 2007; the Secretary may not make adjustments after December 31, 2007.

For purposes of determining a state's allotment, the state's projected expenditures shall include payments projected using §2105(g) (discussed in Section 110) and for certain CHIP-enrolled parents and childless adults (discussed in Section 105).

Section 103. One-Time Appropriation for FY2012

Current Law

No provision.

Explanation of Provision

In FY 2012, a one-time appropriation of $12,500,000,000 shall be made to the Secretary of Health and Human Services to add to the funds already provided under section 2104(a) for that year only. Such funds shall be distributed by the Secretary in a manner consistent with and under the same terms and conditions of section 102 of this Act.

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

Current Law

The territories were to receive 0.25 percent of the total appropriations provided in §2104(a). Later legislation added specific appropriations for the territories in FY1999 to FY2007:

$32,000,000 in FY 1999;
$34,200,000 in FY 2000;
$34,200,000 in FY 2001;
$25,200,000 in FY 2002;
$25,200,000 in FY 2003;
$25,200,000 in FY 2004;
$32,400,000 in FY 2005;
$32,400,000 in FY 2006; and
$40,000,000 in FY 2007.

For FY1999, the $32 million represented approximately 0.75 percent of the total appropriations in §2104(a). For FY2000 to FY2007, the additional appropriation equaled 0.8 percent of the total appropriations in §2104(a). Combined with the 0.25 percent available through the original enacting legislation, the territories were allotted 1.05% of the total appropriations in §2104(a) from FY2000 to FY2007.

The amounts set aside for the territories were distributed according to the following percentages provided in statute: Puerto Rico, 91.6 percent; Guam, 3.5 percent; the Virgin Islands, 2.6 percent; American Samoa, 1.2 percent; and the Northern Mariana Islands, 1.1 percent.

Medicaid (and SCHIP) programs in the territories are subject to spending caps specified in statute. The federal Medicaid matching rate, which determines the share if Medicaid expenditures paid for by the federal government, is statutorily set at 50 percent of the territories. Therefore, the federal government pays 50% of the cost of Medicaid items and services in the territories up to the spending caps. For the 50 states and DC, certain administrative functions have a higher federal match. For example, startup expenses for specified computer systems are matched at 90%, and there is a 100% match for the implementation and operation of immigration status verification systems.

Explanation of Provision

From the national CHIP appropriation, the allotments to the territories are calculated as follows. For FY2008, each territory's allotment is its highest annual federal CHIP spending between FY1998 and FY2007, plus the annual adjustment for health care cost growth and national child population growth. FY2007 spending will be determined by the Secretary based on the most timely and accurate published estimates of the Census Bureau. For FY2009 through FY2012, each territory's allotment is the prior year's allotment, plus the annual adjustment for health care cost growth and national child population growth.

For FY2008 and each fiscal year thereafter, federal matching payments for specified data reporting systems (i.e., the design, development, and operations of claims processing systems and citizenship documentation data systems in each of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa would continue to be subject to the 50% match rate, but such expenditures would be matched with federal funds without regard to the specified spending caps.

The provision would require the Government Accountability Office (GAO) to submit a report to the appropriate committees of Congress not later than September 30, 2009, with regard to the territories' eligible Medicaid and CHIP populations, their historical and projected spending and the ability of capped funding streams to address such needs, the extent to which the federal poverty level is used for determining Medicaid and CHIP eligibility in the territories, and the extent to which the territories participate in data collection and reporting with regard to Medicaid and CHIP and

specifically the extent to which they participate in the Current Population Survey versus the American Community Survey, which are federal surveys that estimate the number of low-income children in the states. The report is also to provide recommendations for improving Medicaid and CHIP funding to the territories.

Section 105. Incentive bonuses for states

Current Law

No provision.

Explanation of Provision

Incentive Pool

A CHIP Incentive Bonuses Pool is established in the U.S. Treasury. The Incentive Pool receives deposits from an initial appropriation in FY2008 of $3 billion, along with transfers from six different potential sources, with the currently available but not immediately required funds invested in interest-bearing U.S. securities that provide additional income into the Incentive Pool. The six sources for deposits are as follows:

- On December 1, 2007, the amount by which states' FY2006 and FY2007 allotments not expended by September 30, 2007, exceed 50% of the federal share of the FY2008 allotment, as determined by the Secretary by not later than October 1, 2007 ;
- On each December 1 from 2008 to 2012, any of the annual CHIP appropriation not used by the states;
- On October 1 of fiscal years 2009 to 2012, the amount by which the unspent funds from the prior year's allotment exceeds the applicable percentage of that allotment. The applicable percentage is 20% for FY2009, and 10% for FY2010, FY2011, and FY2012;
- Any original allotment amounts not expended by the end of their second year of availability;
- On October 1, 2009, any amounts set aside for transition off of CHIP coverage for childless adults that are not expended by September 30, 2009; and
- On October 1 of FY2009 through FY2012, any amounts in the CHIP Contingency Fund in excess of the fund's aggregate cap, as well as any Contingency Fund payments provided to a state that are unspent at the end of the fiscal year following the one in which the funds were provided.

Funds from the Incentive Pool are payable in FY2008 to FY2012 to states that have increased their Medicaid and CHIP enrollment among low-income children above a defined baseline, with associated payments as follows (reduced proportionally if necessary). (For purposes of Incentive Pool policies, a "child" enrolled in Medicaid

means an individual under age 19 — or age 20 or 21, if a state has so elected under its Medicaid plan; and "low-income children" means children in families with incomes at 200% of federal poverty or below.) Beginning in FY2009, a state may receive a payment from the Incentive Pool if its average monthly enrollment of low-income children in CHIP and Medicaid for the coverage period (which is defined as the last two quarters of the preceding fiscal year and the first two quarters of the fiscal year, except that for FY2009 it is based only on the first two quarters of FY2009) exceeds the baseline monthly average.

For FY2009, the baseline monthly average is each state's average monthly enrollment in the first two quarters of FY2007 enrollment (as determined over a 6-month period on the basis of the most recent information reported through the Medicaid Statistical Information System (MSIS) multiplied by the sum of 1.02 and the percentage increase in the population of low-income children in the state from FY2007 to FY2009, as determined by the Secretary based on the most recent published estimates from the Census Bureau before the beginning of FY2009. For FY2010 onward, the baseline monthly average is the prior year's baseline monthly average multiplied by the sum of 1.01 and the percentage increase in the population of low-income children in the state over the preceding fiscal year, as determined by the Secretary based on the most recent published estimates from the Census Bureau before the beginning of the fiscal year.

A state eligible for a bonus shall receive in the last quarter of the fiscal year the following amount, depending on the "excess" of the state's enrollment above the baseline monthly average: (i) If such excess with respect to the number of individuals who are enrolled in the State plan under title XIX does not exceed 2 percent, the product of $75 and the number of such individuals included in such excess; (ii) if such excess with respect to the number of individuals who are enrolled in the State plan under title XIX exceeds 2 percent, but does not exceed 5 percent, the product of $300 and the number of such individuals included in such excess; and (iii) if such excess with respect to the number of individuals who are enrolled in the State plan under title XIX exceeds 5 percent, the product of $625 and the number of such individuals included in such excess. For FY2010 onward, these dollar amounts are to be increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for the calendar year beginning on January 1 of the coverage period over that of the preceding coverage period.

Payments from the Incentive Pool shall 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.

Redistribution of FY2005 Allotments

An appropriation of $5,000,000 is provided to the Secretary for FY2008 for improving the timeliness of MSIS and to provide guidance to states with respect to any new reporting requirements related to such improvements. Amounts appropriated are available until expended. The resulting improvements are to be designed and

implemented so that beginning no later than October 1, 2008, Medicaid and CHIP enrollment data are collected and analyzed by the Secretary within six months of submission.

FY2005 original CHIP allotments unspent at the end of FY2007 are to be redistributed on a proportional basis to states that were projected at any point in FY2007 to exhaust their federal CHIP allotments.

Section 106. Phase-out of coverage for nonpregnant childless adults under CHIP, conditions for coverage of parents

Current Law

Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to modify virtually all aspects of the Medicaid and SCHIP programs. Under Section 1115, the Secretary may waive requirements in Section 1902 (usually, freedom of choice of provider, comparability, and statewideness). For SCHIP, no specific sections or requirements are cited as "waive-able." SCHIP statute simply states that Section 1115, pertaining to research and demonstration projects, applies to SCHIP. States may obtain waivers that allow them to provide services to individuals not traditionally eligible for SCHIP, or limit benefit packages for certain groups as long as the Secretary determines that these programs further the goals of SCHIP.

Approved SCHIP Section 1115 waivers are deemed to be part of a state's SCHIP state plan for purposes of federal reimbursement. Costs associated with waiver programs are subject to each state's enhanced-FMAP. Under SCHIP Section 1115 waivers, states must meet an "allotment neutrality test" where combined federal expenditures for the state's regular SCHIP program and for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment. This policy limits federal spending to the capped allotment levels.

Under current law, including 1115 waiver authority, states cover pregnant women, parents of Medicaid and SCHIP eligible children and childless adults in their SCHIP programs.

The Deficit Reduction Act of 2005 prohibited the approval of new demonstration programs that allow federal SCHIP funds to be used to provide coverage to nonpregnant childless adults, but allowed for the continuation and renewal of such existing Medicaid or SCHIP waiver projects affecting federal SCHIP funds that were approved under the Section 1115 waiver authority before February 8, 2006.

Explanation of Provision

Childless Adults

The provision would prohibit the approval or renewal of Section 1115 demonstration waivers that allow federal CHIP funds to be used to provide coverage to nonpregnant childless adults (hereafter referred to as applicable existing waivers) on or after the date of enactment of this Act. Beginning on or after October 1, 2008, rules regarding the period to which an applicable existing waiver would apply, individuals eligible for coverage under such waivers, and the amount of federal payment available for such coverage would be subject to the following requirements: (1) no federal CHIP funds would be available for coverage of nonpregnant childless adults under an applicable existing waiver after September 30, 2008, (2) State-requested extensions of applicable existing waivers that would otherwise expire before October 1, 2008, would be granted by the Secretary but only through September 30, 2008, and (3) coverage to a nonpregnant childless adult under applicable existing waivers provided during FY2008 will be reimbursed at the CHIP enhanced FMAP rate.

States with applicable existing waivers (that are otherwise terminated under this provision) would be permitted to extend coverage, through FY2009, to individual nonpregnant childless adults who received coverage under the applicable existing waiver at any time during FY2008 (regardless of whether the individual lost coverage at any time during FY2008 and was later provided benefit coverage under the waiver in that fiscal year) subject to the following restrictions: (1) for each such State, the Secretary would be required to set aside an amount as part of a separate allotment equal to the federal share of the State's projected FY2008 expenditures (as certified by the state and submitted to the Secretary by August 31, 2008) for providing coverage under the waiver to such individuals in FY2008 increased by the annual adjustment for per capita health care growth (described in Section 102 of this bill), (2) the Secretary may adjust the set aside amount based on State-reported FY2008 expenditure data (reported on CMS Form 64 or CMS Form 21 not later than November 30, 2008), but in no case shall the Secretary adjust such amount after December 31, 2008, and (3) the Secretary would pay an amount equal to the federal Medicaid matching rate for expenditures related to such coverage (provided during FY2009) up to the set-aside spending cap.

States with existing CHIP waivers to extend coverage to nonpregnant childless adults (that are otherwise terminated under this provision) would be permitted to submit a request to CMS (not later than June 30, 2009) for a Medicaid nonpregnant childless adult waiver. For such states, the Secretary would be required to make a decision to deny or approve such application within 90 days of the date of submission. For such states, if no CMS decision to approve or deny such request has been made as of September 30, 2009, the provision would allow such application to be deemed approved.

States with applicable existing waivers that request a Medicaid nonpregnant childless adult waiver under this provision would be required to meet the following "budget neutrality" requirements. For fiscal year 2010, allowable waiver expenditures for such populations would not be permitted to exceed the total amount payments made to the State (as specified above) for FY2009, increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for fiscal year 2010 over fiscal year 2009). In the case of any succeeding fiscal year, allowable

waiver expenditures for such populations would not be permitted to exceed each such State's set aside amount (described above) for the preceding fiscal year, increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for such fiscal year over the prior fiscal year.

Parents

The provision would also prohibit the approval of additional Section 1115 demonstration waivers that allow federal CHIP funds to be used to provide coverage to parent(s) of a targeted low-income child(ren) (hereafter referred to as applicable existing CHIP parent coverage waiver) on or after the date of enactment of this Act. Beginning on or after October 1, 2009, rules regarding the period to which an applicable existing CHIP parent coverage waiver extends coverage to eligible populations, and the amount of federal payment available for coverage to such populations under the waiver would be subject to the following requirements: (1) State-requested extensions of applicable existing CHIP-financed Section 1115 parent coverage waivers that would otherwise expire before October 1, 2009, would be granted by the Secretary but only through September 30, 2009, and (2) the CHIP enhanced FMAP rate would apply for such coverage to such eligible populations during FY2008 and FY2009.

States with existing CHIP waivers to extend coverage to parent(s) of targeted low-income child(ren) would be permitted to continue such assistance during each of fiscal years 2010, 2011, and 2012 subject to the following requirements: (1) for each such State and for each such fiscal year, the Secretary would be required to set aside an amount as part of a separate allotment equal to the federal share of 110% of the State's projected expenditures (as certified by the state and submitted to the Secretary by August 31 of the preceding fiscal year) for providing waiver coverage to such individuals enrolled in the waiver in the applicable fiscal year, and (2) the Secretary would pay the State from the set aside amount (specified above) for each such fiscal year an amount equal to the applicable percentage for expenditures in the quarter to provide coverage as specified under the waiver to parent(s) of targeted low-income child(ren).

In fiscal year 2010 only, costs associated with such parent coverage would be subject to each such state's CHIP enhanced FMAP for States that meet one of the outreach or coverage benchmarks (listed below) in FY2009, or each such state's Medicaid FMAP rate for all other states. The provision would prohibit federal matching payments for the payment of services beyond the set-aside spending cap.

For fiscal year 2011 or 2012, costs associated with such parent coverage would be subject to: (1) each such state's Reduced Enhanced Matching Assistance Percentage (REMAP) (i.e., a percentage which would be equal to the sum of (a) each such state's FMAP percentage and (b) the number of percentage points equal to one-half of the difference between each such state's FMAP rate and each such state's enhanced FMAP rate) if the state meets one of the coverage benchmarks (listed below) for FY2010 or FY2011 (as applicable), or (2) each such state's FMAP rate if the state failed to meet any of the coverage benchmarks (listed below) for the applicable fiscal year. The provision

would prohibit federal matching payments for the payment of services beyond the set-aside spending cap.

FY2010 outreach and coverage benchmarks include: (1) the state implemented a significant child outreach campaign including (a) the state was awarded an outreach and enrollment grant (under Section 201 of this bill) for fiscal year 2009, (b) the state implemented 1 or more process measures for that fiscal year, or (c) the state has submitted a specific plan for outreach for such fiscal year, (2) the state ranks in the lowest 1/3 of the States in terms of the State's percentage of low-income children without health insurance based on timely and accurate published estimates of the Bureau of the Census, or (3) the State qualified for a payment from the Incentive Fund for the most recent coverage period.

FY2011 and 2012 coverage benchmarks include: (1) the state ranks in the lowest 1/3 of the States in terms of the State's percentage of low-income children without health insurance based on timely and accurate published estimates of the Bureau of the Census, and (2) the State qualified for a payment from the Incentive Fund for the most recent coverage period.

A rule of construction clarifies that states are not prohibited from submitting applications for 1115 waivers to provide medical assistance to a parent of a targeted low-income child.

The General Accountability Office would be required to conduct a study to determine if the coverage of a parent, caretaker relative, or legal guardian of a targeted low-income child increases the enrollment of or quality of care for children, and if such parents, relatives, and legal guardians are more likely to enroll their children in CHIP or Medicaid. Results of the study (and report recommended changes) would be reported to appropriate committees of Congress 2 years after the date of enactment.

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

Current Law

Under SCHIP, states can cover pregnant women ages 19 and older in one of two ways: (1) via a special waiver of program rules (through Section 1115 authority), or (2) by providing coverage as permitted through regulation. In the latter case, coverage includes prenatal and delivery services only.

In general, SCHIP allows states to cover targeted low-income children with family income that is above applicable Medicaid eligibility levels in a given state. States can set the upper income level up to 200% FPL, or if the applicable Medicaid income level was at or above 200% FPL before SCHIP, the upper income limit may be raised an additional 50 percentage points above that level. Other SCHIP eligibility restrictions include (1) the child must be uninsured, (2) the child must be otherwise ineligible for regular Medicaid,

and (3) the child cannot be an inmate of a public institution or a patient in an institution for mental disease, or eligible for coverage under a state employee health plan. States may provide SCHIP coverage to children who are covered under a health insurance program that has been in operation since before July 1, 1997 and that is offered by a state that receives no federal funds for this program. States may use enrollment restrictions such as capping total program enrollment, creating waiting lists, and instituting a minimum period of no insurance (e.g., 6 months) before being eligible.

Under regular Medicaid, states must provide coverage for pregnant women with income up to 133% FPL, and at state option, may extend such coverage to pregnant women with income up to 185% FPL. States must also provide coverage to first-time pregnant women with income that meets former cash assistance program rules (which were generally well below 100% FPL). The period of coverage for these mandatory and optional pregnant women is during pregnancy through the end of the month in which the 60 days postpartum period ends. In addition, waiver authority may be used to cover pregnant women at even higher income levels and for extended periods of time (e.g., 18 or 24 months postpartum).

Under regular Medicaid, states may temporarily enroll pregnant women whose family income appears to be below Medicaid income standards for up to 2 months until a final formal determination of eligibility is made. Entities that may qualify to make such presumptive eligibility determinations for pregnant women include Medicaid providers that are outpatient hospital departments, rural health clinics and certain other clinics, and other entities including certain primary care health centers and rural health care programs funded under Sections 330 and 330A of the Public Health Service Act, grantees under the Maternal and Child Health Block Grant Program, entities receiving funds under the Health Services for Urban Indians program, and entities that participate in WIC, the Commodity Supplemental Food Program, a state perinatal program (as designated by the state), or is the Indian Health Service or a health program or facility operated by tribes or tribal organizations under the Indian Self Determination Act.

Mandatory Medicaid eligibility applies to children under age 6 in families with income at or below 133% FPL. In addition, states may cover newborns under age 1 up to 185% FPL under Medicaid. Children born to Medicaid-eligible pregnant women must be deemed to be eligible for Medicaid from the date of birth up to age 1 so long as the child is a member of the mother's household, and the mother remains eligible for Medicaid (or would remain eligible if pregnant). During this period of deemed eligibility for the newborn, for claiming and payment purposes, the Medicaid identification (ID) number of the mother must also be used for the newborn, unless the state issues a separate ID number for the child during this period. In general, newborns may also be enrolled in SCHIP if they meet the applicable financial standards in a given state, which build on top of Medicaid's rules.

For families with income below 150% FPL, premiums cannot exceed nominal amounts specified in Medicaid regulations, and service-related cost-sharing is limited to nominal Medicaid amounts for the subgroup under 100% FPL and slightly higher

amounts in SCHIP regulations for the subgroup with income between 100-150% FPL. For families with income above 150% FPL, premiums and cost-sharing may be imposed in any amount as long as such costs for higher-income children are not less than the costs for lower-income children. Total premiums and cost-sharing incurred by all SCHIP children cannot exceed 5% of annual family income.

Other cost-sharing protections also apply. Applicable premium and cost-sharing amounts cannot favor children from families with higher income over children in families with lower income. No cost-sharing may be applied to preventive services.

Explanation of Provision

The provision would allow states to provide optional coverage under CHIP to pregnant women, through a state plan amendment, if certain conditions are met, including (1) the state has established an income eligibility level of at least 185% FPL for mandatory, welfare-related qualified pregnant women and optional poverty-related pregnant women under Medicaid, (2) the state does not apply an effective income level under the state plan amendment for pregnant women that is lower than the effective income level (expressed as a percent of poverty and accounting for applicable income disregards) for mandatory, welfare-related qualified pregnant women and optional poverty-related pregnant women under Medicaid on the date of enactment of this provision to be eligible for Medicaid as a pregnant women, (3) the state does not provide coverage for pregnant women with higher family income without covering such pregnant women with a lower family income, (4) the state provides pregnancy-related assistance (defined below) for targeted low-income pregnant women in the same manner, and subject to the same requirements, as the state provides child health assistance for targeted low-income children under the state CHIP plan, and in addition to providing child health assistance for such women, (5) the state does not apply any exclusion of benefits for pregnancy-related assistance based on any pre-existing condition or any waiting period (including waiting periods to ensure that CHIP does not substitute for private insurance coverage), and (6) the state must provide the same cost-sharing protections to pregnant women as applied to CHIP children, and all cost-sharing incurred by targeted low-income pregnant women under CHIP would be capped at 5% of annual family income.

States that elect this new optional coverage for pregnant women under CHIP and that meet all the above conditions associated with this option, may also elect to provide presumptive eligibility for pregnant women, as defined in the Medicaid statute, to targeted low-income pregnant women under CHIP.

Pregnancy-related assistance would include all the services covered as child health assistance under the state's CHIP program, and includes medical assistance that would be provided to a pregnant woman under Medicaid, during pregnancy through the end of the month in which the 60 day postpartum period ends. The upper income limit for coverage of targeted low-income pregnant women under CHIP could be up to the level for coverage of targeted low-income children in the state. As with targeted low-income children under CHIP, the new group of targeted low-income pregnant women must be

determined eligible, be uninsured, and must not be an inmate of a public institution or a patient in an institution for mental disease or eligible for coverage under a state employee health benefit plan. Also as with targeted low-income children, pregnant women may include those covered under a health insurance program that has been in operation since before July 1, 1997 and that is offered by a state that receives no federal funds for this program.

The provision would also deem children born to the new group of targeted low-income pregnant women under CHIP to be eligible for Medicaid or CHIP, as applicable. Such newborns would be covered from birth to age 1. During this period of eligibility, the mother's identification number must also be used for filing claims for the newborn, unless the state issues a separate identification number for that newborn.

The provision would also address States that provide assistance through other options. The option to provide assistance in accordance with the preceding subsections of this section shall not limit any other option for a State to provide (A) child health assistance through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations, or (B) pregnancy-related services through the application of any other waiver authority (as in effect on June 1, 2007).

Any State that provides child health assistance under any authority described in paragraph (1) may continue to provide such assistance, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends, in the same manner as assistance and postpartum services would be provided if provided under the State plan under title XIX, but only if the mother would otherwise satisfy the eligibility requirements that apply under the State child health plan (other than with respect to age) during such period.

A rule of construction clarifies that nothing in this subsection shall be construed to (A) infer the congressional intent regarding the legality or illegality of the content of sections of title 42, Code of Federal Regulations, specified in paragraph (1)(A), or (B) modify the authority to provide pregnancy-related services under a waiver specified in paragraph (1)(B).

For the new group of targeted low-income pregnant women, additional conforming amendments would prohibit cost-sharing for pregnancy-related services and waiting periods prior to enrollment or for the purpose of preventing crowd-out of private health insurance.

Section 108. CHIP contingency fund

Current Law

No provision.

Explanation of Provision

A CHIP Contingency Fund is established in the U.S. Treasury. The Contingency Fund receives deposits through a separate appropriation. For FY2008, the appropriation to the Fund is equal to 12.5% of the available national allotment for CHIP. For FY2009 through FY2012, the appropriation is such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual payments do not exceed 12.5% of that fiscal year's available national allotment for CHIP. Balances that are not immediately required for payments from the Fund are to be invested in U.S. securities that provide addition income to the Fund, as long as the annual payments do not cause the Fund to exceed 12.5% of the available national allotment for CHIP. Amounts in excess of the 12.5% limit shall be deposited into the Incentive Pool. For purposes of the CHIP Contingency Fund, amounts set aside for block grant payments for transitional coverage of childless adults shall not count as part of the available national allotment.

Payments from the Fund are to be used only to eliminate any eligible state's shortfall (that is, the amount by which a state's available federal CHIP allotments are not adequate to cover the state's federal CHIP expenditures, on the basis of the most recent data available to the Secretary or requested from the state by the Secretary).

The Secretary shall separately compute the shortfalls attributable to children and pregnant women, to childless adults, and to parents of low-income children. No payment from the Contingency Fund shall be made for nonpregnant childless adults. Any payments for shortfalls attributable to parents shall be made from the Fund at the relevant matching rate. Contingency funds are not transferable among allotments.

Eligible states, which cannot be a territory, for a month in FY2008 to FY2012 are those that meet any of the following criteria:

- The state's available federal CHIP allotments are at least 95% but less than 100% of its projected federal CHIP expenditures for the fiscal year (i.e., less than 5% shortfall in federal funds), without regard to any payments provided from the Incentive Fund; or
- The state's available federal CHIP allotments are less than 95% of its projected federal CHIP expenditures for the fiscal year (i.e., more than 5% shortfall in federal funds) and that such shortfall is attributable to one or more of the following: (1) One or more parishes or counties has been declared a major disaster and the President has determined individual and public assistance has been warranted from the federal government pursuant to the Stafford Act, or a public health emergency was declared by the Secretary pursuant to the Public Health Service Act; (2) the state unemployment rate is at least 5.5% during any 13 consecutive week period during the fiscal year and such rate is at least 120% of the state unemployment rate for the same period as averaged over the last three fiscal years; (3) the state experienced a recent event that resulted in an increase in the percentage of low-income children in the state without health insurance (as determined on the basis of the most timely and

accurate published estimates from the Census Bureau) that was outside the control of the state and warrants granting the state access to the Fund, as determined by the Secretary.

The Secretary shall make monthly payments from the Fund to all states determined eligible for a month. If the sum of the payments from the Fund exceeds the amount available, the Secretary shall reduce each payment proportionally.

If a state was determined to be eligible in a given fiscal year, that does not make the state eligible in the following fiscal year. In the case of an event that occurred after July 1 of the fiscal year that resulted in the declaration of a Stafford Act or public health emergency that increased the number of uninsured low-income children as described above, any related Contingency Fund payment shall remain available until the end of the following fiscal year

The Secretary shall provide annual reports to Congress on the Contingency Fund, the payments from it, and the events that caused states to apply for payment.

Section 109. 2-year availability of allotments; expenditures counted against oldest allotments

Current Law

SCHIP allotments (currently through FY2007) are available for three years. Allotments unspent after three years are available for reallocation. For example, the FY2004 allotment was available through the end of FY2006; any remaining balances at the end of FY2006 were redistributed to other states.

Explanation of Provision

CHIP allotments through FY2005 are available for three years. CHIP allotments made for FY2006 through FY2012 are available for two years.

Payments to states from the Incentive Pool are available until expended by the state. Payments for a month from the Contingency Fund are available through the end of the fiscal year, except in the case of an event that occurred after July 1 of the fiscal year that resulted in the declaration of a Stafford Act or public health emergency that increased the number of uninsured low-income children.

States' federal CHIP expenditures on or after October 1, 2007, shall be counted first against the Contingency Funds from the earliest available month in the earliest fiscal year, then against the earliest available allotments.

A State may elect, but is not required, to count CHIP expenditures against any incentive bonuses paid to the State.

Expenditures for coverage of nonpregnant childless adults in FY2009 and of parents of targeted low-income children in FY2010 through FY2012 shall be counted only against the amount set aside for such coverage

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

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. There are statutory exceptions to the FMAP formula for the District of Columbia (since FY1998) and Alaska (for FY1998-FY2007). In addition, the territories have FMAPs set at 50% and are subject to federal spending caps.

The enhanced FMAP (E-FMAP) for SCHIP equals a state's Medicaid FMAP increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the FMAP is less than 100%. For example, in states with an FMAP of 60%, the E-FMAP equals the FMAP increased by 12 percentage points (60% + [30% multiplied by 40 percentage points] = 72%). The E-FMAP has a statutory minimum of 65% and maximum of 85%.

Explanation of Provision

For child health assistance or health benefits coverage furnished in any fiscal year beginning with FY2008 to a targeted low-income child whose effective family income would exceed 300% of the federal poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income, states would be reimbursed using the FMAP instead of the E-FMAP for services provided to that child. An exception would be provided for states that, on the date of enactment of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2007 has an approved State plan amendment or waiver or has enacted a State law to submit a State plan amendment to provide child health assistance or health benefits under their state child health plan or its waiver of such plan to children above 300% of the poverty line.

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

Current Law

Section 2105(g) of the Social Security Act permits qualifying states to apply federal SCHIP funds toward the coverage of certain children already enrolled in regular Medicaid (that is, not SCHIP-funded expansions of Medicaid). Specifically, these federal SCHIP funds are used to pay the difference between SCHIP's enhanced Federal Medical Assistance Percentage (FMAP) and the Medicaid FMAP that the state is already receiving for these children. Funds under this provision may only be claimed for expenditures occurring after August 15, 2003.

Qualifying states are limited in the amount they can claim for this purpose to the lesser of the following two amounts: (1) 20% of the state's original SCHIP allotment amounts (if available) from FY1998, FY1999, FY2000, FY2001, FY2004, FY2005, FY2006, and FY2007 (hence the terms "20% allowance" and "20% spending"); and (2) the state's available balances of those allotments. If there is no balance, states may not claim Section 2105(g) spending.

The statutory definitions for qualifying states capture most of those that had expanded their upper-income eligibility levels for children in their Medicaid programs to 185% of the federal poverty level or higher prior to the enactment of SCHIP. Based on statutory definitions, 11 states were determined to be qualifying states: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin.

SCHIP spending under §2105(g) can be used by qualifying states only for Medicaid enrollees (excluding those covered by an SCHIP-funded expansion of Medicaid) who are under age 19 and whose family income exceeds 150% of poverty, to pay the difference between the SCHIP enhanced FMAP and the regular Medicaid FMAP.

Explanation of Provision

Qualifying states under §2105(g) may also use available balances from their CHIP allotments from FY2008 to FY2012 to pay the difference between the regular Medicaid FMAP and the CHIP enhanced FMAP for Medicaid enrollees under age 19 (or age 20 or 21, if the state has so elected in its Medicaid plan) whose family income exceeds 133% of poverty.

Title II – Outreach and Enrollment

Section 201. Grants for outreach and enrollment

Current Law

The federal and state governments share in the costs of both Medicaid and SCHIP, based on formulas defining the federal contribution in federal law. States are responsible for the non-federal share, using state tax revenues, for example, but can also use local government funds to comprise a portion of the non-federal share. Generally, the non-

federal share of costs under Medicaid and SCHIP cannot be comprised of other federal funds.

Under Medicaid, there are no caps on administrative expenses that may be claimed for federal matching dollars. Title XXI specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance, which meets certain requirements. Apart from these benefit payments; SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of SCHIP children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for other specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP benefits and other specific health care activities combined.

Explanation of Provision

The provision would establish a new grant program under CHIP to finance outreach and enrollment efforts that increase participation of eligible children in both Medicaid and CHIP. For the purpose of awarding grants, the provision would appropriate $100 million for each of fiscal years 2008 through 2012. These amounts would be in addition to amounts appropriated for CHIP allotments to states (as per Section 2104 of the CHIP statute) and would not be subject to restrictions on expenditures for outreach activities under current law.

For each fiscal year, the provision would require that ten percent of the funds appropriated for this new grant would be set aside to finance a national enrollment campaign (described below), and an additional 10 percent would be set-side to be used by the Secretary to award grants to Indian Health Service providers and Urban Indian Organizations that receive funds under title V of the Indian Health Care Improvement Act for outreach to, and enrollment of, children who are Indians.

The provision would require the Secretary to develop and implement a national enrollment campaign to improve the enrollment of under-served child populations in Medicaid and CHIP. Such a campaign may include: (1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the programs each Secretary administers that often serve the same children, (2) the integration of information about Medicaid and CHIP in public health awareness campaigns administered by the Secretary, (3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all states participate in such hotlines, (4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy, (5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency, and (6) such other outreach initiatives as the Secretary determines would increase public awareness of Medicaid and CHIP.

In awarding grants, the Secretary would be required to give priority to entities that propose to target geographic areas with high rates of eligible but not enrolled children who reside in rural areas, or racial and ethnic minorities and health disparity populations, including proposals that address cultural and linguistic barriers to enrollment, and which submit the most demonstrable evidence that (1) the entity includes members with access to, and credibility with, ethnic or low-income populations in the targeted communities, and (2) the entity has the ability to address barriers to enrollment (e.g., lack of awareness of eligibility, stigma concerns, punitive fears associated with receipt of benefits) as well as other cultural barriers to applying for and receiving coverage under CHIP or Medicaid.

To receive grant funds, eligible entities would be required to submit an application to the Secretary in such form and manner, and containing such information as the Secretary chooses. As noted above, such applications must include evidence that the entity (a) includes members with access to, and credibility with, ethnic or low-income populations in the targeted communities, and (b) has the ability to address barriers to enrollment (e.g., lack of awareness of eligibility, stigma concerns, punitive fears associated with receipt of benefits) as well as other cultural barriers to applying for and receiving CHIP or Medicaid benefits. The applicable must also include specific quality or outcome performance measures to evaluate the effectiveness of activities funded by the grant. In addition, the applicable must contain an assurance that the entity will (1) conduct an assessment of the effectiveness of such activities against the performance measures, (2) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessment, and (3) in the case of an entity that is not a state, provide the state with enrollment data and other information necessary for the state to make projections of eligible children and pregnant women. The Secretary would be required to make publicly available the enrollment data and information collected and reported by grantees, and would also be required to submit an annual report to Congress on the funded outreach and enrollment activities conducted under the new grant.

Seven types of entities would be eligible to receive grants, including (1) a state with an approved CHIP plan, (2) a local government, (3) an Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act, or an Indian Health Service provider, (4) a federal health safety net organization , (5) a national, local, or community-based public or nonprofit organization, including organizations that use community health workers or community-based doula programs , (6) a faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with requirements of section 1955 of the Public Health Service Act relating to a grant award to non-governmental entities, or (7) an elementary or secondary school.

Federal health safety net organizations include a number of different types of entities, including for example: (1) federally qualified health centers, (2) hospitals that receive disproportionate share hospital (DSH) payments, (3) entities described in Section 340B(a)(4) of the Public Health Service Act (e.g., certain family planning projects,

certain grantees providing early intervention services for HIV disease, certain comprehensive hemophilia diagnostic treatment centers, and certain Native Hawaiian health centers), and (4) any other entity or consortium that serves children under a federally-funded program, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Head Start programs, school lunch programs, and elementary or secondary schools.

The provision defines "community health worker" as an individual who promotes health or nutrition within the community in which the individual resides by (1) serving as a liaison between communities and health care agencies, (2) providing guidance and social assistance to residents, (3) enhancing residents' ability to effectively communicate with health care providers, (4) providing culturally and linguistically appropriate health or nutrition education, (5) advocating for individual and community health or nutrition needs, and (6) providing referral and follow-up services.

In the case of a State that is awarded an Outreach and Enrollment grant, the State would be required to meet a maintenance of effort requirement with regard to the state share of funds spent on outreach and enrollment activities under the CHIP state plan. For such states, the funds spent on outreach and enrollment under the state plan for a fiscal year would not permitted to be less than the State share of funds spent in the fiscal year preceding the first fiscal year for which the grant is awarded.

The provision would add translation and interpretation services to the specific health care activities that can be reimbursed under CHIP. Translation or interpretation services in connection with the enrollment and use of services under CHIP by individuals for whom English is not their primary language (as found by the Secretary for the proper and efficient administration of the state plan) would be matched at either 75% or the sum of the enhanced FMAP for the state plus five percentage points, whichever is higher.

In addition, the 10% limit on payments for other specific health care activities in current CHIP statute would not apply to expenditures for outreach and enrollment activities funded under this section.

Section 202. Increased outreach and enrollment of Indians

(a) Agreements with States for Medicaid and CHIP Outreach on or Near Reservations to Increase the Enrollment of Indians in Those Programs

Current Law

No provision in the Social Security Act.

Section 404(a) of the IHCIA requires the Secretary to make grants or enter into contracts with Tribal Organizations for establishing and administering programs on or near federal Indian reservations and trust areas and in or near Alaska Native villages. The purpose of the programs is to assist individual Indians to enroll in Medicare, apply

for Medicaid and pay monthly premiums for coverage due to financial need of such individuals. Section 404(b) of the IHCIA directs the Secretary, through the IHS, to set conditions for any grant or contract. The conditions include, but are not limited to: (1) determining the Indian population that is, or could be, served by Medicare and Medicaid; (2) assisting individual Indians to become familiar with and use benefits; (3) providing transportation to Indians to the appropriate offices to enroll or apply for medical assistance; and (4) developing and implementing both an income schedule to determine premium payment levels for coverage of needy individuals and methods to improve Indian participation in Medicare and Medicaid. Section 404(c) of the IHCIA authorizes the Secretary, acting through the IHS, to enter into agreements with tribes, Tribal Organizations, and Urban Indian Organizations to receive and process applications for medical assistance under Medicaid and benefits under Medicare at facilities administered by the IHS, or by a tribe, Tribal Organization or Urban Indian Organization under the Indian Self-Determination Act.

Explanation of Provision

The provision would amend Section 1139 of the Social Security Act (replacing the current Section 1139 provision dealing with an expired National Commission on Children).

The provision would encourage states to take steps to provide for enrollment of Indians residing on or near a reservation in Medicaid and CHIP. The steps could include outreach efforts such as: outstationing of eligibility workers; entering into agreements with the IHS, Indian Tribes (ITs), Tribal Organizations (TOs), and Urban Indian Organizations (UIOs) to provide outreach; education regarding eligibility, benefits, and enrollment; and translation services. The provision would not affect the arrangements between states and Indian Tribes, Tribal Organizations, and Urban Indian Organizations to conduct administrative activities under Medicaid and CHIP.

The provision would require the Secretary, acting through CMS, to take such steps as necessary to facilitate cooperation with and agreements between states, and the IHS, ITs, TOs, or UIOs relating to the provision of benefits to Indians under Medicaid and CHIP.

The provision would specify that the following terms have the meanings given to these terms in Section 4 of the Indian Health Care Improvement Act: Indian, Indian Tribe, Indian Health Program, Tribal Organization, and Urban Indian Organization.

(b) Nonapplication of 10 Percent Limit On Outreach and Certain Other Expenditures

Current Law

Title XXI of the Social Security Act provides states with annual federal SCHIP allotments based on a formula set in law. State SCHIP payments are matched by the

federal government at an enhanced rate that builds on the base rate applicable to Medicaid. The SCHIP statute also specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. States may also provide benefits to SCHIP children, called targeted low-income children, through enrollment in Medicaid. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, SCHIP statute specifies that payments for these four other specific health care activities cannot exceed 10% of the total amount of expenditures for benefits (excluding payments for services rendered during periods of presumptive eligibility under Medicaid) and other specific health care activities combined.

Explanation of Provision

The provision would exclude from the 10% cap on CHIP payments for the four other specific health care activities described above: (1) expenditures for outreach activities to families of Indian children likely to be eligible for CHIP or Medicaid, or under related waivers, and (2) related informing and enrollment assistance activities for Indian children under such programs, expansions, or waivers, including such activities conducted under grants, contracts, or agreements entered into under Section 1139 of this Act.

Title III – Removal of Barriers to Enrollment

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

Current Law

To be eligible for the full range of benefits offered under Medicaid, an individual must be a citizen or national of the United States or a qualified alien. Nonqualified aliens can only receive limited emergency Medicaid benefits. Noncitizens who apply for full Medicaid benefits have been required since 1986 to present documentation that indicates a "satisfactory immigration status."

Due to recent changes in federal law, citizens and nationals also must present documentation that proves citizenship and documents personal identity in order for states to receive federal Medicaid reimbursement for services provided to them. This citizenship documentation requirement was included in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and modified by the Tax Relief and Health Care Act of 2006 (P.L. 109-432). Before the DRA, states could accept self-declaration of citizenship for Medicaid, although some chose to require additional supporting evidence.

The citizenship documentation requirement is outlined under Section 1903(x) of the Social Security Act and applies to Medicaid eligibility determinations and redeterminations made on or after July 1, 2006. The law specifies documents that are acceptable for this purpose and exempts certain groups from the requirement, including people who receive Medicare benefits, Social Security benefits on the basis of a disability, Supplemental Security Income benefits, child welfare assistance under Title IV-B of the Social Security Act, or adoption or foster care assistance under Title IV-E of the Social Security Act. An interim final rule on the requirement was issued in July 2006, and a final rule was issued in July 2007.

The citizenship documentation requirement does not apply to SCHIP. However, some states use the same enrollment procedures for all Medicaid and SCHIP applicants. As a result, it is possible that some SCHIP enrollees would be asked to present evidence of citizenship.

Explanation of Provision

As part of its Medicaid state plan and with respect to individuals declaring to be U.S. citizens or nationals for purposes of establishing Medicaid eligibility, a state would be required to provide that it satisfies existing Medicaid citizenship documentation rules under Section 1903(x) or new rules under Section 1902(dd). The Secretary would not be allowed to waive this requirement.

Under a new Section 1902(dd), a state could meet its Medicaid state plan requirement for citizenship documentation by: (1) submitting the name and Social Security number (SSN) of an individual to the Commissioner of Social Security as part of a plan established under specified rules and (2) in the case of an individual whose name or SSN is invalid, providing the individual with 90 days to present evidence of citizenship as defined in Section 1903(x) and disenrolling the individual within 30 days after the end of the 90-day period if evidence is not provided.

A state opting for name and SSN validation would be required to establish a program under which it submits each month to the Commissioner of Social Security for verification the name and SSN of each individual enrolled in Medicaid that month who has attained the age of 1 before the date of the enrollment. In establishing its program, a state could enter into an agreement with the Commissioner to provide for the electronic submission and verification of name and SSN before an individual is enrolled in Medicaid.

At such times and in such form as the Secretary may specify, states would be required to provide information on the percentage of invalid names and SSNs submitted each month. If the average monthly percentage for any fiscal year is greater than 7%, the state shall develop and adopt a corrective plan and pay the Secretary an amount equal to total Medicaid payments for the fiscal year for individuals who provided invalid information multiplied by the ratio of the number of individuals with invalid information in excess of the 7% limited divided by the total number of individuals with invalid

information. The Secretary could waive, in certain limited cases, all or part of such payment if a state is unable to reach the allowable error rate despite a good faith effort by the state. This provision shall not apply to a State for a fiscal year, if there is an agreement with the Commissioner to provide for the electronic submission and verification of name and SSN before an individual is enrolled in Medicaid, as of the close of the fiscal year.

States would receive 90% reimbursement for costs attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement name and SSN validation, and 75% for the operation of such systems.

The provision would also clarify requirements under the existing Section 1903(x). It would add "a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe" to the list of documents that provide satisfactory documentary evidence of citizenship or nationality, except for tribes located within states having an international border whose membership includes noncitizens, who would only be allowed to use such documents until the Secretary of HHS issues regulations authorizing the presentation of other evidence. It would require states to provide citizens with the same reasonable opportunity to present evidence that is provided under Section 1137(d)(4)(A) to noncitizens who must present evidence of satisfactory immigration status. Groups that are exempt from the Section 1903(x) citizenship documentation requirement would remain the same as under current law, except for the inclusion of a permanent exemption for children who are deemed eligible for Medicaid coverage by virtue of being born to a mother on Medicaid. The provision would clarify that deemed eligibility applies to children born to noncitizen women on emergency Medicaid, and would require separate identification numbers for children born to these women.

In order to receive reimbursement for an individual who has, or is, declared to be a U.S. citizen or national for purposes of establishing CHIP eligibility, a state would be required to meet the Medicaid state plan requirement for citizenship documentation described above. The 90% and 75% reimbursement for name and SSN validation would be available under SCHIP, and would not count towards a state's CHIP administrative expenditures cap.

Except for technical amendments made by the provision and the application of citizenship documentation to CHIP, which would be effective upon enactment, the provision would be effective as if included in the Deficit Reduction Act of 2005. States would be allowed to provide retroactive eligibility for certain individuals who had been determined ineligible under previous citizenship documentation rules.

Section 302. Reducing administrative barriers to enrollment

Current Law

During the implementation of SCHIP states instituted a variety of enrollment facilitation and outreach strategies to bring eligible children into Medicaid and SCHIP. As a result, substantial progress was made at the state level to simplify the application and enrollment processes to find, enroll, and maintain eligibility among those eligible for the program.

Explanation of Provision

The provision would require the State plan to describe the procedures used to reduce the administrative barriers to the enrollment of children and pregnant women in Medicaid and CHIP, and to ensure that such procedures are revised as often as the State determines is appropriate to reduce newly identified barriers to enrollment. States would be deemed to comply with the above-listed requirement if (1) the State's application and renewal forms, and information verification processes are the same under Medicaid and CHIP for establishing and renewing eligibility for children and pregnant women, and (2) the state does not require a face-to-face interview during the application process.

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

Current Law

Under Medicaid, a provision in the Omnibus Budget Reconciliation Act (OBRA) of 1990 created the health insurance premium payment (HIPP) program. The original HIPP provision required state Medicaid programs to pay a Medicaid beneficiary's share of costs for group (employer-based) health coverage for any Medicaid enrollee for whom employer-based coverage is available when that coverage is both comprehensive and cost effective for the state. An individual's enrollment in an employer plan is considered cost effective if paying the premiums, deductibles, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the state's expected cost of directly providing Medicaid-covered services. Under the original provision, states were also required to purchase employer-based health insurance for non-Medicaid eligible family members if such family coverage was necessary for Medicaid-eligible individual to receive coverage, and as long as it was still cost-effective. States were also to provide coverage for those Medicaid covered services that are not included in the private plans. In August 1997, as part of the Balanced Budget Act, Congress amended the mandatory nature of the HIPP provision. Today, states can opt to use Medicaid funds to pay for

premiums and other cost-sharing for Medicaid beneficiaries when coverage is available, comprehensive, and cost-effective.

Under SCHIP, the Secretary has the authority to approve funding for the purchase of "family coverage" if it is cost effective relative to the amount paid to cover only the targeted low-income children and does not substitute for coverage under group health plans that would otherwise be provided to the children. While the term "family coverage" is not specifically defined in the statute, it has been interpreted to refer to either coverage for the entire family under an SCHIP program or under an employer-sponsored health insurance plan. In addition, states using SCHIP funds for employer-based plan premiums must ensure that SCHIP minimum benefits are provided and SCHIP cost-sharing ceilings are met.

Because of these requirements, implementation of premium assistance programs under Medicaid and SCHIP are not widespread. States cited difficulty in identifying potential enrollees, determining whether the subsidy would be cost-effective, and obtaining necessary information (e.g., information about the availability of employer-sponsored plans, covered benefits, available contributions, and the remaining costs) as some of the barriers to the implementation of such programs.

In August 2001, the Bush Administration introduced the Health Insurance Flexibility and Accountability (HIFA) Initiative under the Section 1115 waiver authority. Under HIFA, states were to direct unspent SCHIP funds to extend coverage to uninsured populations with annual income less than 200% FPL and to use Medicaid and SCHIP funds to pay premium costs for waiver enrollees who have access to Employer Sponsored Insurance (ESI). This resulted in an increased emphasis on states' use of the Section 1115 waiver authority to offer premium assistance for employer-based health coverage in lieu of full Medicaid and/or SCHIP coverage. ESI programs approved under the Section 1115 waiver authority are not subject to the same current law constraints required under Medicaid's HIPP program or SCHIP's family coverage variance option (i.e., the comprehensiveness and cost-effectiveness tests).

Explanation of Provision

The provision would allow states to offer a premium assistance subsidy for qualified employer sponsored coverage to all targeted low-income children who are eligible for child health assistance and have access to such coverage. Qualified employer sponsored coverage would be defined as a group health plan or health insurance coverage offered through an employer that (1) qualifies as credible health coverage as a group health plan under the Public Health Service Act, (2) for which the employer contributes at least 40 percent toward the cost of the premium, and (3) is non-discriminatory in a manner similar to section 105(h)of the Internal Revenue Code but would not allow employers to exclude workers who had less than 3 years of service. Qualified employer-sponsored insurance would not include (1) benefits provided under a health flexible spending arrangement, (2) a high deductible health plan purchased in conjunction with a health savings account as defined in the Internal Revenue Code of 1986.

The provision would establish a new cost effectiveness test for ESI programs. A group health plan or health insurance coverage offered through an employer would be considered qualified employer sponsored coverage if the state establishes that (1) the cost of such coverage is less than the expenditures that the State would have made to enroll the child or the family (as applicable) in CHIP, or (2) the State establishes that the aggregate amount of State expenditures for the purchase of all such coverage for targeted low-income children under CHIP (including administrative expenses) does not exceed the aggregate amount of expenditures that the State would have made for providing coverage under the CHIP state plan for all such children.

Premium assistance subsidies would be considered child health assistance for the purpose of making federal matching payments under the CHIP program, and the state would be considered a secondary payor for any items or services provided under ESI coverage. The provision defines premium assistance subsidies as an amount equal to the difference between the employee contribution for the employee only, and the employee contribution for the employee and CHIP-eligible child, less applicable premium cost sharing imposed under title XXI (including the employee contribution toward the 5% total annual aggregate cost-sharing limit under CHIP). States would be permitted to provide a premium assistance subsidy as reimbursement for out-of-pocket expenses directly to an employee, or directly to the employer. At the employer's option, the provision permits the employer to notify the State that it elects to opt out of being directly paid a premium assistance subsidy on behalf of an employee. In the event of such notification, the employer would be required to withhold the total amount of the employee contribution required for enrollment of the employee (and the child) in the ESI coverage and then the State would then pay the premium subsidy directly to the employee.

States would be required to provide supplemental coverage for each targeted low-income child enrolled in the ESI plan consisting of items or services that are not covered, or are only partially covered, and cost-sharing protections consistent with the requirements of CHIP. States would be permitted to directly pay out-of-pocket expenditures for cost-sharing imposed under the qualified ESI coverage and collect all (or any) portion for cost-sharing imposed on the family.

Waiting periods (to prevent crowd-out of private coverage with public coverage) imposed under the CHIP state plan would also apply to premium assistance coverage. Parents would be permitted to disenroll their child(ren) from ESI coverage and enroll them in CHIP coverage effective on the first day of any month for which the child is eligible for such coverage.

States that provide ESI coverage to parents of targeted low-income children, would be permitted to offer a premium assistance subsidy to eligible parents in the same manner as that State offers such subsidy to eligible child(ren). The amount of the premium subsidy would be increased to take into account the cost of enrollment of the parent in the

ESI coverage, or at state option, the cost of the enrollment of the child's family (if the states determines that it is cost-effective).

This provision would not limit the state's authority to offer premium assistance under the Medicaid HIPP program, a section 1115 demonstration waiver, or any other authority in effect prior to the enactment of this Act. States would be required to inform parents about the availability of premium assistance subsidies for CHIP eligible children in qualified employer-sponsored insurance, how the family would elect such subsides during the application process and ensure that parents are fully informed of the choices for receiving child health assistance under the CHIP or through the receipt of a premium assistance subsidy.

The provision would also allow States to provide premium assistance subsidies for enrollment of targeted low-income children in coverage under a group health plan or health insurance coverage offered through an employer if it is determined that such coverage is actuarially equivalent to CHIP benchmark benefits coverage, or CHIP benchmark-equivalent coverage. Plans that meet the CHIP benefit coverage requirements would not be required to provide supplemental coverage for benefits and cost-sharing protections as required under CHIP. Such provisions would be applied to Medicaid-eligible children and to the parents of Medicaid-eligible children in the same manner as they are applied to CHIP.

Finally, the provision would require the General Accountability Office to submit a report to the appropriate committees of Congress on cost and coverage issues relating to any State premium assistance programs for which federal matching payments are made under Medicaid, CHIP, or the Section 1115 waiver authority. Such report will be due to Congress no later than January 1, 2009.

Section 402. Outreach, education, and enrollment assistance

Current Law

SCHIP states plans are required to include a description of the procedures in place to provide outreach to children eligible for SCHIP child health assistance, or other public or private health programs to (1) inform these families of the availability of SCHIP coverage, and (2) to assist them in enrolling such children in SCHIP. In addition, states are required to provide a description of the state's efforts to ensure coordination between SCHIP and other public and private health coverage.

There is a limit on federal spending for SCHIP administrative expenses, which include activities such as data collection and reporting, as well as outreach and education. For federal matching purposes, a 10% cap applies to state administrative expenses. This cap is tied to the dollar amount that a state draws down from its annual allotment to cover benefits under SCHIP, as opposed to 10% of a state's total annual allotment. In other words, no more than 10% of the federal funds that a state draws down for SCHIP benefit expenditures can be used for administrative expenses.

Explanation of Provision

The provision would require states to include a description of the procedures in place to provide outreach, education, and enrollment assistance for families of children likely to be eligible for premium assistance subsidies under CHIP or a waiver approved under Section 1115. For employers likely to provide qualified employer-sponsored coverage, the state is required to include the specific resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the CHIP state plan. Expenditures for such outreach activities would not be subject to the 10 percent limit on spending for administrative costs associated with the CHIP program.

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

Current Law

Under the Internal Revenue Code, a group health plan is required to provide special enrollment opportunities to qualified individuals. Special enrollment refers to the opportunity given to qualified individuals to enroll in a health plan without having to wait until a late enrollment opportunity or open season. Such individuals must have lost eligibility for other group coverage, or lost employer contributions towards health coverage, or added a dependent due to marriage, birth, adoption, or placement for adoption. In addition, the individual must meet the health plan's substantive eligibility requirements, such as being a full-time worker or satisfying a waiting period. Health plans must give qualified individuals at least 30 days after the qualifying event (e.g., loss of eligibility) to make a request for special enrollment.

The same special enrollment opportunities apply to group health plans and health insurance issuers offering group health insurance under the Employee Retirement Income Security Act.

The Employee Retirement Income Security Act specifies the persons who may bring civil action to enforce the provisions under this statute. Such persons include a plan participant or beneficiary, a fiduciary, the Secretary of Labor, and a State. Current law allows the Secretary to assess a maximum financial penalty against a plan administrator or employer for certain violations, including failure to meet the existing notice requirement.

Explanation of Provision

The provision would require (under the Internal Revenue Code) a group health plan to permit an eligible but not enrolled employee (or dependent(s) of such an employee) to enroll for coverage under the group health plan if either of the following conditions are met: (1) the employee or dependent(s) is/are covered under Medicaid or CHIP, and coverage of the employee or dependent(s) is terminated as a result of loss of eligibility and the employee requests coverage under the group health plan not later than 60 days after the date of coverage termination, or (2) the employee or dependent(s) becomes eligible for assistance, with respect to coverage under the group health plan under Medicaid or CHIP (including under any waiver or demonstration project), if the employee requests coverage under the group health plan no later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

Each employer that maintains a group health plan in a State that provides premium assistance under Medicaid or CHIP would be required to provide each employee a written notice of the potential opportunities for premium assistance available in the State under Medicaid and CHIP. For compliance purposes, the employer may use any State-specific model notice issued by the Secretary of Labor or the Secretary of Health and Human Services in accordance with the model notice requirements established under this section of the bill.

The plan administer of the group health plan would be required to disclose to the State, upon request, information about the benefits available under the group health plan so as to permit the State to make a determination concerning cost-effectiveness, and in order for the State to provide supplemental benefits if required.

The provision includes conforming amendments. A group health plan and a health insurance issuer offering group health insurance (under the Employee Retirement Income Security Act) would be required to permit an eligible but not enrolled employee (or dependent(s) of such an employee) to enroll for coverage under the group health plan if either of the following conditions are met: (1) the employee or dependent(s) is/are covered under Medicaid or CHIP, and coverage of the employee or dependent(s) is terminated as a result of loss of eligibility and the employee requests coverage under the group health plan not later than 60 days after the date of coverage termination, or (2) the employee or dependent(s) becomes eligible for assistance, with respect to coverage under the group health plan under Medicaid or CHIP (including under any waiver or demonstration project), if the employee requests coverage under the group health plan not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

Each employer that maintains a group health plan in a State that provides premium assistance under Medicaid or CHIP would be required to provide each employee a written notice of the potential opportunities for premium assistance available in the State under Medicaid and CHIP. Not later than 1 year after the date of enactment, the Secretary of Labor and the Secretary of Health and Human Services (HHS), in consultation with State Medicaid Directors and State CHIP Directors, would be required

to develop model notices to enable employers to comply with notice requirements in a timely manner. Model notices would include information regarding how an employee would contact the State for information regarding premium assistance and how to apply for such assistance.

The plan administer of the group health plan would be required to disclose to the State, upon request, information about the benefits available under the group health plan so as to permit the State to make a determination concerning cost-effectiveness, and in order for the State to provide supplemental benefits if required.

The HHS Secretary and the Labor Secretary would be required to jointly establish a Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group not later than 60 days after the date of enactment. The purpose of the Working Group would be to develop the model coverage coordination disclosure form, and to identify the impediments to effective coordination of coverage available to families. The purpose of the disclosure form would be to allow the State to determine the availability and cost-effectiveness of coverage, and allow for coordination of coverage for enrollees of such plans. The forms will include (1) information that will allow for the determination of an employee's eligibility for coverage under the group health plan, (2) the name and contact information of the plan administrator of the group health plan, (3) benefits offered under the plan, (4) premiums and cost-sharing under the plan, and (5) any other information relevant to coverage under the plan.

The Working Group would consist of no more than 30 members and be composed of representatives from the Department of Labor, the Department of Health and Human Services, State directors of Medicaid and CHIP programs, employers (including owners of small businesses and their trade or industry representatives and certified human resource and payroll professionals), plan administrations and plan sponsors of group health plans, and children and other beneficiaries of Medicaid and CHIP. Members would be required to serve without compensation. The Department of Health and Human Services and the Department of Labor would be required to jointly provide appropriate administrative support to the Working Group, including technical assistance. The Working Group would be required to submit the model coverage coordination disclosure form, along with a report containing recommendations for appropriate measures to address impediments to effective coordination of coverage between Medicaid, CHIP and group health plans, to the Labor Secretary and the HHS Secretary no later than 18 months after the date of enactment. The Secretaries shall jointly submit a report regarding the Working Group report recommendations to each chamber of the Congress no later than 2 months after receipt of the report from the Working Group. The Working Group shall terminate 30 days after the issuance of its report.

The Labor Secretary and the HHS Secretary would be required to develop the initial model notices, and the Labor Secretary would provide such notices to employers no later than 1 year after the date of enactment. Each employer would be required to provide initial annual notices to its employees beginning the first year after the date on which the model notices are first issued. The model coverage coordination disclosure form would

also apply to requests made by States beginning the first year after the date on which the model notices are first issued.

The provision would amend current law by allowing the Labor Secretary to assess a civil penalty (up to $100 a day) against an employer for failure to meet the new notice requirement established under this section of the bill. Each violation with respect to any employee would be treated as a separate violation. The Labor Secretary would also be allowed to assess a civil penalty (up to $100 a day) against a plan administrator for failure to comply with the new disclosure requirement established under this section of the bill. Each violation with respect to any participant or beneficiary would 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

Current Law

The Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) are both actively involved in funding and implementing an array of quality improvement initiatives, though only AHRQ has engaged in activities specific to children.

In November 2002, CMS started the Quality Initiative (QI), a multi-faceted effort to improve health care quality. This program includes the Nursing Home Quality Initiative, the Home Health Quality Initiative, the National Voluntary Hospital Quality Reporting Initiative, and the Physician Focused Quality Initiative. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included provisions for hospitals to report data on quality indicators. In addition, the MMA included a variety of provisions designed to promote quality care, such as demonstrations that focus on improving the treatment of chronic illnesses and on identifying effective approaches for rewarding superlative performance. In 2005, quality reporting was expanded for inpatient hospital services and extended to home health. The development of plans for value-based purchasing in hospitals and home health settings was also required. In 2006, quality reporting was extended to hospital outpatient services and ambulatory service centers. Additionally, the 2007 Physician Quality Reporting Initiative (PQRI) implemented a voluntary quality reporting system for physicians and other eligible professionals with incentive payments for covered professional services tied to the reporting of claims data.

None of the CMS QI programs to date have focused on children. Rather, most have focused on the general population, adults with chronic conditions, or the frail elderly.

AHRQ has made quality improvement for children a priority in recent years. In part, this is because of the high costs incurred by children on Medicaid/SCHIP.

Many AHRQ projects to implement and evaluate improved health care strategies for the care of children are underway. These include:

1. Pediatric Quality Indicators that includes a set of measures that can be used with hospital inpatient discharge data to detect patient safety events and potentially avoidable hospitalizations.
2. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Medicaid uses CAHPS to measure quality of care for children with special health care needs.
3. AHRQ's Child Health Care Quality Toolbox lists tips and tools for evaluating health care quality for children. It is available to providers and consumers at www.ahrq.gov/chtoolbx/index.htm.

Other AHRQ-supported initiatives to improve the quality and safety of health care for children and adolescents, focusing on health care IT, and the development of pediatric electronic medical records, among other quality improvement activities.

Explanation of Provision

(a) Development of Child Health Quality Measures For Children Enrolled in Medicaid or CHIP.

The provision would add a new section to the Social Security Act defining child health quality improvement activities for children enrolled in Medicaid and CHIP. Not later than January 1, 2009, the Secretary would be required to identify and publish for general comment an initial recommended core set of child health quality measures for use by states with respect to Medicaid and CHIP, health insurance issuers and managed care entities that enter into contracts under Medicaid and CHIP, and providers under those two programs.

With consultation with specific groups (identified below), the Secretary must identify existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time. Based on such measures, the Secretary publish an initial core set of child health quality measures that includes, but is not limited to, the following: (1) duration of insurance coverage over a 12-month period, (2) availability of a full range of preventive services, treatments, and services for acute conditions, and treatments to correct or ameliorate the effects of chronic physical and mental conditions, (3) availability of care in a range of ambulatory and inpatient settings, and (4) measures that, taken together, can be used to estimate the overall national quality of health care for children and to perform

comparative analyses of pediatric health care quality and racial, ethnic, and socio-economic disparities in child health and health care for children.

Not later than 2 years after the enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary, in consultation with the states, must develop a standardized format for reporting information and procedures and approaches that encourage states to use the initial core measurement set to voluntarily report information regarding quality of pediatric care under Medicaid and CHIP.

In addition, the Secretary must disseminate information to states regarding best practices with respect to measuring and reporting quality of care for children, and must facilitate adoption of such best practices. In developing these best practices approaches, the Secretary must give particular attention to state measurement techniques that ensure timeliness and accuracy of provider reporting, encourage provider reporting compliance and encourage successful quality improvement strategies, and improve efficiency in data collection using health information technology.

Not later than January 1, 2010, and every 3 years thereafter, the Secretary must report to Congress on (1) the status of the Secretary's efforts to improve quality related to the duration and stability of health insurance coverage for children under Medicaid and CHIP, (2) the quality of children's health care under those programs, including preventive health services, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions, as well as to aid in growth and development of children, and (3) quality of children's health care, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care. In these reports to Congress, the Secretary must also describe the status of voluntary reporting by states under Medicaid and CHIP utilizing the initial core set of quality measures, and provide any recommendations for legislative changes needed to improve quality of care provided to Medicaid and CHIP children, including recommendations for quality reporting by states. The Secretary must also provide technical assistance to states to assist them in adopting and utilizing core child health quality measures for their Medicaid and CHIP programs.

The provision defines "core set" to mean a group of valid, reliable and evidence-based quality measures for children that provide information regarding the quality of health coverage and health care for children, address the needs of children throughout the developmental age span, and that allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions, and diagnostic and treatment services to correct or ameliorate physical, mental or developmental conditions that could become chronic if left untreated or poorly treated.

(b) Advancing and Improving Pediatric Quality Measures.

The provision would also require the Secretary to establish a pediatric quality measures program not later than January 1, 2010. The purpose of this program would be to (1) improve and strengthen the initial core child health care quality measures, (2) expand on existing pediatric quality measures used by both public and private purchasers and advance the development of new and emerging measures, and (3) increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchases of children's health care services, providers and consumers.

At a minimum, the pediatric quality measures developed under this program must be (1) evidence-based and where appropriate, risk-adjusted, (2) designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care, (3) designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparisons at the state, plan and provider level, (4) periodically adjusted, and (5) responsive to child health needs, services and stability of coverage.

In identifying gaps in existing pediatric quality measures and establishing priorities for the development and use of such measures, the Secretary must consult with a variety of entities, including (1) states, (2) institutional and non-institutional providers that specialize in the care and treatment of children, particularly those with special needs, (3) dental professionals, including pediatric dental professionals, (4) primary care providers for children and families living in medically under-served areas, or who are members of population subgroups at heightened risk for poor health outcomes, (5) national organizations representing consumers and purchasers of children's health care, (6) national organizations and individuals with expertise in pediatric health quality measurement, and (7) voluntary consensus standard setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

In addition, the Secretary must award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children's health care services across the domains of quality identified above, and must also award grants and contracts for the (1) development of consensus on evidence-based measures for children's health care services, (2) dissemination of such measures to public and private purchasers of health care for children, and (3) updating of such measures as necessary.

Beginning no later than January 1, 2012 and annually thereafter, the Secretary must publish recommended changes to the core measures described above that must reflect the testing, validation, and consensus process for the development of pediatric quality measures also described above.

The term "pediatric quality measure" means a measurement of clinical care that is capable of being examined through the collection and analysis of relevant information, that is developed in order to assess one or more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the

clinical care system, the process of care, the outcome of care, or patient experiences in care.

(c) Annual State Reports Regarding State-Specific Quality of Care Measures Applied Under Medicaid or CHIP.

Each state with an approved state plan for Medicaid or CHIP must report annually to the Secretary the following: (1) state-specific child health quality measures, including measures of duration and stability of insurance coverage; quality with respect to preventive services and care for acute and chronic conditions as well as services to ameliorate the effects of physical and mental conditions, and to aid in growth and development; clinical quality, health care safety, family experience with health care, care delivered in the most integrated setting, and elimination of racial, ethnic and socioeconomic disparities in health care; and other measures in the initial core quality measurement set identified above, and (2) state-specific information on the quality of care provided to children under Medicaid and CHIP, including information collected through external quality reviews of Medicaid managed care organizations (under Section 1932) and Medicaid benchmark plans (under Section 1937), and CHIP benchmark plans (under Section 2103). Not later than September 30, 2009, and annually thereafter, the Secretary must collect, analyze and make publicly available the information reported by states as described above.

(d) Demonstration Projects for Improving the Quality of Children's Health Care and the Use of Health Information Technology.

During FY2008 through FY2012, the Secretary must award not more than 10 grants to states and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care furnished under Medicaid and CHIP. Such projects would include efforts designed to: (1) experiment with and evaluate new measures of the quality of children's health care (including testing the validity and suitability for reporting of such measures), (2) promote the use of health information technology in care delivery for children, or (3) evaluate provider-based models that improve the delivery of services to children, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety and efficiency of health care for children.

In awarding these grants, the Secretary must ensure that (1) only one demonstration project funded by such a grant shall be conducted in a state, and (2) such demonstration projects must be conducted evenly between states with large urban areas and states with large rural areas. Grants may be conducted on a multi-state basis, as needed.

Of the total amount appropriated for this new grant program for a fiscal year (described below), $20 million must be used to carry out these activities.

(e) Development of Model Electronic Health Record Format for Children Enrolled in Medicaid or CHIP.

Not later than January 1, 2009, 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 CHIP. Such an electronic health record would be (1) subject to state laws, accessible to parents, caregivers and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, (2) designed to allow interoperable exchanges that conform with federal and state privacy and security requirements, (3) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality, and (4) capable of being incorporated into, and otherwise compatible with, other standards developed for electronic health records. Of the total amount appropriated for this new grant program for a fiscal year, $5 million must be used to carry out these activities.

(f) Study of Pediatric Health and Health Care Quality Measures.

Not later than 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 across the age span and in relation to preventive care, treatments for acute conditions, and treatments to ameliorate or correct physical, mental, and developmental conditions in children. In conducting this study, the IOM must: (1) consider all the major national population-based reporting systems sponsored by the federal government, including reporting requirements under federal grant programs and national population surveys and estimates conducted directly by the federal government, (2) identify the information regarding child health and health care quality that each system is designed to capture and generate, the study and reporting periods covered by each system, and the extent to which the information is made widely available through publication, (3) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment, and (4) make recommendations regarding improving and strengthening the timeliness, quality, and public transparency and accessibility of information about child health and health care quality. Of the total amount appropriated for this new grant program, up to $1 million must be used to carry out these activities.

(g) Rule of Construction.

No evidence-based quality measure developed, published, or used as a basis of measurement or reporting under this section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual child who is eligible for and receiving assistance under Medicaid or CHIP.

(h) Appropriations.

An appropriation of $45 million for FY2008 through FY2012 would be made for the purpose of carrying out the provisions of this section. Such funds would remain available until expended.

The provision would also use the federal medical assistance percentage (FMAP) applicable to a given state to determine the federal share of costs incurred by states for the development or modification of existing claims processing and retrieval systems as is necessary for the efficient collection and reporting on child health measures.

Section 502. Improved information regarding access to coverage under CHIP

Current Law

Under SCHIP, states must assess the operation of the SCHIP state plan in each fiscal year, including the progress made in reducing the number of uncovered low-income children. They must also report to the Secretary of HHS, by January 1 following the end of the fiscal year, the results of that assessment.

Federal regulations stipulate that each annual report include the following additional information: (1) progress in meeting strategic objectives and performance goals identified in the state SCHIP plan, (2) effectiveness of policies to discourage the substitution of public coverage for private coverage, (3) identification of successes and barriers in state plan design and implementation, and the approaches the state is considering to overcome these barriers, (4) progress in addressing any specific issues (such as outreach) that the state plan proposed to periodically monitor and assess, (5) an updated 3-year budget, including any changes in the sources of non-federal share of state plan expenditures, (6) identification of total state expenditures for family coverage and total number of children and adults, respectively, provided family coverage during the preceding fiscal year, and (7) current income standards and methodologies for its SCHIP Medicaid expansion program, separate SCHIP program, and its regular Medicaid program, as appropriate.

Explanation of Provision

(a) Inclusion of Process and Access Measures in Annual State Reports.

The provision would require each state to include the following information in its annual CHIP report to the Secretary of HHS: (1) eligibility criteria, enrollment, and retention data (including information on continuity of coverage or duration of benefits), (2) data regarding the extent to which the state uses process measures with respect to determining the eligibility of children, including measures such as 12-months of continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility, (3) data regarding denials of eligibility and redeterminations of eligibility, (4) data regarding access to primary and specialty services, access to networks

of care, and care coordination provided under the state CHIP plan, using quality of care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, (5) if the state provides child health assistance in the form of premium assistance for the purchase of coverage under a group health plan, data regarding the provision of such assistance, including the extent to which employer-sponsored health insurance coverage is available for children eligible for CHIP, the range of the monthly amount of such assistance provided on behalf or a child or family, the number of children or families provided such assistance on a monthly basis, the income of the children or families provided such assistance, the benefits and cost-sharing protection provided under the state CHIP plan to supplement the coverage purchased with such premium assistance, the effective strategies the state engages in to reduce any administrative barriers to the provision of such assistance, and, the effects, if any, of the provision of such assistance on preventing the coverage under CHIP from substituting for coverage provided under employer-sponsored health insurance offered in the state, and (6) to the extent applicable, a description of any state activities that are designed to reduce the number of uncovered children in the state, including through a state health insurance connector program or support for innovative private health coverage initiatives.

(b) GAO Study and Report on Access to Primary and Specialty Services.

The provision would require GAO to conduct a study of children's access to primary and specialty services under Medicaid and CHIP, including (1) the extent to which providers are willing to treat children eligible for such programs, (2) information on such children's access to networks of care, (3) geographic availability of primary and specialty services under such programs, (4) the extent to which care coordination is provided for children's care under Medicaid and CHIP, and (5) as appropriate, information on the degree of availability of services for children under such programs.

In addition, not later than 2 years after the date of enactment of this Act, GAO must submit a report to the appropriate committees of Congress on this study that includes recommendations for such federal and state legislative and administrative changes as GAO determines are necessary to address any barriers to access to children's care under Medicaid and CHIP that may exist

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

Current Law

A number of sections of the Social Security Act apply to states under title XXI (SCHIP) in the same manner as they apply to a state under title XIX (Medicaid). These include:

- Section 1902(a)(4)(C) (relating to conflict of interest standards).
- Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

- Section 1903(w) (relating to limitations on provider taxes and donations).
- Section 1920A (relating to presumptive eligibility for children).

Explanation of Provision

The provision would add the same requirements for CHIP managed care entities as currently exist under Medicaid. Specifically, the provision would add 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

Current Law

States may provide SCHIP through an expansion of their Medicaid programs. Expenditures for such populations of targeted low-income children are matched at the enhanced FMAP rate and are paid out of SCHIP allotments.

Explanation of Provision

With respect to expenditures for Medicaid for fiscal years 2007 and 2008 only, a state may elect (1) to cover optional poverty-related children and, may apply less restrictive income methodologies to such individuals (via authority in Section 1902(r) or through Section 1931(b)(2)(C)), for which the regular Medicaid FMAP, rather than the enhanced FMAP applicable to CHIP, would be used to determine the federal share of such expenditures, or (2) to receive the regular Medicaid FMAP, rather than the enhanced CHIP FMAP, for CHIP children under an expansion of the state's Medicaid program. This provision would be repealed as of October 1, 2008 (i.e., the beginning of fiscal year 2009). States electing these options would be "held harmless" for related expenditures in FY2007 and FY2008, once this repeal takes effect.

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

Current Law

P.L. 107-300 requires the heads of Federal agencies annually to review programs they oversee that are susceptible to significant erroneous payments, and to estimate the amount of improper payments, to report those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures.

The Center for Medicare and Medicaid Services (CMS), the federal agency within HHS that administers the Medicaid and SCHIP programs, issued an interim final rule with comment period on August 28, 2006, regarding Payment Error Rate Measurement (PERM) for the Medicaid and SCHIP programs. This rule was effective on October 1, 2006. In addition to P.L. 107-300, this regulation points to Sections 1102, 1902(a)(6) and 2107(b)(1) of the Social Security Act which contains the Secretary's general rulemaking authority and obligation of the states to provide information, as the Secretary may require, to monitor program performance. Section 1902(a)(27)(B) also requires states to require providers to furnish State Medicaid Agencies and the Secretary with information regarding payments claimed by Medicaid providers for furnishing Medicaid services. Payment error rates will be calculated for fee-for-service (FFS) claims, managed care claims and for eligibility determinations. The preamble to this regulation notes that CMS will hire Federal contractors to review Medicaid and SCHIP FFS and managed care claims and to calculate the state-specific and national error rates for both programs. States will calculate the state-specific eligibility error rates. Based on those rates, the Federal contractor will calculate the national eligibility error rate for each program. CMS plans to sample a subset of states each year rather than measure every state every year.

With respect to Medicaid and SCHIP eligibility reviews under PERM, states selected for review in a given year must conduct reviews of a statistically valid random sample of beneficiary claims to determine if improper payments were made based on errors in the state agency's eligibility determinations. States must have a CMS-approved sampling plan. In addition to reporting error rates, states must also submit a corrective action plan based on its error rate analysis, and must return overpayments of federal funds.

Medicaid Eligibility Quality Control (MEQC) is operated by State Medicaid agencies to monitor and improve the administration of its Medicaid program. The traditional MEQC program is based on State reviews of Medicaid beneficiaries identified through a statistically reliable statewide sample of cases selected from the eligibility files. These reviews are conducted to determine whether the sampled cases meet applicable Title XIX eligibility requirements and to determine if a State has made erroneous excess payments in its program. Erroneous excess payments for medical assistance" reflect: a) payments made on behalf of ineligible individuals and families, and b) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

The SCHIP statute specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. States may also provide benefits to SCHIP children, called targeted low-income children, through enrollment in Medicaid. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, SCHIP

statute specifies that payments for these four other specific health care activities cannot exceed 10% of the total amount of expenditures for benefits (excluding payments for services rendered during periods of presumptive eligibility under Medicaid) and other specific health care activities combined.

Explanation of Provision

The provision would apply a federal matching rate of 90 percent to expenditures related to administration of PERM requirements applicable to CHIP.

The provision would also exclude from the 10% cap on CHIP administrative costs all expenditures related to the administration of PERM requirements applicable to CHIP in accordance with P.L. 107-300, existing regulations, and any related or successor guidance or regulations.

In addition, the Secretary must not calculate or publish any national or state-specific error rate based on the application of PERM requirements to CHIP until after the date that is 6 months after the date on which a final rule implementing such requirements (described below) is in effect for all states. Any calculation of a national error rate or a state specific error rate after such a final rule is in effect for all states may only be inclusive of errors, as defined in such final rule or in guidance issued within a reasonable time frame after the effective date for such final rule that includes detailed guidance for the specific methodology for error determinations.

The final rule implementing the PERM requirements must include: (1) clearly defined criteria for errors for both states and providers, (2) a clearly defined process for appealing error determinations by review contractors, and (3) clearly defined responsibilities and deadlines for states in implementing any corrective action plans.

After the final PERM rule is in effect for all states, a state for which the PERM requirements were first in effect under an interim final rule for FY2007 may elect to accept any payment error rate determined in whole or in part for the state on the basis of data for that fiscal year or may elect to not have an payment error rate determined on the basis of such data and, instead, must be treated as if FY2010 were the first year for which the PERM requirements apply to the state.

If the final PERM rule is not in effect for all states by July 1, 2008, a state for which the PERM requirements were first in effect under an interim final rule for FY2008 may elect to accept any payment error rate determined in whole or in part for the state on the basis of data for that fiscal year, or may elect to not have any payment error rate determined on the basis of such data and, instead, must be treated as if FY2011 were the first fiscal year for which the PERM requirements apply to the state.

In addition, the provision would require the Secretary to review the Medicaid Eligibility Quality Control (MEQC) requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing

redundancies. A state may elect, for purposes of determining the erroneous excess payments for medical assistance ratio applicable to the state under MEQC, to substitute data resulting from the application of PERM requirements after the final PERM rule is in effect for all states for the data used for the MEQC requirements.

The Secretary must also establish state-specific sample sizes for application of the PERM requirements with respect to CHIP for FY2009 and thereafter, on the basis of information as the Secretary determines is appropriate. In establishing such sample sizes, the Secretary must, to the greatest extent possible (1) minimize the administrative cost burden on states under Medicaid and CHIP, and (2) maintain state flexibility to manage these programs.

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

Current Law

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll (for up to 2 months) children whose family income appears to be below applicable Medicaid income standards, until a formal determination of eligibility is made. Payments 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.

Explanation of Provision

The provision would strike the language in existing CHIP statute that sets the federal share of costs incurred during periods of presumptive eligibility for children at the Medicaid FMAP rate, and also strikes the language that allows payment out of CHIP allotments for Medicaid benefits received by Medicaid children during periods of presumptive eligibility.

Section 604. Improving data collection

Current Law

As discussed in Section 102, the percentage of the SCHIP appropriation that is allotted to individual states is based primarily on state-level estimates of (1) the number of low-income children and (2) the number of uninsured low-income children, based on a three-year average of the Annual Social and Economic (ASEC) Supplements (formerly known as the March supplements) to the Census Bureau's Current Population Survey (CPS). Based on these CPS estimates, some states' share of the available national allotment in the second year of SCHIP (FY1999) was going to differ markedly from the prior year's (e.g., a share of the available national allotment in FY1999 that would have been approximately 40% lower or higher than in FY1998). As a result, legislation was enacted to base the FY1999 SCHIP allotments on the states' share of the available national allotment as calculated for FY1998.

Separate legislation was also enacted to add two new floors and a ceiling to ensure that a state's share of the available national allotment did not change by more than certain amounts, as compared to the state's prior-year share and the state's FY1998/FY1999 share.

Another piece of legislation was also enacted that required appropriate adjustments to the CPS (1) to produce statistically reliable annual state data on the number of low-income children who do not have health insurance coverage, so that real changes in the uninsurance rates of children can reasonably be detected; (2) to produce data that categorizes such children by family income, age, and race or ethnicity; and (3) where appropriate, to expand the sample size used in the state sampling units, to expand the number of sampling units in a state, and to include an appropriate verification element. For this purpose, $10 million was appropriated annually, beginning in FY2000. Because of this legislation, the number of sampled households in the ASEC CPS increased by about 50% (34,500 households). Even with the sample expansion, the margins of error of the state-level estimates of the number of low-income children, and particularly the estimates of low-income children without health insurance, can be relatively high, especially in smaller states.

Explanation of Provision

Besides the $10 million provided annually for the CPS since FY2000, an additional $10 million (for a total of $20 million additionally) is appropriated. In addition to the current-law requirements of the additional appropriation, for data collection beginning in FY2008, in appropriate consultation with the HHS Secretary, the Secretary of Commerce shall do the following:

- Make appropriate adjustments to the CPS to develop more accurate state-specific estimates of the number of children enrolled in CHIP or Medicaid;
- Make appropriate adjustments to the CPS to improve the survey estimates used to compile the state-specific and national number of low-income children without health insurance for purposes of determining annual CHIP allotments, and for making payments to states from the CHIP Incentive Pool, the CHIP Contingency Fund, and, to the extent applicable to a State, from the block grant set aside for CHIP payments on behalf of parents in FY2010 through FY2012;
- Include health insurance survey information in the American Community Survey (ACS) related to children;
- Assess whether ACS estimates, once such survey data are first available, produce more reliable estimates than the CPS for CHIP allotments and payments;
- On the basis of that assessment, recommend to the HHS Secretary whether ACS estimates should be used in lieu of, or in some combination with, CPS estimates for CHIP purposes; and
- Continue making the adjustments to expansion of the sample size used in State sampling units, the number of sampling units in a State, and using an appropriate verification element.

If the Commerce Secretary recommends to the HHS Secretary that ACS estimates should be used instead of, or in combination with, CPS estimates for CHIP purposes, the HHS Secretary may provide a transition period for using ACS estimates, provided that the transition is implemented in a way that avoids adverse impacts on states.

Section 605. Deficit Reduction Act Technical Correction

State Flexibility in Benefit Packages

Current Law

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

Under Medicaid, categorically needy (CN) eligibility groups include families with children, the elderly, certain individuals with disabilities, and certain other pregnant women and children who meet applicable financial eligibility standards. Some CN eligibility groups must be covered while others are optional. Medically needy (MN) groups include the same types of individuals, but different, typically higher financial standards apply. All MN eligibility groups are optional.

The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage which is nearly identical to plans available under SCHIP (described above). For any child under age 19 in one of the major mandatory and optional CN eligibility groups (defined in Section 1902(a)(10)(A)), wrap-around benefits to the DRA benchmark and benchmark-equivalent coverage includes EPSDT (described above). In traditional Medicaid, EPSDT is available to individuals under age 21 in CN groups, and may be offered to individuals under 21 in MN groups.

DRA identifies a number of groups as exempt from mandatory enrollment in benchmark or benchmark equivalent plans. One such exempted group is children in foster care receiving child welfare services under Part B of title IV of the Social Security Act and children receiving foster care or adoption assistance under Part E of such title.

Explanation of Provision

The provision would require that EPSDT be covered for any individual under age 21 who is eligible for Medicaid through the state plan under one of the major mandatory and optional CN groups and is enrolled in benchmark or benchmark-equivalent plans authorized under DRA. The provision would also give states flexibility in providing

coverage of EPSDT services through the issuer of benchmark or benchmark-equivalent coverage or otherwise.

The provision would also make a correction to the reference to children in foster care receiving child welfare services.

Finally, not later than 30 days after the date the Secretary approves a state plan amendment to provide benchmark or benchmark-equivalent coverage under Medicaid, the Secretary must publish in the Federal Register and on the internet website of CMS, a list of the provisions in Title XIX that the Secretary has determined do not apply in order to enable the state to carry out such a state plan amendment and the reason for each such determination.

The amendments made by this provision would become effective as if included in Section 6044(a) of the DRA (i.e., March 31, 2006).

Section 606. Elimination of confusing program references

Current Law

P.L. 106-113 directed the Secretary of HHS or any other Federal officer or employee, with respect to references to the program under Title XXI of the Social Security Act, in any publication or official communication to use the term "SCHIP" instead of "CHIP" and to use the term "State children's health insurance program" instead of "children's health insurance program."

Explanation of Provision

The provision would repeal the section in P.L 106-113 providing the program references to "SCHIP" and "State children's health insurance program" for official publication and communication purposes.

Title VII – Revenue Provisions

See attached "Description of the Revenue Provisions for Markup of the State Children's Health Insurance Program" prepared by the staff of the Joint Committee on Taxation.

Title VIII – Effective Date

Section 801. Effective date

Current Law

No provision.

Explanation of Provision

The effective date of this bill would be October 1, 2007, whether or not final regulations to carry out provisions in the bill have been promulgated by that date. In the case of both current state CHIP and Medicaid plans, if the Secretary of HHS determines that a state must pass new state legislation to implement the requirements of this bill, the state's existing CHIP and/or Medicaid plans, if applicable, would not be considered to be 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 this bill. In the case of a state that has a 2-year legislative session, each year of such session must be considered to be a separate regular session of the state legislature.

Preliminary CBO Estimate of Changes in SCHIP and Medicaid Enrollment of Children under the Chairman's Mark for the CHIP Reauthorization Act of 2007

These figures are subject to revision pending a review of the final legislative language.

All figures are average monthly enrollment, in millions of individuals. Components may not sum to totals because of rounding.

	SCHIP /a/				Medicaid /b/				SCHIP/Medicaid total		
	Enrollees moved to SCHIP	Reduction in the uninsured	Reduction in private coverage	Total	Enrollees moved to SCHIP	Reduction in the uninsured	Reduction in private coverage	Total	Reduction in the uninsured	Reduction in private coverage	Total
FISCAL YEAR 2012:											
CBO's baseline projections				3.3				25.0			28.3
Effect of providing funding to maintain current SCHIP programs	0.6	0.8	0.5	1.9	-0.6	n.a.	n.a.	-0.6	0.8	0.5	1.3
Effect of additional SCHIP funding and other provisions:											
Additional enrollment within existing eligibility groups /c/ /d/	n.a.	0.9	0.6	1.6	n.a.	1.8	0.4	2.2	2.7	1.1	3.8
Expansion of SCHIP eligibility to new populations	n.a.	0.6	0.6	1.1	n.a.	n.a.	n.a.	n.a.	0.6	0.6	1.1
Subtotal	n.a.	1.5	1.2	2.7	n.a.	1.8	0.4	2.2	3.3	1.6	4.9
Total proposed changes	0.6	2.3	1.7	4.6	-0.6	1.8	0.4	1.6	4.1	2.1	6.2
Estimated enrollment under proposal				7.9				26.6			34.5

Notes:

/a/ The figures in this table include the program's adult enrollees, who account for less than 10 percent of total SCHIP enrollment.

/b/ The figures in this table do not include children who receive Medicaid because they are disabled.

/c/ For simplicity of display, the Medicaid figures in this line include the additional children enrolled as a side effect of expansions of SCHIP eligibility.

/d/ The Medicaid figures and SCHIP/Medicaid totals in this line include about 100,000 adults who would gain eligibility under section 301 of the bill.

n.a. = not applicable

Preliminary CBO Estimate of Titles I Through VI of the Chairman's Mark for the CHIP Reauthorization Act of 2007

These figures are subject to revision pending a review of the final legislative language.

Figures are outlays, by fiscal year, in billions of dollars. Costs or savings of less than $50 million are shown with an asterisk. Components may not sum to totals because of rounding.

Section	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-12	2008-17
CHANGES IN DIRECT SPENDING												
SCHIP outlays from the funding provided in sections 101 and 103 of the bill	2.3	4.2	6.1	7.3	8.4	0.4	-0.7	-0.6	-0.4	-0.3	28.2	26.5
Medicaid outlays due to interactions with the SCHIP outlays shown above	-0.3	0.3	1.2	1.6	1.8	4.6	6.1	7.1	7.7	8.4	4.7	38.5
Other changes in direct spending that are not included with the SCHIP and Medicaid totals above												
103 Additional funding for territories	*	*	*	*	*	*	*	*	*	*	0.1	0.1
107 Contingency fund	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.4	1.1
201 Grants for outreach and enrollment	*	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.7	1.6
301 Revise requirement to document citizenship	0.6	0.3	0.3	0.4	0.4	0.4	0.4	0.5	0.5	0.6	2.0	4.3
501 Require development of health quality measures	*	*	*	0.1	0.1	*	*	*	*	*	0.2	0.4
604 Improved data collection	*	*	*	*	*	*	*	*	*	*	0.1	0.1
Subtotal	0.8	0.5	0.6	0.7	0.7	0.8	0.8	0.9	0.9	0.9	3.4	7.7
Total changes in direct spending	2.7	5.1	8.0	9.5	11.0	5.8	6.2	7.3	8.2	9.0	36.3	72.8
CHANGES IN REVENUES												
On-budget revenues (income taxes, Medicare payroll taxes)	*	0.1	0.1	0.1	0.1	0.1	*	*	*	*	0.5	0.7
Off-budget revenues (Social Security payroll taxes)	0.1	0.2	0.2	0.2	0.2	0.1	*	*	*	0.1	0.8	1.1
Total changes in revenues	0.1	0.2	0.3	0.3	0.4	0.1	0.1	0.1	0.1	0.1	1.3	1.7
Net budgetary effect of Titles I through VI	**2.6**	**4.8**	**7.7**	**9.2**	**10.6**	**5.7**	**6.1**	**7.3**	**8.1**	**9.0**	**35.0**	**71.1**
Memorandum:												
SCHIP outlays under CBO's baseline	5.4	5.4	5.5	5.5	5.6	5.5	5.3	5.3	5.2	5.1	27.4	53.8
Additional SCHIP outlays under proposal	2.4	4.3	6.3	7.4	8.6	0.6	-0.5	-0.5	-0.3	-0.2	29.0	28.1
Total SCHIP outlays under proposal	7.8	9.7	11.8	12.9	14.2	6.1	4.7	4.8	4.9	5.0	56.4	82.0

7/13/2007

DESCRIPTION OF THE REVENUE PROVISIONS FOR MARKUP OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Scheduled for Markup
before the
SENATE COMMITTEE ON FINANCE
on July 17, 2007

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

July 13, 2007
JCX-43-07

CONTENTS

INTRODUCTION

The Senate Committee on Finance has scheduled a markup on July 17, 2007. This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of the revenue provisions for markup of the State Children's Health Insurance Program.

[1] This document may be cited as follows: Joint Committee on Taxation, *Description of the Revenue Provisions for Markup of the State Children's Health Insurance Program* (JCX-43-07), July 13, 2007. This document can also be found on the web at www.house.gov/jct.

I. INCREASE TOBACCO TAX RATES AND MODIFY CERTAIN DEFINITIONS

A. Increase Excise Tax Rates on Tobacco Products and Cigarette Papers and Tubes

Present Law

Rates of excise tax on tobacco products and cigarette papers and tubes

Tobacco products and cigarette papers and tubes manufactured in the United States or imported into the United States are subject to Federal excise tax at the following rates:[2]

- Cigarettes weighing not more than three pounds per thousand ("small cigarettes") are taxed at the rate of $19.50 per thousand ($0.39 per pack);
- Cigarettes weighing more than three pounds per thousand ("large cigarettes") are taxed at the rate of $40.95 per thousand, except that, if they measure more than six and one-half inches in length, they are taxed at the rate applicable to small cigarettes, counting each two and three-quarter inches (or fraction thereof) of the length of each as one cigarette;
- Cigars weighing not more than three pounds per thousand ("small cigars") are taxed at the rate of $1.828 per thousand;
- Cigars weighing more than three pounds per thousand ("large cigars") are taxed at the rate equal to 20.719 percent of the manufacturer's or importer's sales price but not more than $48.75 per thousand;
- Cigarette papers are taxed at the rate of $0.0122 for each 50 papers or fractional part thereof, except that, if they measure more than six and one-half inches in length, they are taxable by counting each two and three-quarter inches (or fraction thereof) of the length of each as one cigarette paper;
- Cigarette tubes are taxed at the rate of $0.0244 for each 50 tubes or fractional part thereof, except that, if they measure more than six and one-half inches in length, they are taxable by counting each two and three-quarter inches (or fraction thereof) of the length of each as one cigarette tube;
- Snuff is taxed at the rate of $0.585 per pound, and proportionately at that rate on all fractional parts of a pound;
- Chewing tobacco is taxed at the rate of $0.195 per pound, and proportionately at that rate on all fractional parts of a pound;

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[2] Sec. 5701. Except where otherwise stated, all section references are to the Internal Revenue Code of 1986, as amended (the "Code").

- Pipe tobacco is taxed at the rate of $1.0969 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 $1.0969 per pound, and proportionately at that rate on all fractional parts of a pound.

Floor stocks tax and foreign trade zones

Special tax and duty rules apply with respect to foreign trade zones. In general, merchandise may be brought into a foreign trade zone without being subject to the general customs laws of the United States. Such merchandise may be stored in a foreign trade zone or may be subjected to manufacturing or other processes there. The United States Customs and Border Protection agency of the Department of Homeland Security ("Customs") may determine internal revenue taxes and liquidate duties imposed on foreign merchandise in such foreign trade zones. Articles on which such taxes and applicable duties have already been paid, or which have been admitted into the United States free of tax, that have been taken into a foreign trade zone from inside the United States, may be held under the supervision of a customs officer. Such articles may later be released back into the United States free of further taxes and duties.[3]

Description of Proposal

Rate increases

Under the proposal, the rates of excise tax on tobacco products and cigarette papers and tubes are increased, generally in a proportionate manner. The special rules under present law relating to large cigarettes and cigarette papers and tubes longer than six and one-half inches remain the same. The rates under the proposal 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;

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[3] 19 U.S.C. sec. 81c(a).

- 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.

Floor stocks tax and foreign trade zone treatment

The proposal also imposes a tax on floor stocks. Taxable articles (i.e., those articles listed above) manufactured in the United States or imported into the United States which are removed before January 1, 2008 and held on that date for sale by any person are subject to a floor stocks tax. The floor stocks tax is equal to the excess of the applicable tax under the new rates over the applicable tax at the present-law rates. The person holding the article on January 1, 2008 to which the floor stocks tax applies is liable for the tax. Each such person is allowed a $500 credit against the floor stocks tax.

Notwithstanding any other provision of law, the floor stocks tax applies to an article located in a foreign trade zone on January 1, 2008, provided that internal revenue taxes have been determined, or customs duties have been liquidated, with respect to such article before such date, or such article is held on a tax-and-duty-paid basis on such date under the supervision of a customs officer.

For purposes of determining the floor stocks tax, component members of a "controlled group" (as modified) are treated as one taxpayer.[4] "Controlled group" for these purposes means a parent-subsidiary, brother-sister, or combined corporate group with more than 50-percent ownership with respect to either combined voting power or total value. Under regulations, similar principles may apply to a group of persons under common control where one or more persons are not a corporation.

The proposal provides that the floor stocks tax shall be paid on or before April 1, 2008, in the manner prescribed by Treasury regulations. In general, all of the rules, including penalties, applicable with respect to taxes on tobacco products and cigarette papers and tubes apply to the floor stocks tax. The person who bore the ultimate burden of the floor stocks tax may be treated as the person entitled to a credit of refund of such tax.

[4] Controlled group is defined in section 1563.

Effective Date

The proposal applies to articles removed after December 31, 2007.

B. Modify Definition of Roll-Your-Own Tobacco

Present Law

Federal excise taxes are imposed upon tobacco products and cigarette papers and tubes.[5] Tobacco products are cigars, cigarettes, snuff, chewing tobacco, pipe tobacco, and roll-your-own tobacco. A "cigar" is any roll of tobacco wrapped in leaf tobacco or in any substance containing tobacco, other than any roll of tobacco which is a cigarette. A "cigarette" is (i) any roll of tobacco wrapped in paper or in any substance not containing tobacco; and (ii) any roll of tobacco wrapped in any substance containing tobacco which, because of its appearance, the type of tobacco used in the filler, or its packaging and labeling, is likely to be offered to, or purchased by, consumers as a cigarette. "Roll-your-own tobacco" is any tobacco, which because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes. "Cigarette paper" is paper, or any other material except tobacco, prepared for use as a cigarette wrapper. A "cigarette tube" is cigarette paper made into a hollow cylinder for use in making cigarettes.[6]

Wrappers containing tobacco are not within the definition of cigarette papers or tubes because they contain tobacco. They are also not generally within the definition of roll-your-own tobacco because they are usually used to make cigars, not cigarettes. For the same reason, loose tobacco suitable for making roll-your-own cigars is not considered to be roll-your-own tobacco.

Description of Proposal

Under the proposal, roll-your-own tobacco also includes any tobacco, which because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigars, or for use as wrappers for making cigars.

Effective Date

The proposal applies to articles removed after December 31, 2007.

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[5] Sec. 5701.

[6] Sec. 5702.

II. STRENGTHEN REGULATORY AND ENFORCEMENT AUTHORITY WITH RESPECT TO TOBACCO AND ALCOHOL

A. Clarify Statute of Limitations Pertaining to Excise Taxes Imposed on Imported Alcohol, Tobacco Products and Cigarette Papers and Tubes

Present Law

Under the Code, amounts of tax must generally be assessed within three years after a tax return is filed, and no proceeding in court without assessment for the collection of such tax may begin after such period has expired.[7] If no return is filed (but is required), the tax may be assessed, or a proceeding in court for the collection of such tax may be initiated without assessment, at any time.[8]

Customs collects duties and excise taxes on imports. Importers of taxable articles relating to tobacco and alcohol must file a tax return with Customs.[9] In general, the limitations period for fixing and assessing duties and taxes with respect to an import is one year from the date of entry or removal.[10] Under the applicable customs law, with some limited exceptions, any duty or tax imposed on an import is final and conclusive upon all persons, including the United States, unless a protest is filed within 180 days or a court action is timely commenced.[11]

Description of Proposal

The proposal clarifies the tax and customs law in the area of alcohol and tobacco products by providing that, notwithstanding customs law, the general statute of limitations for assessment under the Code (sec. 6501) applies with respect to taxes imposed under chapters 51 (relating to distilled spirits, wines, and beer) and 52 (relating to tobacco products and cigarette papers and tubes) of the Code.

No inference is intended regarding the applicability of the statute of limitations under the Code to pending cases or to excise taxes imposed other than under chapters 51 and 52 of the Code.

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[7] Sec. 6501(a).

[8] Sec. 6501(c)(3).

[9] 24 C.F.R. sec. 41.81(b) (tobacco products and cigarette papers and tubes); sec. 5061(a) (distilled spirits, wines, and beer).

[10] 19 U.S.C. sec. 1504(a). The Secretary may extend this period under certain circumstances and with notice to the importer.

[11] 19 U.S.C. sec. 1514(a) & (c)(3).

Effective Date

The proposal is effective for articles imported into the United States after the date of enactment.

B. Impose Immediate Tax on Unlawfully Manufactured Tobacco Products and Cigarette Papers and Tubes

Present Law

Manufacturers and importers of tobacco products and proprietors of export warehouses must obtain a permit to engage in such businesses.[12] A permit is obtained by application to the Secretary of the Treasury or his delegate ("Secretary").[13] A manufacturer of tobacco products or cigarette papers or tubes, or an export warehouse proprietor, must file a bond and obtain approval of such bond from the Secretary.[14] In general, excise taxes on tobacco products and cigarette papers and tubes manufactured in the United States are determined at the time of removal. In the case of taxes on tobacco products and cigarette papers and tubes removed during any semimonthly period under bond for deferred payment of tax, payment is due no later than the 14th day after the last day of such semimonthly period.[15]

Distilled spirits, wines, and beer produced at any place other than a place required by the Code are subject to tax immediately on production.[16] There is no rule that imposes immediate tax on tobacco products and cigarette papers and tubes that are produced by an out-of-compliance manufacturer.

Description of Proposal

Under the proposal, in the case of any tobacco products or cigarette papers or tubes produced in the United States at any place other than the premises of a manufacturer that has obtained a permit (if required) and approval of a bond, the excise tax is due and payable immediately upon manufacture, unless they are produced solely for the person's own personal consumption or use.

Effective Date

The proposal is effective on the date of enactment.

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[12] Sec. 5713. A "manufacturer of tobacco products" does not include (1) a person who produces tobacco products solely for the person's own personal consumption or use, and (2) a proprietor of a customs bonded manufacturing warehouse with respect to the operation of such warehouse. Sec. 5702(d).

[13] Sec. 5712.

[14] Sec. 5711.

[15] Sec. 5703.

[16] Sec. 5006(c)(2) (distilled spirits); sec. 5041(f) (wines); sec. 5054(a)(3) (beer).

C. Permit, Reporting, and Recordkeeping Requirements for Manufacturers and Importers of Processed Tobacco

Present Law

Tobacco products and cigarette papers and tubes are subject to Federal excise tax.[17] Tobacco products are cigars, cigarettes, smokeless tobacco, pipe tobacco, and roll-your-own tobacco.[18] Manufacturers and importers of tobacco products and export warehouse proprietors must obtain a permit from the Secretary of the Treasury or his delegate ("Secretary").[19] Manufacturers and importers of tobacco products or cigarette papers or tubes, and export warehouse proprietors, must also periodically make an inventory and certain reports and keep certain records, all as prescribed by the Secretary.[20]

Description of Proposal

The proposal creates a new category of manufacturers and importers who are subject to regulation but not to Federal excise tax. Under the proposal, manufacturers and importers of "processed tobacco" are subject to the present-law permit, inventory, reporting, and recordkeeping requirements. Processed tobacco is any tobacco other than tobacco products. A manufacturer of processed tobacco is any person who processes any tobacco other than tobacco products, and an importer includes an importer of processed tobacco. However, the processing of tobacco does not include the farming or growing of tobacco or the handling of whole tobacco leaf solely for sale, shipment, or delivery to a manufacturer of tobacco products or processed tobacco. For example, under the proposal an importer of "cut rag" tobacco or a leaf processor that manufactures such tobacco is subject to the general permit, inventory, reporting, and recordkeeping requirements of the Code but is not subject to Federal excise tax (unless it also imports or manufactures tobacco products or cigarette papers or tubes).

Effective Date

The proposal is effective on January 1, 2008.

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[17] Sec. 5701.

[18] Sec. 5702.

[19] Sec. 5713.

[20] Sec. 5721 (inventories); sec. 5722 (reports); sec. 5741 (records).

D. Broaden Authority to Deny, Suspend, and Revoke Tobacco Permits

Present Law

Manufacturers and importers of tobacco products and proprietors of export warehouses must obtain a permit to engage in such businesses.[21] A permit is obtained by application to the Secretary. The Secretary may deny the application if (1) the business premises are inadequate to protect the revenue; (2) the activity to be carried out at the business premises does not meet such minimum capacity or activity requirements as prescribed by the Secretary; (3) the applicant is, by reason of his business experience, financial standing, or trade connections, not likely to maintain operations in compliance with the applicable provisions of the Code; or (4) such applicant has failed to disclose any material information required or made any material false statement in the application.[22]

A permit is conditioned upon compliance with the rules of the Code and related regulations pertaining to taxes and regulation of tobacco products and cigarette papers and tubes. The Secretary may suspend or revoke a permit after a notice and hearing if the holder (1) has not in good faith complied with those rules; (2) has violated any other provision of the Code involving intent to defraud; (3) has violated the conditions of the permit; (4) has failed to disclose any material information required or made any material false statement in the permit application; or (5) has failed to maintain the business premises in such a manner as to protect the revenue.[23]

Description of Proposal

Under the proposal, the Secretary may deny an application for a permit if the applicant has been convicted of a felony violation of a Federal or State criminal law relating to tobacco products or cigarette papers or tubes, or if, by reason of previous or current legal proceedings involving a violation of Federal criminal felony laws relating to tobacco products or cigarette papers or tubes, such applicant is not likely to maintain operations in compliance with the applicable provisions of the Code.

Similarly, a permit may be suspended or revoked if the holder is convicted of a felony violation of a Federal or State criminal law relating to tobacco products or cigarette papers or tubes, or if, by reason of previous or current legal proceedings involving a violation of Federal criminal felony laws relating to tobacco products or cigarette papers or tubes, such applicant is not likely to maintain operations in compliance with the applicable provisions of the Code.

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[21] Sec. 5713.

[22] Sec. 5712.

[23] Sec. 5713.

Effective Date

The proposal is effective on the date of enactment.

III. MISCELLANEOUS PROPOSALS

A. Modifications to Corporate Estimated Tax Payments

Present Law

In general, corporations are required to make quarterly estimated tax payments of their income tax liability. For a corporation whose taxable year is a calendar year, these estimated tax payments must be made by April 15, June 15, September 15, and December 15.

Under present law, in the case of a corporation with assets of at least $1 billion, the payments due in July, August, and September, 2012, shall be increased to 114.50 percent of the payment otherwise due and the next required payment shall be reduced accordingly.

Description of Proposal

The proposal reduces the percentage from 114.50 percent to 113.25 percent.

Effective Date

The proposal is effective on the date of enactment.

JOINT COMMITTEE ON TAXATION
July 13, 2007
JCX-44-07

ESTIMATED REVENUE EFFECTS OF THE REVENUE PROVISIONS RELATING TO THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM, SCHEDULED FOR MARKUP BY THE COMMITTEE ON FINANCE ON JULY 17, 2007

Fiscal Years 2008 - 2017

[Millions of Dollars]

Provision	Effective	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-12	2008-17
I. Increase Tax Rates and Modify Certain Definitions													
A. Increase in excise tax rate to $1.00 per pack of cigarettes and generally proportionate increases for other tobacco products and cigarette papers and tubes	ara 12/31/07	6,198	7,601	7,366	7,312	7,251	7,194	7,134	7,072	7,008	6,945	35,728	71,081
B. Modify definition of roll-your-own tobacco	ara 12/31/07	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	1	2
Total of Increase Tax Rates and Modify Certain Definitions		**6,198**	**7,601**	**7,366**	**7,312**	**7,251**	**7,194**	**7,134**	**7,072**	**7,008**	**6,945**	**35,729**	**71,083**
II. Strengthen Regulatory and Enforcement Authority With Respect to Tobacco and Alcohol													
A. Clarify statute of limitations pertaining to excise taxes imposed on imported alcohol, tobacco products, and cigarette papers and tubes	aiiUSa DOE	*Negligible Revenue Effect*											
B. Impose immediate tax on unlawfully manufactured tobacco products and cigarette papers and tubes	DOE	*Negligible Revenue Effect*											
C. Permit, reporting, and recordkeeping requirements for manufacturers and importers of processed tobacco	1/1/08	*Negligible Revenue Effect*											
D. Broaden authority to deny, suspend, and revoke tobacco permits	DOE	*Negligible Revenue Effect*											
Total of Strengthen Regulatory and Enforcement Authority With Respect to Tobacco and Alcohol		***Negligible Revenue Effect***											
III. Decrease the Required Corporate Estimated Tax Payments Due in July, August, and September 2012 from 114.50 to 113.25 Percent of the Payment Otherwise Due for Corporations With Assets of at Least $1 Billion	**DOE**	**---**	**---**	**---**	**---**	**-774**	**774**	**---**	**---**	**---**	**---**	**-774**	**---**
NET TOTAL		**6,198**	**7,601**	**7,366**	**7,312**	**6,477**	**7,968**	**7,134**	**7,072**	**7,008**	**6,945**	**34,955**	**71,083**

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

Legend for "Effective" column: aiiUSa = articles imported into the United States after ara = articles removed after DOE = date of enactment

[1] Gain of less than $500,000.

Modifications to the Chairman's Mark of
The Children's Health Insurance Program Reauthorization Act of 2007

Improve funding for the territories under CHIP and Medicaid:

On Page 6 in **Section 104:**

-- Strike "would continue to be subject to the 50% match rate, but such expenditures would be matched with federal funds" on lines 4 – 6 of the second paragraph in the Explanation of Provision
-- Replace with "would be subject to the 90% federal match rate for the start-up expenses associated with such systems and the 75% federal match rate for the operation of such systems."

Delay effective date of CHIP contingency fund by one year:

On Page 16 **in Section 108.**
-- Strike "FY2008" on line 2 of the first paragraph and replace with "FY2009"
-- Strike "FY2009" on line 3 of the first paragraph and replace with "FY2010"
-- Strike "FY2008" on line 1 of the fourth paragraph and replace with "FY2009"

Technical correction to 2-year availability of allotments:

On Page 17 **in Section 109.**
-- Strike "FY2005" on line 1 of the first paragraph in the Explanation of Provision and replace with "FY2006"
-- Strike "FY2006" on line 2 of the first paragraph in the Explanation of Provision and replace with "FY2007"

Technical clarification: $100 million in grants for outreach and enrollment:

On Page 20 in **Section 201.**
-- Strike "each of" on line 4 of the first paragraph in the Explanation of Provision

Express Lane State Option:

On Page 24, before **Title III**, insert two new sections, 203 and 204, as follows:

Section 203. Option for states to rely on findings by an Express Lane agency to determine components of a child's eligibility for Medicaid or CHIP

Current Law

Medicaid law and regulations contain requirements regarding determinations of eligibility and applications for assistance. Generally, the Medicaid agency must determine the eligibility of each applicant no more than 90 days from the date of

application for disability-based applications and 45 days for all other applications. The agency must assure that eligibility for care and services under the plan is determined in a manner consistent with the best interests of the recipients.

In limited circumstances outside agencies are permitted to determine eligibility for Medicaid. For example, when a joint TANF-Medicaid application is used the state TANF agency may make the Medicaid eligibility determination, or the Secretary may enter into an agreement with a given state to allow the Social Security Administration (SSA) to determine Medicaid eligibility of aged, blind, or disabled individuals in that state.

Applicants must attest to the accuracy of the information submitted on their Medicaid applications, and sign application forms under penalty of perjury. Each state must have an income and eligibility verification system under which (1) applicants for Medicaid and several other specified government programs must furnish their Social Security numbers to the state as a condition for eligibility, and (2) wage information from various specified government agencies is used to verify eligibility and to determine the amount of available benefits. Subsequent to initial application, states must request information from other federal and state agencies, to verify applicants' income, resources, citizenship status, and validity of Social Security number (e.g., income from the Social Security Administration (SSA), unearned income from the Internal Revenue Service (IRS), unemployment information from the appropriate state agency, qualified aliens must present documentation of their immigration status, which states must then verify with the Immigration and Naturalization Service, and the state must verify the SSN with the Social Security Administration). States must also establish a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility determinations. State Medicaid overpayments made on behalf of individuals due to an error in determining eligibility may not exceed 3% of the State's total Medicaid expenditures in a given fiscal year. Erroneous excess payments that exceed the 3% error rate will not be matched with Federal Medicaid funds.

With regard to criteria for State Personnel Administration and Offices, current law requires each state plan to establish and maintain methods of personnel administration in accordance with the Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. States must assure compliance with the standards by local jurisdictions; assure that the U.S. Civil Service Commission has reviewed and determined the adequacy of state laws, regulations, and policies; obtain statements of acceptance of the standards by local agencies; submit materials to show compliance with these standards when requested by HHS; and have in effect an affirmative action plan, which includes specific action steps and timetables, to assure equal employment opportunity.

SCHIP defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. Federal law requires that eligibility for Medicaid and SCHIP be coordinated when states implement separate SCHIP programs.

In these circumstances, applications for SCHIP coverage must first be screened for Medicaid eligibility.

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards for up to 2 months until a final formal determination of eligibility is made. Entities qualified to make presumptive eligibility determinations for children 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. These Medicaid presumptive eligibility rules for children also apply to SCHIP.

Explanation of Provision

The provision would create a three year demonstration program that would allow up to 10 states to use Express Lane at Medicaid and CHIP enrollment and renewal. The demonstration would provide $44 million for systems upgrades and implementation (not coverage costs) and $5 million for an independent evaluation of the demonstration at the end of three years and a report on the demonstration's effectiveness to Congress. The report would be due one year after completion of the demonstration.

The Demonstration would allow states the option to rely on a finding made by an Express Lane Agency within the preceding 12 months to determine whether a child under age 19 (or at state option age 20, or 21) has met one or more of the eligibility requirements (e.g., income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid (including the waiver of requirements of this title).

If a finding from an Express Lane agency results in a child not being found eligible for Medicaid or CHIP, the State would be required to determine Medicaid or CHIP eligibility using its regular procedures. The provision does not relieve states of their obligation to determine eligibility for medical assistance under Medicaid, or prohibit state options intended to increase enrollment of eligible children under Medicaid or CHIP. In addition, the provision requires states to inform the families (especially those whose children are enrolled in CHIP) that they may qualify for lower premium payments or more comprehensive health coverage under Medicaid if the family's income were directly evaluated for an eligibility determination by the State Medicaid agency, and at the family's option they can seek a regular Medicaid eligibility determination.

The provision would allow States to rely on an Express Lane Agency finding that a child is a qualified alien as long as the Agency complies with guidance and regulatory procedures issued by the Secretary of Homeland Security for eligibility determinations of qualified aliens, and verifications of immigration status (that meet the requirements of Section 301 of this bill).

States that opt to use an Express Lane Agency to determine eligibility for Medicaid or CHIP may meet the CHIP screen and enroll requirements by using any of the following requirements: (1) establishing a threshold percentage of the Federal poverty level that is 30 percentage points (or such other higher number of percentage points) as the state determines reflects the income methodologies of the program administered by the Express Lane Agency and the Medicaid State plan, (2) providing that the child satisfies all income requirements for Medicaid eligibility, or (3) providing that such child has a family income that exceeds the Medicaid income eligibility threshold that serves as the lower income eligibility threshold for CHIP.

The provision would allow states to provide for presumptive eligibility under CHIP for a child who, based on an eligibility determination of an income finding from an Express Lane agency, would qualify for child health assistance under CHIP. During the period of presumptive eligibility, the State may determine the child's eligibility for CHIP based on telephone contact with family members, access to data available in electronic or paper format, or other means that minimize to the maximum extent feasible the burden on the family.

A State may initiate a Medicaid eligibility determination (and determine program eligibility) without a program application based on data obtained from sources other than the child (or the child's family), but such child can only be automatically enrolled in Medicaid (or CHIP) if the family affirmatively consented to being enrolled through affirmation and signature on an Express Lane agency application. The provision requires the State to have procedures in place to inform the individual of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations created by the enrollment (if applicable), and the actions the individual must take to maintain enrollment and renew coverage. For children who consent to enrollment in the State plan, the provision would allow the State to waive signature requirements on behalf of such child.

States that participate in the Express Lane Eligibility Demonstration would not be required to direct a child (or a child's family) to submit information or documentation previously submitted by the child or family to an Express Lane agency that the State relies on for its Medicaid eligibility determination. A participating state may rely on information from an Express Lane agency when evaluating a child's eligibility for Medicaid or SCHIP without a separate, independent confirmation of the information at the time of enrollment.

An Express Lane agency must be a public agency determined by the State agency to be capable of making the determinations described in the provisions of this section and

is identified in the state plan under this title or Title XXI. Express Lane Agencies would include: (1) a public agency that determines eligibility for assistance under a State program funded under part A of title IV, a program funded under Part D of title IV a State child health plan under title XXI, the Food Stamp Act of 1977, the Head Start Act, the Richard B. Russell National School Lunch Act, the Child Nutrition Act of 1966, or the Child Care and Development Block Grant, the Steward B. McKinney Homeless Assistance Act, the United States Housing Act of 1937, the Native American Housing Assistance and Self-Determination Act of 1996, (2) a state specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings, and (3) a public agency that is subject to an interagency agreement limiting the disclosure and use of such information for eligibility determination purposes.

Programs run through Title XX (SSBG) are not eligible Express Lane agencies. Private for-profit organizations are not eligible Express Lane agencies. Current law applies regarding the ability of Medicaid to contract with non-profit and for-profit agencies to administer the Medicaid application process with clarifying language that nothing in this demonstration exempts states from the merit-based system for Medicaid employees. A rule of construction would also clarify that states may not use the Express Lane option as a means of avoiding current merit-based employment requirements for Medicaid determinations.

In addition, the provision would require such agencies to notify the child's family (1) of the information that will be disclosed under this provision, (2) that the information will be used solely for the purposes of determining eligibility under Medicaid and CHIP, (3) that the family may elect not to have the information disclosed for such purposes. The Express Lane agency must also enter into or be subject to an interagency agreement to limit the disclosure and use of such information.

As part of the demonstration, signatures under penalty of perjury would not be required on a Medicaid application form attesting to any element of the application for which eligibility is based on information received from a source other than an applicant. The provision would provide that any signature requirement for a Medicaid application may be satisfied through an electronic signature.

States participating in the Demonstration will have to code which children are enrolled in Medicaid or CHIP by way of Express Lane for the duration of the demonstration. States must take a statistically valid sample, approved by CMS, of the children enrolled via Express Lane annually for full Medicaid eligibility review to determine eligibility error rate. States submit the error rate to CMS and if the error rate exceeds 3% either of the first two years, the state must show CMS what corrective actions are in place to improve upon their error rate and will be required to reimburse erroneous excess payments that exceed the allowable error rate of 3%. However, CMS does not have the authority to apply the error rate derived from the Express Lane sample to the entire Express Lane or Medicaid child population, or to take other punitive action against a state based on the error rate. States that participate in the Express Lane

demonstration will continue to be subject to existing requirements under Medicaid requiring states to reimburse erroneous excess payments that exceed the allowable error rate of 3% consistent with 1903(u).

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

Current Law

Each state must have an income and eligibility verification system under which (1) applicants for Medicaid and several other specified government programs must furnish their Social Security numbers to the state as a condition for eligibility, and (2) wage information from various specified government agencies is used to verify eligibility and to determine the amount of available benefits. Subsequent to initial application, states must request information from other federal and state agencies, to verify applicants' income, resources, citizenship status, and validity of Social Security number (e.g., income from the Social Security Administration (SSA), unearned income from the Internal Revenue Service (IRS), unemployment information from the appropriate state agency, qualified aliens must present documentation of their immigration status, which states must then verify with the Immigration and Naturalization Service, and the state must verify the SSN with the Social Security Administration). States must also establish a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility determinations.

Explanation of Provision

The provision would authorize federal or State agencies or private entities with potential data sources relevant for the determination of eligibility under Medicaid (e.g., eligibility files, vital records about births, etc.) to share such information with the Medicaid agency if: (1) the child (or such child's parent, guardian, or caretaker relative) has provided advanced consent to disclosure, and has not objected to disclosure, (2) such data are used solely for the purpose of identifying, enrolling, and verifying potential eligibility for Medicaid medical assistance, and (3) an interagency agreement prevents the unauthorized use, disclosure, or modification of such data, and otherwise meets federal standards for safeguarding privacy and data security, and requires the State agency to use such data for the purposes of child enrollment in Medicaid. The provision would impose criminal penalties for persons who engage in unauthorized activities with such data.

For purposes of the Express Lane Demonstration only, the provision would also authorize the Medicaid and CHIP programs to receive data directly relevant to eligibility determinations and determining the correct amount of benefits under such program from (1) the National New Hires Database, (2) the National Income Data collected by the Commissioner of Social Security, or (3) data about enrollment in insurance that may help to facilitate outreach and enrollment under Medicaid, CHIP and certain other programs.

Technical Correction: Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP

On Page 25 in **Section 301:**
-- Between "with" and "90" on line 5 on the second paragraph under Explanation of Provision, insert "an opportunity to cure the invalid determination with the Social Security Administration, followed by"

Additional State option for providing premium assistance

On Page 30 in **Section 401**, before the first full paragraph, insert the following:

Each state has the option to establish an employer/family premium assistance purchasing pool for employers with less than 250 employees who have at least one CHIP-eligible employee (pregnant woman) or child.

The state, or a state designated entity, will identify and offer access to not less than two privately delivered health products that meet the CHIP benefits benchmark.

States that provide ESI coverage to parents of targeted low-income children, would be permitted to offer a premium assistance subsidy to eligible parents in the same manner as that State offers such subsidy to eligible child(ren). The amount of the premium subsidy would be increased to take into account the cost of enrollment of the parent in the ESI coverage, or at state option, the cost of the enrollment of the child's family (if the states determines that it is cost-effective).

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

On Page 35 in **Section 501.**
-- Insert "including services to promote healthy birth and prevent and treat premature birth," after "acute conditions," in line 8 of the last paragraph on the page

On Page 38 in Subsection (d)
-- Strike "or" in line 7 of the first paragraph
-- Insert prior to the period at the end of line 8 ", or (4) demonstrate the impact of the model electronic health record format for children on improving pediatric health, including the effects of chronic childhood health conditions, and pediatric health care quality as well as reducing health care costs"

On Page 38:
--Insert new subsection (e) as follows:

Current Law

Greater awareness of the obesity crisis and its long-term social and economic implications has encouraged policy makers to fund an array of programs aimed at promoting physical activity and appropriate nutrition. While many of these have been state-based efforts, the federal government has actively funded obesity research as well as health promotion campaigns and public health surveillance systems.

Title III of the Public Health Service Act (42 USC) obliges the Secretary of Health and Human Services to "conduct... encourage, cooperate with, and render assistance to other appropriate public authorities, scientific institutions, and scientists in the conduct of, and promote the coordination of, research, investigations, experiments, and demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments". In carrying out these responsibilities, the Secretary is authorized to make grants-in-aid to universities, hospitals, laboratories, other public or private institutions, and to individuals for research projects.

The National Academy of Sciences (NAS) recently noted that the fundamental problem plaguing national programs seeking to address the obesity crisis is that these efforts "remain fragmented and small-scale". Moreover, obesity prevention programs remain largely uncoordinated. Although many federal agencies are involved in overseeing different types of obesity-related programs, including the Centers for Disease Control and Prevention (CDC), the Department of Agriculture, the National Institutes of Health, and Department of Health and Human Services, NAS concluded that the lack of a dedicated funding stream for obesity prevention and inadequate coordination between federal agencies has led to inefficient uses of resources or unnecessary redundancies in programmatic efforts.

Another problem is that many federal funding streams available to support healthy lifestyles among children have been very narrowly focused on small target populations or they have only addressed obesity indirectly. Examples of the former include efforts which have exclusively targeted low-income families (usually, Medicaid recipients); by contrast, health education courses aimed at American Indians with Type 2 diabetes exemplify the types of federally-funded efforts which have indirectly served as obesity prevention programs but which have reached very limited numbers of individuals in the aggregate.

Explanation of Provision

The Secretary, in consultation with the Administrator of the Centers for Medicare and Medicaid Services, shall conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such a project. The model will (1) identify behavioral risk factors for obesity among children; (2) identify needed clinical preventive and screening benefits among those children identified as target individuals on the basis of such risk factors; (3) provide ongoing support to such target individuals and their families to reduce risk factors and promote the appropriate use of preventive and screening benefits;

and (4) be designed to improve health outcomes, satisfaction, quality of life, and appropriate use of items and services for which medical assistance is available under CHIP and Medicaid.

Eligible entities include a city, county, or Indian tribe; a local or tribal educational agency; an accredited university, college, or community college; a federally-qualified health center; a local health department; a health care provider; a community-based organization; or any other entity determined appropriate by the Secretary, including a consortium or partnership.

An eligible entity awarded a grant under this provision shall use the funds to (1) carry out community-based activities related to reducing childhood obesity, (2) carry out age-appropriate school-based activities that are designed to reduce childhood obesity, (3) carry out educational, counseling, promotional, and training activities through the local health care delivery systems, and (4) provide, through qualified health professionals, training and supervision for community health workers to engage in educational efforts related to obesity.

Not later than 3 years after the Secretary implements the demonstration project under this subsection, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates beneficiary satisfaction under the project, and includes any other information the Secretary deems appropriate. $25 million is authorized for this purpose.

--Reorder existing subsections (e), (f), (g), and (h)

New Mental and Dental Health Provisions

On Page 48, before Title VII, insert two new sections, 607 and 608, as follows:

Section 607. Mental Health Parity in CHIP Plans

Current Law

In 1996, Congress passed the Mental Health Parity Act (MHPA) that established new federal standards for mental health coverage offered by group health plans, most of which are employment-based. Under provisions included in the 1997 Balanced Budget Act (P.L. 105-33), Medicaid managed care plans and SCHIP programs must comply with the requirements of MHPA.

Medicaid expansions under SCHIP follow Medicaid rules. Thus, when such expansions provide for enrollment in Medicaid managed care plans, the MHPA applies. Separate state programs under SCHIP follow SCHIP rules that have broader application than the Medicaid rules. In separate state SCHIP programs, to the extent that a health insurance issuer offers group health insurance coverage, which can include, but is not limited to managed care, the MHPA applies.

Under MHPA, Medicaid and SCHIP plans may define what constitutes mental health benefits (if any). The MHPA prohibits group plans from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than those applicable to medical and surgical coverage. Full parity is not required, that is, group plans may still impose more restrictive treatment limits (e.g., with respect to total number of outpatient visits or inpatient days) or cost-sharing requirements on mental health coverage compared to their medical and surgical services.

Under Medicaid managed care, state Medicaid agencies contract with managed care organizations (MCOs) to provide a specified set of benefits to enrolled beneficiaries. These MCOs may be paid under a variety of arrangements, but are frequently reimbursed on the basis of a pre-determined monthly fee (called a capitation rate) for each enrolled beneficiary. The contracted benefits may include all, some, or none of the mandatory and optional mental health services covered under the state Medicaid plan. When Medicaid managed care plans do not include all covered mental health benefits, these additional services are sometimes "carved out" to a separate, specialized behavioral health managed care entity (usually subject to its own prepaid capitation rates), or may be provided in the fee-for-service setting, in which Medicaid providers are paid directly by the state Medicaid agency for each covered service delivered to a Medicaid beneficiary. All prepaid Medicaid managed care contracts that cover medical/surgical benefits and mental health benefits must comply with the MHPA without exemptions. The MHPA does not apply to fee-for-service arrangements because state Medicaid agencies do not meet the definition of a group health plan.

With respect to covered benefits, separate SCHIP programs tend to look more like private insurance models than like Medicaid. That is, these programs are more likely to cover traditional benefits (e.g., inpatient hospital services, physician services) that would be found in employer-based health insurance plans than certain service categories that are largely unique to Medicaid (e.g., EPSDT, residential treatment facilities, intermediate care facilities for the mentally retarded or ICF/MRs, and institutions for mental disease or IMDs). Most separate SCHIP programs also provide services through managed care plans, although this situation varies by state.. Again, all or some covered mental health services may be included in MCO contracts, or carved out to specialized behavioral health managed care plans, or may be provided on a fee-for-service basis.

Under CHIP, states may provide coverage under their Medicaid programs (MXP), create a new separate SCHIP program (SSP), or both. Under SSPs, states may elect any of three benefit options: (1) a benchmark plan, (2) a benchmark-equivalent plan, or (3) any other plan that the Secretary of HHS deems would provide appropriate coverage for the target population (called Secretary-approved benefit plans). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under FEHBP, (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state.

Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and outpatient hospital services, physician services, lab/x-ray, and well-child care including immunizations), and must include at least 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services).

Explanation of Provision

This section prohibits discriminatory limits on mental health care in separate CHIP plans by directing that any financial requirements or treatment limitations that apply to mental health or substance abuse services must be no more restrictive than the financial requirements or treatment limits that apply to other medical services. It also eliminates a current law provision that authorizes states to reduce the mental health coverage provided to 75 percent of the coverage provided in CHIP benchmark plans.

Section 608. Dental Health Grants

Current Law

Under SCHIP, states may provide coverage under their Medicaid programs (MXP), create a new separate SCHIP program (SSP), or both. Under SSPs, states may elect any of three benefit options: (1) a benchmark plan, (2) a benchmark-equivalent plan, or (3) any other plan that the Secretary of HHS deems would provide appropriate coverage for the target population (called Secretary-approved benefit plans). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under FEHBP, (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state.

Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and outpatient hospital services, physician services, lab/x-ray, and well-child care including immunizations), and must include at least 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services).

SCHIP regulations specify that, regardless of the type of SCHIP health benefits coverage, states must provide coverage of well-baby and well-child care (as defined by the state), age-appropriate immunizations based on recommendations of the Advisory Committee on Immunization Practices (ACIP), and emergency services.

Explanation of Provision

This section provides up to $200 million in federal grants for states to improve the availability of dental services and strengthen dental coverage for children covered under CHIP. States that receive grants would be required to maintain prior levels of spending for dental services provided under CHIP.

Section 801. Effective date

Page 49
-- Insert "except with respect to section 301" after "bill" in the first sentence
-- Add a new last sentence, "With respect to section 301, the effective date will be October 1, 2008."

Preliminary CBO Estimate of Changes in SCHIP and Medicaid Enrollment of Children under the Modified Chairman's Mark for the CHIP Reauthorization Act of 2007

These figures are subject to revision pending a review of the final legislative language.

All figures are average monthly enrollment, in millions of individuals. Components may not sum to totals because of rounding.

	SCHIP /a/				Medicaid /b/				SCHIP/Medicaid total		
	Enrollees moved to SCHIP	Reduction in the uninsured	Reduction in private coverage	Total	Enrollees moved to SCHIP	Reduction in the uninsured	Reduction in private coverage	Total	Reduction in the uninsured	Reduction in private coverage	Total
FISCAL YEAR 2012:											
CBO's baseline projections				3.3				25.0			28.3
Effect of providing funding to maintain current SCHIP programs	0.6	0.8	0.5	1.9	-0.6	n.a.	n.a.	-0.6	0.8	0.5	1.3
Effect of additional SCHIP funding and other provisions:											
Additional enrollment within existing eligibility groups /c/ /d/	n.a.	0.9	0.6	1.5	n.a.	1.7	0.4	2.2	2.7	1.0	3.7
Expansion of SCHIP eligibility to new populations	n.a.	0.6	0.6	1.1	n.a.	n.a.	n.a.	n.a.	0.6	0.6	1.1
Subtotal	n.a.	1.5	1.2	2.6	n.a.	1.7	0.4	2.2	3.2	1.6	4.8
Total proposed changes	0.6	2.2	1.7	4.5	-0.6	1.7	0.4	1.5	4.0	2.1	6.1
Estimated enrollment under proposal				7.9				26.5			34.4

Notes:

/a/ The figures in this table include the program's adult enrollees, who account for less than 10 percent of total SCHIP enrollment.

/b/ The figures in this table do not include children who receive Medicaid because they are disabled.

/c/ For simplicity of display, the Medicaid figures in this line include the additional children enrolled as a side effect of expansions of SCHIP eligibility.

/d/ The Medicaid figures and SCHIP/Medicaid totals in this line include about 100,000 adults who would gain eligibility under section 301 of the bill.

n.a. = not applicable

Preliminary CBO Estimate of Titles I - VI of the Modified Chairman's Mark for the CHIP Reauthorization Act of 2007

These figures are subject to revision pending a review of the final legislative language.

Figures are outlays, by fiscal year, in billions of dollars. Costs or savings of less than $50 million are shown with an asterisk. Components may not sum to totals because of rounding.

Section	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-12	2008-17
CHANGES IN DIRECT SPENDING												
SCHIP outlays from the funding provided in sections 101, 103, and 104 of the bill	2.3	4.2	6.1	7.3	8.4	0.4	-0.7	-0.6	-0.4	-0.3	28.3	26.6
Medicaid outlays due to interactions with the SCHIP outlays shown above	-0.3	0.3	1.2	1.6	1.8	4.6	6.1	7.1	7.7	8.4	4.7	38.6
Other changes in direct spending that are not included with the SCHIP and Medicaid totals above												
104 Additional funding for territories	*	*	*	*	*	*	*	*	*	*	0.1	0.1
108 Contingency fund	0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	1.1
201 Grants for outreach and enrollment	*	*	*	*	*	*	*	*	*	*	0.1	0.3
203 Demonstration project	*	*	*	*	0	0	0	0	0	0	*	*
301 Revise requirement to document citizenship	0	0.3	0.3	0.4	0.4	0.4	0.4	0.5	0.5	0.6	1.4	3.7
501 Require development of health quality measures	*	*	*	0.1	0.1	*	*	*	*	*	0.2	0.4
604 Improved data collection	*	*	*	*	*	*	*	*	*	*	0.1	0.1
608 Dental health grants	*	*	*	*	*	0	0	0	0	0	0.2	0.2
Subtotal	0.1	0.5	0.5	0.6	0.6	0.7	0.7	0.7	0.8	0.8	2.4	6.0
Total changes in direct spending	2.1	5.1	7.9	9.4	10.8	5.7	6.0	7.2	8.0	8.9	35.3	71.2
CHANGES IN REVENUES												
On-budget revenues (income taxes, Medicare payroll taxes)	*	0.1	0.1	0.1	0.1	0.1	*	*	*	*	0.5	0.7
Off-budget revenues (Social Security payroll taxes)	0.1	0.2	0.2	0.2	0.2	0.1	*	*	*	0.1	0.8	1.1
Total changes in revenues	0.1	0.2	0.3	0.3	0.4	0.1	0.1	0.1	0.1	0.1	1.3	1.7
Net budgetary effect of Titles I through VI	**2.0**	**4.8**	**7.6**	**9.1**	**10.5**	**5.5**	**6.0**	**7.1**	**8.0**	**8.8**	**34.0**	**69.4**
Memorandum:												
SCHIP outlays under CBO's baseline	5.4	5.4	5.5	5.5	5.6	5.5	5.3	5.3	5.2	5.1	27.4	53.8
Additional SCHIP outlays under proposal	2.3	4.3	6.2	7.4	8.5	0.6	-0.6	-0.5	-0.3	-0.2	28.7	27.7
Total SCHIP outlays under proposal	7.7	9.7	11.7	12.9	14.1	6.1	4.7	4.8	4.9	5.0	56.1	81.6

July 17, 2007

Number	Senator	Summary	Offset
1	Bingaman-Stabenow #1	Delays implementation by one-year of provisions that transition childless adults to Medicaid to ensure states have adequate time to adjust to new policy.	Increase, as necessary, in the federal tax rate for cigarettes and other tobacco products.
2	Bingaman-Kerry #2	Make technical changes to citizenship documentation requirements.	If necessary, increase in the federal tax rate for cigarettes and other tobacco products.
3	Bingaman/Kerry/ Lincoln/Salazar #3	Gives states the option to use income eligibility information from other federal programs to speed enrollment of eligible kids into SCHIP or Medicaid.	Expands the Medicaid drug rebate paid by pharmaceutical manufactures to include Medicaid Manage Care Organizations (MCOs). If necessary, increases the federal tax rate for cigarettes and other tobacco products.
4	Bingaman/Kerry/ Lincoln/Salazar #4	Gives states the option to use income eligibility information from other federal programs to speed enrollment of eligible kids into SCHIP or Medicaid.	Increase in the drug rebate paid by pharmaceutical manufactures to State Medicaid programs.
5	Bingaman/Kerry/ Lincoln/Salazar #5	Gives states the option to use income eligibility information from other federal programs to speed enrollment of eligible kids into SCHIP or Medicaid.	Increase, as necessary, in the federal tax rate for cigarettes and other tobacco products.
6	Bingaman/Smith #6	Creates improvements to the Medicare Part D low-income subsidy to ensure improved access for low-income seniors.	To be provided.
7	Bingaman/Schumer/ Kerry/Lincoln/ Cantwell/Salazar #7	Extends the existing one-year moratorium for an additional year on CMS rule limiting Medicaid payments to Safety-net providers.	Increase in the drug rebate paid by pharmaceutical manufactures to State Medicaid programs.
8	Bingaman/Kerry/ Salazar #8	Makes critical improvements to Medicare Savings Programs (MSPs) to provide assistance to low-income seniors and other low-income Medicare beneficiaries with Medicare cost sharing requirements. Specifically, the amendment phases-in: 1) an increase in the threshold of the Specified Low Income Beneficiary (SLMB) program to 135% of the Federal Poverty Level (i.e., would make the Qualified Individual (QI) program permanent 2) an indexing of the asset test for MSPs by the Consumer Price Index (CPI).	Reduction in payments to Medicare Private Fee for Service plans.

9	Bingaman/Kerry/ Salazar #9	Makes critical improvements to Medicare Savings Programs (MSPs) to provide assistance to low-income seniors and other low-income Medicare beneficiaries with Medicare cost sharing requirements. Specifically, the amendment phases-in: 1) an increase in the threshold of the Specified low income beneficiary (SLMB) program to 135% of the Federal Poverty Level (i.e., would make the Qualified Individual (QI) program permanent) (QI) an indexing of the asset test for MSPs by the Consumer Price Index (CPI).	Increase, as necessary, in the federal tax rate for cigarettes and other tobacco products.
10	Bingaman/Kerry/ Salazar #10	Makes critical improvements to Medicare Savings Programs (MSPs) to provide assistance to low-income seniors and other low-income Medicare beneficiaries with Medicare cost sharing requirements. Specifically, the amendment phases-in: 1) an increase in the threshold of the Specified low income beneficiary (SLMB) program to 135% of the Federal Poverty Level (i.e., would make the Qualified Individual (QI) program permanent) (QI) an indexing of the asset test for MSPs by the Consumer Price Index (CPI).	Increase in the drug rebate paid by pharmaceutical manufactures to State Medicaid programs.
11	Bingaman/Kerry/ Salazar #11	Makes critical improvements to Medicare Savings Programs (MSPs) to provide assistance to low-income seniors and other low-income Medicare beneficiaries with Medicare cost sharing requirements. Specifically, the amendment phases-in: 1) an increase in the threshold of the Specified low income beneficiary (SLMB) program to 135% of the Federal Poverty Level (i.e., would make the Qualified Individual (QI) program permanent) (QI) an indexing of the asset test for MSPs by the Consumer Price Index (CPI).	Expands the Medicaid drug rebate paid by pharmaceutical manufactures to include Medicaid Manage Care Organizations (MCOs).
12	Kerry/Smith/ Bingaman/Wyden/ Lincoln #1	S-CHIP Mental Health Parity.	Additional increase in the tobacco tax necessary to make budget-neutral.
13	Kerry/Bingaman #2	State Option to Cover Legal Immigrant Children and Pregnant Women.	Increase minimum rebate for Medicaid prescription drugs to extent necessary to make budget neutral.
14	Kerry #3	State Option to Allow Small Business S-CHIP Buy-In.	To be determined.
15	Kerry #4	Creation of a Medicaid and CHIP Payment and Access Commission.	Senator Kerry does not believe this amendment will result in additional costs.

16	Kerry #5	Unfair Treatment of Individuals Making Allowable Transfers Correction Amendment.	To be determined.
17	Kerry #6	Meaningful Hardship Waivers Technical Correction Amendment.	To be determined.
18	Kerry #7	Allowing for the return of gifts technical correction amendment.	to be determined.
19	Kerry #8	To provide sufficient funding to cover half of all uninsured children.	Over two years, phase-down the benchmark for Private Fee-for-Service plans under Medicare Advantage to 100% of fee-for-service. Additionally, it would reduce the benchmark for other other Medicare advantage plans to 120% while creating a pool of funds to reward high performing plans as measured by NCQA.
20	Kerry/Bingaman #9	To provide sufficient funding and incentive to enroll half of all uninsured children.	Apply Medicaid rebate to drugs dispensed through managed care; increase taxes on cigarettes by an additional 25 cents (including corresponding proportional increase on other tobacco products) and increase minimum rebate for Medicaid prescription drugs to extent necessary to make budget-neutral.
21	Kerry/Bingaman #10	To provide sufficient funding and incentive to enroll half of all uninsured children.	An increase in the tobacco tax that is sufficient to keep the mark revenue neutral.

22	Kerry #11	To provide sufficient funding and incentive to enroll half of all uninsured children.	The amendment is offset by closing the following corporate tax loopholes: 1) Codify the economic substance doctrine (13.6 billion over ten years) 2)Repeal section 199 deduction for major integrated oil companies for income attributable to domestic production of oil and natural gas ($9.4 billion) 3) Change the tax treatment of individuals that expatriate ($444 million over ten years) 4)Modify the effective date of leasing provisions of the American Jobs Creation Act of 2004 ($3.25 billion over ten years) 5) Revises the corporate inversion effective date and makes other changes (1.3 over ten years) 6) Eliminate the distinction between foreign oil and gas extraction income and foreign oil related income ($3.2 billion over ten years)
23	Kerry/Bingaman #12	To provide sufficient funding and incentive to enroll half of all uninsured children.	An increase in the tobacco tax that is sufficient to keep the mark revenue neutral.
24	Lincoln/Salazar/ Roberts #1	To require the Secretary of Health and Human Services to provide adequate pharmacy reimbursement under Medicaid by amending Section 1927(e) of the Social Security Act to revise the definition and use of "Average Manufacturer Price" (AMP) in establishing Federal upper reimbursement limits.	To be provided.
25	Lincoln/Snowe/Kerry/ Salazar #2	Optimizing care of high risk infants to assure optimal growth and development, and to prevent the major causes of re-hospitalization in the first year of life.	
26	Lincoln #3	To express a sense of the Senate that legislation passed by the Congress to reauthorize the State Children's Health Insurance Program should include optometry as a basic service required in any benchmark equivalent coverage package as part of the scope of health insurance coverage provided.	

27	Wyden #1	Relief from 10% cap for voluntary programs to encourage education, screening and behavior modifications that will reduce Type 2 Juvenile Diabetes and Childhood Obesity.	
28	Schumer #1	Diabetes Screening and Treatment in the SCHIP Program.	The amendment is offset by the requisite increase in the Medicaid rebate for pharmaceutical manufacturers.
29	Schumer #2	Diabetes Screening and Treatment in the Medicaid Program.	The amendment is offset by the requisite increase in the Medicaid rebate for pharmaceutical manufacturers.
30	Schumer #3	State Employee Coverage.	The amendment is offset by the requisite increase in the Medicaid rebate for pharmaceutical manufacturers.
31	Schumer #4	Parity for Territories.	The amendment is offset by the requisite increase in the Medicaid rebate for pharmaceutical manufacturers
32	Stabenow #1	To ensure parity for all waivers.	To the extent necessary, Medicaid drug rebates would be increased
33	Stabenow/Salazar/ Bingaman/Wyden/ Kerry #2	To define the term "school based health centers" within the Social Security Act for recognition under the Medicaid and SCHIP provisions	To the extent necessary, an increase in Medicaid drug rebates
34	Stabenow #3	To increase appropriations for pediatric health quality and information technology demonstration projects to develop a model electronic health record	To the extent necessary, an increase in Medicaid drug rebates
35	Salazar/Bingaman #1	To require the Secretary of HHS to conduct a demonstration project under section 115 of the Social Security Act to provide nurse home visitation services under Medicaid and CHIP. Also requires HHS to conduct a study regarding the cost-effectiveness of nurse home visitation programs.	Increase pharmaceutical rebate under Medicaid and/or expand Medicaid drug rebate by manufacturers to include managed care organizations

36	Salazar/Roberts/ Bingaman #2	This amendment would establish a Federally Qualified Health center prospective payment system in SCHIP similar to the payment system established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) for FQHC services provided under Medicaid. Under the amendment, states that operate separate and/or combination SCHIP programs will be required to reimburse FQHCs based on the Medicaid Prospective Payment System.	Increase in the Medicaid pharmaceutical drug rebate.
37	Salazar #3	This amendment would change the statutory language for Medicaid rehabilitate services for billing assessments to include services to restore, retain or attain independent functioning.	To be decided.
38	Salazar #4	This amendment imposes a one-year moratorium on CMS from taking any action (through promulgation of regulation, issuance of regulatory guidance, use of federal payment audit and disallowance procedures, or other administrative action, policy or practice) to - (1) finalize or otherwise implement regulations with respect to the rehabilitative services described in Section 1905(a)(13) under title XIX of the Social Security Act. (2) place restrictions on coverage of or payment for school-based administration, transportation or medical services under title XIX of such Act.	To be provided.
39	Lott #1	Apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would increase the child tax credit (IRC section 24) to $1080 for 2008.	Strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP" as they pertain to enrollment of adults
40	Lott #2	The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would extend the college tuition deduction (IRC section 222) through the end of 2008.	Strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP as they pertain to enrollment of adults.

41	Lott #3	The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would reduce the 10 percent income tax bracket to 9.6 percent for 2008.	Strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP as they pertain to enrollment of adults.
42	Lott #4	The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would allow the personal exemption to be claimed under the Alternative Minimum Tax with respect to children..	Strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP as they pertain to enrollment of adults.
43	Lott #5	The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would reduce the tobacco excise tax by 3 percent of the otherwise applicable tax.	Strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP as they pertain to enrollment of adults.
44	Lott #6	The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would eliminate the increase in the excise tax on "large cigars" under the Chairman's Mark.	Strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP as they pertain to enrollment of adults.
45	Lott #7	The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non pregnant adults. The amendment would apply any savings from reduced outlays to deficit reduction.	Strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP as they pertain to enrollment of adults.
46	Snowe #1	Childhood Obesity Demonstration Project	Strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP as they pertain to enrollment of adults.

47	Snowe/Bingaman #1	SCHIP Dental and Mental Health Mandate and Dental Wrap	Increase the minimum Medicaid drug rebate to the extent necessary.
48	Snowe/Bingaman #2	SCHIP Dental and Mental Health Mandate and Dental Wrap	Expand the Medicaid drug rebate paid by pharmaceutical manufactures to include Medicaid Manage Care Organizations (MCOs).
49	Kyl #1	Prior to the effective date of the Act, the Congressional Budget Office must certify that the bill will not result in a crowd out" effect (i.e., a reduction in private coverage due to SCHIP) of greater than 20 percent.	
50	Kyl #2	Prior to the effective date of the Act, the Congressional Budget Office must certify that the bill would not result in reduced enrollment or a change in covered benefits from fiscal year 2013 through fiscal year 2017.	
51	Kyl #3	Repeal of the Alternative Minimum Tax	No offset will be provided.
52	Kyl #4	Waiving AMT Penalties and Interest	No offset will be provided.
53	Kyl #5	Small Cigars Modification	No offset will be provided.
54	Smith #1	Ensuring seamless transition to new citizen documentation system.	Senator Smith does not believe this policy will result in additional costs.
55	Smith #2	Family and small to medium sized business premium assistance purchasing pool.	Senator Smith does not believe this policy will result in additional costs.
56	Smith #3	Supplemental Security Income (SSI) Extension and Disabled Asylees and Refugees.	Reduction of Federal tax refunds to recover unemployment insurance debts due to fraud.
57	Smith #4	Early Treatment for HIV Medicaid Demonstration Projects	To be provided
58	Smith #5	Pathways to Independence Act of 2007.	There is no cost associated with this amendment.
59	Smith/Bingaman #6	Home and Community-Based Services Co-payment Equity Act	To be provided.
60	Smith/Bingaman#7	Medicare Part D Outreach and Enrollment Enhancement Act.	To be provided.
61	Bunning #1	Eliminate the exemption for covering children about 300% of poverty at the SCHIP matching rate.	
62	Ensign #1	Disease Prevention and Treatment Research .	
63	Ensign #2	The amendment prohibits SCHIP funds from being used to provide health assistance to any non-pregnant adult.	

64	Ensign #3	To prohibit a State from using SCHIP funds on non-pregnant adults until the State first demonstrates that it has adequately covered its SCHIP-eligible population as defined in current law.	
65	Ensign #4	To prohibit States from providing SCHIP coverage to individuals above 200 percent of the Federal Poverty Level unless the State has demonstrated that it has enrolled 95 percent of SCHIP eligible children.	
66	Ensign #5	The amendment would eliminate the enhanced SCHIP Federal matching assistance percentage and replace it with the Federal medical assistance percentage.	
67	Ensign #6	To require cost-sharing requirements in SCHIP.	
68	Ensign #7	To improve access to health care.	

Bingaman

Bingaman-Stabenow Amendment # 1 to CHIP Reauthorization

Ensuring State Flexibility and Protecting Adult Populations Currently Receiving Coverage through SCHIP

Summary:
Delays implementation by one-year of provisions within the Chairman's mark that transition childless adults to Medicaid to ensure states have adequate time to adjust to new policy.

Offset:
Increase, as necessary, in the federal tax rate for cigarettes and other tobacco products.

Background:

A core function of the SCHIP program is to provide flexibility to states to cover low-income populations they deem most appropriate. With more than 45 million uninsured Americans, SCHIP should be an occasion for moving forward, not for adopting policies that will result in an increase in the number of people without coverage or inhibit states' efforts to reduce the number of uninsured in their state. *Furthermore, it is important to note that all states that currently cover adult populations have done so with the full approval of the Bush Administration.*

Arguments that covering adult populations jeopardizes coverage of children set up a false choice. In 2006, only approximately 10 percent of SCHIP enrollees included adult populations. Eliminating or restricting such coverage would not address the financing crises facing some states. Two-thirds of states with SCHIP shortfalls in 2006 do not use any SCHIP funds to cover parents. *States do not in any way cover adults at the expense of children.*

In fact, states have fully prioritized coverage of children in receiving approval from CMS to cover adult populations. For example, states have imposed no limits nor have they decreased eligibility of coverage for children. Furthermore, they have pursued myriad policies to ensure that they are enrolling and retaining children eligible for Medicaid and SCHIP. Finally, to the degree that states may spend their full SCHIP allotment, they spend SCHIP dollars first on children and then on adult populations.

Covering children remains a national priority and, despite the common rhetoric, adult coverage is wholly consistent with this goal. Ten years after the creation of SCHIP, adult coverage has not and need not impede coverage of children and the constant drumbeat to the contrary is a distraction that has no basis in fact.

This amendment would not make adult coverage an option in SCHIP, nor does it undue the policy outlined in the Chairman's Mark of transitioning childless adult populations to the Medicaid program. Instead, the amendment provides critical time to states, which are operating their SCHIP programs with the full approval of the U.S. Department of Health and Human Services, to adapt to this new policy.

Contact: Frederick Isasi 4-0164

Bingaman-Kerry Amendment # 2 to CHIP Reauthorization

Increase Coverage of Low-Income U.S. Citizens in Medicaid and SCHIP by Making Technical Improvements to Citizenship Documentation Requirements

Summary:
Modifies the Chairman's mark to make technical improvements to Citizenship Documentation requirements.

Offset:
If necessary, increase in the federal tax rate for cigarettes and other tobacco products.

Background:

Since July 1, 2006, most U.S. citizens and nationals applying for or renewing their Medicaid coverage face a new federal requirement to provide documentation of their citizenship status. Recent reports indicate that tens of thousands of U.S. citizens, and in particular children, are inappropriately being denied Medicaid benefits simply because they don't have access to newly required documentation. Many Medicaid experts believe these requirements may be one of the significant obstacles to children receiving the Medicaid coverage to which they are entitled. Hospitals, physicians, and pharmacies may not be willing to treat these individuals until they have a source of payment, but they cannot qualify for Medicaid until they produce a birth certificate and ID.

This new federal requirement was added to the Medicaid program by the Deficit Reduction Act of 2005 (DRA), enacted February 8, 2006. The Tax Relief and Health Care Act of 2006 (TRHCA), signed into law December 20, 2006, included some amendments to the DRA citizenship documentation requirement, primarily to exempt certain groups. Prior to enactment of the DRA, states were permitted to use their discretion in requiring such citizenship documentation.

Under Section 6036 of the DRA, citizens applying for or renewing their Medicaid coverage must provide "satisfactory documentary evidence of citizenship or nationality." The DRA specifies documents that are acceptable for this purpose and authorizes the HHS Secretary to designate additional acceptable documents. No federal matching funds are available for services provided to individuals who declare they are citizens or nationals unless the state obtains satisfactory evidence of their citizenship or determines that they are subject to a statutory exemption.

It is important to note that citizenship documentation requirements do not affect Medicaid rules relating to immigrants – they apply to individuals claiming to be citizens. Most new legal immigrants are excluded from Medicaid during their first five years in the U.S. and undocumented immigrants remain eligible for Medicaid emergency services only.

al changes to Chairman's mark to ensure that new
s equitable as possible. Specifically, the amendment
btained a social security number at the time of
rovided SCHIP or Medicaid coverage during the time
. Similarly, the amendment also clarifies that
Security administration to acquire an existing social
nd Medicaid coverage during this period. Second, the
ual triggers a social security "mis-match" the
fy why a mismatch occurred (e.g., change of name)
quired by 1903(x). Third, the amendment will ensure
individuals who are not citizens. Specifically, the
individuals for whom social security numbers can
able to provide satisfactory documentation as defined
a social security number.

The amendment will make several technical changes to Chairman's mark to ensure that new citizenship documentation provisions are as equitable as possible. Specifically, the amendment will ensure that individuals that have not obtained a social security number at the time of applying for Medicaid or SCHIP may be provided SCHIP or Medicaid coverage during the time needed to acquire a social security number. Similarly, the amendment also clarifies that individuals that are must contact the Social Security administration to acquire an existing social security number may be provided SCHIP and Medicaid coverage during this period. Second, the amendment would clarify that if an individual triggers a social security "mis-match" the individual will have an opportunity to clarify why a mismatch occurred (e.g., change of name) before having to provide documentation required by 1903(x). Third, the amendment will ensure that state audit error rates will only include individuals who are not citizens. Specifically, the amendment would exclude from error rates individuals for whom social security numbers can not be verified if the individuals have been able to provide satisfactory documentation as defined at 1903(x) subsequent to the submission of a social security number.

Contact: Frederick Isasi 4-0164

Bingaman, Kerry, Lincoln, Salazar Amendment # 3 to CHIP Reauthorization

Dramatically Reducing Administrative Barriers to SCHIP and Medicaid Enrollment by Providing States the Option of "Express Lane Eligibility."

Summary:
Gives states the option to use income eligibility information from other federal programs to speed enrollment of eligible kids into SCHIP or Medicaid. This policy has enjoyed broad bi-partisan support for many years.

Offset:
Expands the Medicaid drug rebate paid by pharmaceutical manufactures to include Medicaid Manage Care Organizations (MCOs). If necessary, increases the federal tax rate for cigarettes and other tobacco products.

Background:

Overview

This amendment gives states the option to implement Express Lane Eligibility to cover the millions of uninsured children who are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) but are not enrolled. The policy described in this amendment has enjoyed broad bi-partisan support for many years. With the flexibility this amendment provides, states can do any or all of the following:

- Grant income-eligibility for Medicaid or SCHIP if another public program has already found that the family has low enough income to qualify for health coverage;
- Access extra federal resources to develop the hardware and software needed to exchange data electronically with other programs (as well as to otherwise update eligibility systems) – similar federal dollars are already available for systems that process provider claims;
- Access other publicly-held data to determine children's eligibility rather than delaying or denying health coverage by forcing families to complete needless paperwork;
- Enroll eligible children in Medicaid or SCHIP if their parents are given an opportunity to decline coverage and do not respond;
- Create similar Express Lane eligibility for pregnant women or other adults and/or use other programs' findings to expedite the determination of eligibility factors other than income.

Why Express is Needed

More than 70% of low-income uninsured children live in families that already receive benefits through Food Stamps, the National School Lunch Program, or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Recognizing this, a provision was added to the Agricultural Risk Protection Act of 2000 that allowed schools to share school lunch information with state health insurance agencies to use for outreach and enrollment. While this provision has inspired numerous states to connect health coverage systems to other public benefit

programs, two major obstacles have prevented states from making the most of this linkage. First, each benefit program has its own technical rules for evaluating and counting income. These differences force state Medicaid and SCHIP agencies to require families to complete new application forms even after another program has already found them to be sufficiently low income that they meet the eligibility standards for health coverage. Second, in most states the Medicaid and SCHIP computers cannot communicate with the computers housing eligibility data for other programs. By hand, state employees must gather data from the non-health program, convey it to the health program, evaluate the data, and enter it manually into health program files. Outdated computer systems have made this strategy expensive, cumbersome, and ultimately unsustainable.

This amendment will overcome both these obstacles. It authorizes a strategy called "Express Lane" that lets states grant eligibility for Medicaid and SCHIP based on the determinations of other public programs, setting aside methodological differences between programs. It provides states with the necessary financial resources to develop automated connections between health coverage systems and other sources of information about eligibility, including other public programs. It is a commonsense approach to improving children's health outreach and enrollment that allows a state, if it chooses, to coordinate enrollment into Medicaid and SCHIP through other public programs.

This amendment will give states the option to use income eligibility information from other federal programs to speed enrollment of eligible kids into SCHIP or Medicaid. It would also provide federal resources to develop the hardware and software needed to facilitate the exchange of electronic data among federal programs and would allow states to access publicly-held data to determine children's eligibility rather than delaying or denying health coverage by making families complete duplicative paperwork.

Express Lane Eligibility Will Continue to Permit State Health Programs and the Finance Committee to Define Eligibility and Safeguard Program Integrity for Medicaid and SCHIP

Although Express Lane eligibility would permit Medicaid and SCHIP agencies to draw on the findings of other need-based programs, such procedures would not alter the health programs' eligibility standards, which would remain under the control of the Finance Committee in the Senate and health agencies in the states. For example, while the food stamp program uses its own methodology to calculate income, Express Lane Eligibility would cover only children whose income, as found by the food stamp program, was low enough to meet Medicaid or SCHIP standards.

More importantly, the income thresholds of other need-based programs tend to be substantially lower than SCHIP eligibility levels, as noted above. Accordingly, slight variations in eligibility methodologies between these programs or changes in the methodologies of other programs would be highly unlikely to extend health coverage to otherwise ineligible children with incomes above 200 percent of FPL, the usual SCHIP standard. Stated differently, Express Lane provisions would likely affect only low-income children who qualify for Medicaid or SCHIP under the most widely shared, uncontroversial view of eligibility.

It is also worth noting the considerable federal precedent for sharing eligibility data between programs. As discussed below, Supplemental Security Income (SSI) and Medicaid eligibility data establish eligibility for Medicare Part D low-income subsidies; Food Stamps and Temporary Assistance for Needy Families (TANF) eligibility data provide eligibility for NSLP; Medicaid eligibility establishes eligibility for WIC; etc.

Finally, even without data sharing or Express Lane eligibility, Medicaid and SCHIP eligibility has always been impacted by changes to other public assistance programs, such as unemployment compensation, housing subsidies, educational grants and loans, nutrition programs for the elderly, child care payments, etc. Some of these benefits count as income for Medicaid purposes. If such benefits shrink or the number of recipients declines, the number of Medicaid-eligible individuals grows. Other benefits are excluded in determining Medicaid eligibility. Increases to the latter benefits raise effective income-eligibility thresholds for Medicaid by elevating the amount of purchasing power individuals can have and still qualify for health coverage. In short, Medicaid and SCHIP have never existed in a bubble; their eligibility has always been affected by multiple public assistance programs; and so Express Lane eligibility is not a radical departure from past practice.

The Importance of Including Medicaid MCOs in Medicaid Drug Rebate Program

The amendment also will ensure that Medicaid managed care plans will have access to the same "best price" as traditional Medicaid and has the potential to save the federal government billions of dollars over five years. Currently, the Medicaid drug rebate ensures that State Medicaid programs receive the best price for prescription drugs for their Medicaid beneficiaries. Unfortunately, health plans that serve over 10 million Medicaid beneficiaries cannot access the same discounts through the federal drug rebate program. As a result, States pay more for the acquisition of prescription drugs for these health plan enrollees than for beneficiaries in fee-for-service Medicaid – ultimately raising the costs to Federal and State governments.

Even with this price disadvantage, the total cost of prescription drugs for health plans is less on a per member per month basis because of health plans' greater use of generics and case management. Unfortunately, many states are considering carving prescription drugs out from health plans for the sole purpose of obtaining the rebate – thereby undermining plans' ability to maintain a comprehensive care and disease management program that includes prescription drugs.

This amendment would undue these distortions that will lead to inefficiencies and wasted federal dollars by ensuring that Medicaid MCOs have access to the same pricing as fee-for-service Medicaid. In addition, the amendment would include provisions to preserve the ability of health plans to coordinate care, protect the 340B drug discount program against "double dipping," and allows plans to maintain positive formularies while ensuring that plans comply with rules governing formularies and utilization management. Under this amendment, Medicaid beneficiaries would have access to all FDA-approved drugs through a prior authorization process, just as they do in the fee-for-service programs.

Last year, the Congressional Budget Office and the CMS Actuary estimated that this policy change would save the Federal government approximately $2 billion over 5 years. The core policy described in this offset was offered as an amendment to the Deficit Reduction Act of 2005 and was accepted by the Senate on a vote of 54 – 45 (vote number 291).

Contact: Frederick Isasi 4-0164

Bingaman, Kerry, Lincoln, Salazar Amendment # 4 to CHIP Reauthorization

Dramatically Reducing Administrative Barriers to SCHIP and Medicaid Enrollment by Providing States the Option of "Express Lane Eligibility."

Summary:
Gives states the option to use income eligibility information from other federal programs to speed enrollment of eligible kids into SCHIP or Medicaid. This policy has enjoyed broad bi-partisan support for many years.

Offset:
Increase in the drug rebate paid by pharmaceutical manufactures to State Medicaid programs.

Note: this offset has passed the Senate this year as part of the Iraq Supplemental Appropriation. Specifically, a 4.9 percent increase in the rebate passed the Senate this year as part of the Iraq Supplemental Appropriations.

Background:

Overview

This amendment gives states the option to implement Express Lane Eligibility to cover the millions of uninsured children who are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) but are not enrolled. The policy described in this amendment has enjoyed broad bi-partisan support for many years. With the flexibility this amendment provides, states can do any or all of the following:

- Grant income-eligibility for Medicaid or SCHIP if another public program has already found that the family has low enough income to qualify for health coverage;
- Access extra federal resources to develop the hardware and software needed to exchange data electronically with other programs (as well as to otherwise update eligibility systems) – similar federal dollars are already available for systems that process provider claims;
- Access other publicly-held data to determine children's eligibility rather than delaying or denying health coverage by forcing families to complete needless paperwork;
- Enroll eligible children in Medicaid or SCHIP if their parents are given an opportunity to decline coverage and do not respond;
- Create similar Express Lane eligibility for pregnant women or other adults and/or use other programs' findings to expedite the determination of eligibility factors other than income.

Why Express is Needed

More than 70% of low-income uninsured children live in families that already receive benefits through Food Stamps, the National School Lunch Program, or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Recognizing this, a provision was added to the Agricultural Risk Protection Act of 2000 that allowed schools to share school lunch

information with state health insurance agencies to use for outreach and enrollment. While this provision has inspired numerous states to connect health coverage systems to other public benefit programs, two major obstacles have prevented states from making the most of this linkage. First, each benefit program has its own technical rules for evaluating and counting income. These differences force state Medicaid and SCHIP agencies to require families to complete new application forms even after another program has already found them to be sufficiently low income that they meet the eligibility standards for health coverage. Second, in most states the Medicaid and SCHIP computers cannot communicate with the computers housing eligibility data for other programs. By hand, state employees must gather data from the non-health program, convey it to the health program, evaluate the data, and enter it manually into health program files. Outdated computer systems have made this strategy expensive, cumbersome, and ultimately unsustainable.

This amendment will overcome both these obstacles. It authorizes a strategy called "Express Lane" that lets states grant eligibility for Medicaid and SCHIP based on the determinations of other public programs, setting aside methodological differences between programs. It provides states with the necessary financial resources to develop automated connections between health coverage systems and other sources of information about eligibility, including other public programs. It is a commonsense approach to improving children's health outreach and enrollment that allows a state, if it chooses, to coordinate enrollment into Medicaid and SCHIP through other public programs.

This amendment will give states the option to use income eligibility information from other federal programs to speed enrollment of eligible kids into SCHIP or Medicaid. It would also provide federal resources to develop the hardware and software needed to facilitate the exchange of electronic data among federal programs and would allow states to access publicly-held data to determine children's eligibility rather than delaying or denying health coverage by making families complete duplicative paperwork.

Express Lane Eligibility Will Continue to Permit State Health Programs and the Finance Committee to Define Eligibility and Safeguard Program Integrity for Medicaid and SCHIP

Although Express Lane eligibility would permit Medicaid and SCHIP agencies to draw on the findings of other need-based programs, such procedures would not alter the health programs' eligibility standards, which would remain under the control of the Finance Committee in the Senate and health agencies in the states. For example, while the food stamp program uses its own methodology to calculate income, Express Lane Eligibility would cover only children whose income, as found by the food stamp program, was low enough to meet Medicaid or SCHIP standards.

More importantly, the income thresholds of other need-based programs tend to be substantially lower than SCHIP eligibility levels, as noted above. Accordingly, slight variations in eligibility methodologies between these programs or changes in the methodologies of other programs would be highly unlikely to extend health coverage to otherwise ineligible children with incomes above 200 percent of FPL, the usual SCHIP standard. Stated differently, Express Lane provisions

would likely affect only low-income children who qualify for Medicaid or SCHIP under the most widely shared, uncontroversial view of eligibility.

It is also worth noting the considerable federal precedent for sharing eligibility data between programs. As discussed below, Supplemental Security Income (SSI) and Medicaid eligibility data establish eligibility for Medicare Part D low-income subsidies; Food Stamps and Temporary Assistance for Needy Families (TANF) eligibility data provide eligibility for NSLP; Medicaid eligibility establishes eligibility for WIC; etc.

Finally, even without data sharing or Express Lane eligibility, Medicaid and SCHIP eligibility has always been impacted by changes to other public assistance programs, such as unemployment compensation, housing subsidies, educational grants and loans, nutrition programs for the elderly, child care payments, etc. Some of these benefits count as income for Medicaid purposes. If such benefits shrink or the number of recipients declines, the number of Medicaid-eligible individuals grows. Other benefits are excluded in determining Medicaid eligibility. Increases to the latter benefits raise effective income-eligibility thresholds for Medicaid by elevating the amount of purchasing power individuals can have and still qualify for health coverage. In short, Medicaid and SCHIP have never existed in a bubble; their eligibility has always been affected by multiple public assistance programs; and so Express Lane eligibility is not a radical departure from past practice.

Contact: Frederick Isasi 4-0164

Bingaman, Kerry, Lincoln, Salazar Amendment # 5 to CHIP Reauthorization

Dramatically Reducing Administrative Barriers to SCHIP and Medicaid Enrollment by Providing States the Option of "Express Lane Eligibility."

Summary:
Gives states the option to use income eligibility information from other federal programs to speed enrollment of eligible kids into SCHIP or Medicaid. This policy has enjoyed broad bi-partisan support for many years.

Offset:
Increase, as necessary, in the federal tax rate for cigarettes and other tobacco products.

Background:

Overview

This amendment gives states the option to implement Express Lane Eligibility to cover the millions of uninsured children who are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) but are not enrolled. The policy described in this amendment has enjoyed broad bi-partisan support for many years. With the flexibility this amendment provides, states can do any or all of the following:

- Grant income-eligibility for Medicaid or SCHIP if another public program has already found that the family has low enough income to qualify for health coverage;
- Access extra federal resources to develop the hardware and software needed to exchange data electronically with other programs (as well as to otherwise update eligibility systems) – similar federal dollars are already available for systems that process provider claims;
- Access other publicly-held data to determine children's eligibility rather than delaying or denying health coverage by forcing families to complete needless paperwork;
- Enroll eligible children in Medicaid or SCHIP if their parents are given an opportunity to decline coverage and do not respond;
- Create similar Express Lane eligibility for pregnant women or other adults and/or use other programs' findings to expedite the determination of eligibility factors other than income.

Why Express is Needed

More than 70% of low-income uninsured children live in families that already receive benefits through Food Stamps, the National School Lunch Program, or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Recognizing this, a provision was added to the Agricultural Risk Protection Act of 2000 that allowed schools to share school lunch information with state health insurance agencies to use for outreach and enrollment. While this provision has inspired numerous states to connect health coverage systems to other public benefit programs, two major obstacles have prevented states from making the most of this linkage. First, each benefit program has its own technical rules for evaluating and counting income. These

differences force state Medicaid and SCHIP agencies to require families to complete new application forms even after another program has already found them to be sufficiently low income that they meet the eligibility standards for health coverage. Second, in most states the Medicaid and SCHIP computers cannot communicate with the computers housing eligibility data for other programs. By hand, state employees must gather data from the non-health program, convey it to the health program, evaluate the data, and enter it manually into health program files. Outdated computer systems have made this strategy expensive, cumbersome, and ultimately unsustainable.

This amendment will overcome both these obstacles. It authorizes a strategy called "Express Lane" that lets states grant eligibility for Medicaid and SCHIP based on the determinations of other public programs, setting aside methodological differences between programs. It provides states with the necessary financial resources to develop automated connections between health coverage systems and other sources of information about eligibility, including other public programs. It is a commonsense approach to improving children's health outreach and enrollment that allows a state, if it chooses, to coordinate enrollment into Medicaid and SCHIP through other public programs.

This amendment will give states the option to use income eligibility information from other federal programs to speed enrollment of eligible kids into SCHIP or Medicaid. It would also provide federal resources to develop the hardware and software needed to facilitate the exchange of electronic data among federal programs and would allow states to access publicly-held data to determine children's eligibility rather than delaying or denying health coverage by making families complete duplicative paperwork.

Express Lane Eligibility Will Continue to Permit State Health Programs and the Finance Committee to Define Eligibility and Safeguard Program Integrity for Medicaid and SCHIP

Although Express Lane eligibility would permit Medicaid and SCHIP agencies to draw on the findings of other need-based programs, such procedures would not alter the health programs' eligibility standards, which would remain under the control of the Finance Committee in the Senate and health agencies in the states. For example, while the food stamp program uses its own methodology to calculate income, Express Lane Eligibility would cover only children whose income, as found by the food stamp program, was low enough to meet Medicaid or SCHIP standards.

More importantly, the income thresholds of other need-based programs tend to be substantially lower than SCHIP eligibility levels, as noted above. Accordingly, slight variations in eligibility methodologies between these programs or changes in the methodologies of other programs would be highly unlikely to extend health coverage to otherwise ineligible children with incomes above 200 percent of FPL, the usual SCHIP standard. Stated differently, Express Lane provisions would likely affect only low-income children who qualify for Medicaid or SCHIP under the most widely shared, uncontroversial view of eligibility.

It is also worth noting the considerable federal precedent for sharing eligibility data between programs. As discussed below, Supplemental Security Income (SSI) and Medicaid eligibility

data establish eligibility for Medicare Part D low-income subsidies; Food Stamps and Temporary Assistance for Needy Families (TANF) eligibility data provide eligibility for NSLP; Medicaid eligibility establishes eligibility for WIC; etc.

Finally, even without data sharing or Express Lane eligibility, Medicaid and SCHIP eligibility has always been impacted by changes to other public assistance programs, such as unemployment compensation, housing subsidies, educational grants and loans, nutrition programs for the elderly, child care payments, etc. Some of these benefits count as income for Medicaid purposes. If such benefits shrink or the number of recipients declines, the number of Medicaid-eligible individuals grows. Other benefits are excluded in determining Medicaid eligibility. Increases to the latter benefits raise effective income-eligibility thresholds for Medicaid by elevating the amount of purchasing power individuals can have and still qualify for health coverage. In short, Medicaid and SCHIP have never existed in a bubble; their eligibility has always been affected by multiple public assistance programs; and so Express Lane eligibility is not a radical departure from past practice.

Contact: Frederick Isasi 4-0164

Bingaman-Smith Amendment # 6 to CHIP Reauthorization

Protecting Low-income Seniors by Making Improvements to the Medicare Drug Benefit Low-Income Subsidy

Summary:
Creates important improvements to the Medicare Part D low-income subsidy to ensure improved access for low-income seniors. This policy has been endorsed by AARP, Families USA, Consumers Union, the National Senior Citizens Law Center, the National Committee to Preserve Social Security and Medicare, the Center for Medicare Advocacy, the National Alliance of State and Territorial AIDS Directors, and the Campaign for America's Future.

Offset:
To be provided.

Background:

Data indicates that a shockingly low number of seniors eligible for the LIS benefit are actually receiving the benefit. According to the January 2007 report by the National Council on Aging (NCOA), The Next Steps: Strategies to Improve the Medicare Part D Low-Income Subsidy, only 35% to 42% of beneficiaries who could have successfully applied for the LIS in 2006 were actually receiving it. Exacerbating this problem, NCOA also reports that overall LIS enrollment rates are slowing. In total for 2007, NCOA estimates that between 3.4 and 4.4 million beneficiaries still must be identified and enrolled in the LIS. Furthermore, data indicates that certain LIS requirements result in many low-income seniors that should be eligible for the benefit being denied enrollment in LIS. I believe the modest policy changes created by the legislation I and Senator Smith are introducing will ensure that all low-income beneficiaries have access to the LIS.

The single most significant barrier to LIS eligibility is the asset test, which accounts for approximately 41 percent of LIS denials. As reported by NCOA, the asset test penalizes low-income retirees who may have very modest savings. For example, approximately half of the people that failed the asset test have excess assets of $35,000 or less. These people tend to be older, female, widowed, and living alone. In addition the asset test is inherently discriminatory against certain categories of people (e.g., people who rent their homes).

This amendment will dramatically improve this inequity by raising both the standard and alternative resource limits. The upper limit for the alternative resource test would be $27,500 for an individual and $55,000 for a couple. This will capture about half of individuals and two-thirds of couples who have been denied LIS because of excess resources.

As recommended by OIG in fall 2006, this amendment also allows the Internal Revenue Service (IRS) to transfer tax filing information to the Social Security Administration (SSA) so they can better target beneficiaries who might be eligible for the LIS. In addition, this amendment creates an expedited LIS application process for pre-screened beneficiaries, prohibits the reporting of retirement account balances, life-insurance policies and in-kind contributions when determining

a beneficiary's resource level, and prohibits LIS benefits from being counted as resources for the purposes of determining eligibility for other federal programs

Contact: Frederick Isasi 4-0164

Bingaman, Schumer, Kerry, Lincoln, Cantwell, Salazar Amendment # 1 to CHIP Reauthorization

Extension of Moratorium on CMS Rule Limiting Medicaid Payments to Safety-net Providers

Summary:
Extends the existing one-year moratorium for an additional year on CMS rule limiting Medicaid payments to Safety-net Providers.

Offset:
Increase in the drug rebate paid by pharmaceutical manufactures to State Medicaid programs

Note: this offset has passed the Senate this year as part of the Iraq Supplemental Appropriation. Specifically, a 4.9 percent increase in the rebate passed the Senate this year as part of the Iraq Supplemental Appropriations

Background:

On January 18, 2007, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal State-Financial Partnership" that would make sweeping changes to public and other safety net provider payment and financing arrangements with State Medicaid programs. The proposed rule would: impose a cost limit on Medicaid payments to public and other safety net providers; impose a new federal definition of public provider status; and, greatly restrict the sources of non-federal share funding through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). The Administration estimated that the proposed rule would cut $3.87 billion from the Medicaid program over the next five years.

Over 400 comment letters were submitted to CMS on the proposed rule, none of which expressed support for the rule and the overall majority of which called for its withdrawal. In addition, 65 Senators and 263 Members of the House went on record in opposition to the rule since it was released in January. Finally, a budget neutral reserve fund to block this regulation was approved by the Senate this year.

Congress showed its opposition to the rule by including a one-year moratorium in the recent supplemental appropriations bill (P.L. 110-28). The moratorium prohibits implementation of this rule for one year from the date of enactment of the supplemental. The supplemental was negotiated extensively by Congress and the White House and a deal was reached on May 23. On May 25 – the day the President signed the supplemental (and the moratorium) into law – the Administration put the final rule on display and published it in the Federal Register on May 29. The most damaging components of the proposed rule remain in the final rule, including Medicaid cuts limiting public and other safety net providers to cost.

By waiting to issue the final rule until after Congress completed its work on the moratorium but before the President signed it into law, the Administration undercut the carefully negotiated timing of the one-year moratorium. Congress had adopted the moratorium when the rule was still in proposed form, and the one-year length was based on the assumption that if it expired without further legislative action, the cuts would not go into effect until at least 60 days after the Administration completed and published a final rule. By issuing a final rule when it did, the Administration effectively shortened the length of the period Congress had granted to itself to resolve the issues raised by the regulation. An extension of the moratorium is necessary to restore the original intent of the moratorium to allow Congress a reasonable time to consider these complex issues thoughtfully and thoroughly before any devastating cuts to the health care safety net get implemented.

Contact: Frederick Isasi 4-0164

Bingaman, Kerry, Salazar Amendment # 8 to CHIP Reauthorization

Improvements to Medicare Savings Programs (MSPs) to Provide Assistance to Low-income Seniors

Summary:
Makes critical improvements to Medicare Savings Programs (MSPs) to provide assistance to low-income seniors and other low-income Medicare beneficiaries with Medicare cost sharing requirements. Specifically, the amendment phases-in: 1) an increase in the threshold of the Specified Low Income Beneficiary (SLMB) program to 135 % of the Federal Poverty Level (i.e., would make the Qualified Individual (QI) program permanent) 2) an indexing of the asset test for MSPs by the Consumer Price Index (CPI).

Offset:
Reduction in payments to Medicare Private Fee For Service plans. If necessary, eliminates the Stabilization fund for Medicare Regional PPO program and reduce Medicare Advantage Indirect Medical Education (IME) payments. If necessary, further reduce Medicare Advantage payments.

Background:

The Importance of Making Improvements to the Medicare Savings Programs

This amendment makes two modest, long overdue changes to Medicaid law that would help to stabilize and update important protections for low-income Medicare beneficiaries that are intended to reduce financial barriers to care. The amendment makes permanent the Qualified Individual program and requires annual indexing of the asset eligibility ceiling for all Medicare Savings Programs.

The Qualified Individual (QI) program was created in the Balanced Budget Act of 1997 to provide low-income seniors and people with disabilities with critical assistance by paying for their Medicare Part B premiums. Currently, the program is funded through time-limited grants to states to pay Part B premiums for beneficiaries with incomes between 120-135% of poverty, and assets below $4,000 for singles and $6,000 for couples. **The program is scheduled to expire again on September 30, 2007.**

The QI program has been very unstable in recent years, with reauthorizations made for short periods of time and often at the very last minute just before the program was scheduled to expire. Such instability causes havoc and uncertainty in the lives of those beneficiaries who rely on the benefit and runs counter to the goal of the Medicare program of providing health care security to those in greatest need. This amendment will stabilize the program by folding it into the Specified Low-Income Medicare Beneficiary (SLMB) program, which is a guaranteed Medicare Savings Program (MSP) not subject to a sunset, that pays Part B premiums for beneficiaries with incomes between 100-120% of poverty. The amendment would simply phase-in an increase in this threshold to 135% of poverty.

In addition, the amendment would provide a phase-in of a long-overdue index for MSP asset test. The absence of indexing over the past decades has meant that every year it has become more difficult to qualify for MSP protections. Not only has current law been penalizing responsible beneficiaries for creating a small nest egg of savings during their working lives, it also has failed to keep up with the cost of living.

According to a June 2006 report of the National Academy of Social Insurance entitled *Improving the Medicare Savings Programs*: "Compared to all Medicare beneficiaries, those who are eligible for the Medicare Savings Programs are more likely to be old, female, black or Hispanic, and living alone. They are also more likely to be in fair or poor health. Thus, they not only have more limited means than other Medicare beneficiaries but a greater need for medical services."

As noted, Qualified Individuals have incomes under 135 percent of poverty – only $1,150 per month. These seniors and people with disabilities are routinely forced to make difficult decisions relating to life's necessities, such as whether to buy food, pay for heat or shelter, or expend their precious resources on medical care.

To that end, the impact that the program has on these individuals' lives cannot be overestimated. The Medicare Part B premium is currently $93.50 per month ($1,122 per year) – almost 10 percent of the total income for a QI eligible beneficiary. Premiums have increased by almost 60% over the past 4 years, and are expected to rise in January to over $100 per month.

But the QI benefit is worth even more than the amount of the Part B premium. QI status enables the recipient to receive the full Part D low-income subsidy – no premium, no deductible, no coverage gap and very low cost-sharing. CMS estimates the value of the full LIS to be about $3,300 for 2007. Without this amendment, beneficiaries currently receiving QI and LIS would lose QI in 2008 and would be required to apply separately for LIS.

This amendment is intended to make a modest policy extension and a modest policy change, both non-controversial, yet very important for a worthy, vulnerable population. Low-income Medicare beneficiaries need and deserve the assistance and security provided under these proposals.

Contact: Frederick Isasi 4-0164

Bingaman, Kerry, Salazar Amendment # 9 to CHIP Reauthorization

Improvements to Medicare Savings Programs (MSPs) to Provide Assistance to Low-Income Seniors

Summary:
Makes critical improvements to Medicare Savings Programs (MSPs) to provide assistance to low-income seniors and other low-income Medicare beneficiaries with Medicare cost sharing requirements. Specifically, the amendment phases-in: 1) an increase in the threshold of the Specified Low Income Beneficiary (SLMB) program to 135 % of the Federal Poverty Level (i.e., would make the Qualified Individual (QI) program permanent) 2) an indexing of the asset test for MSPs by the Consumer Price Index (CPI).

Offset:
Increase, as necessary, in the federal tax rate for cigarettes and other tobacco products.

Background:

The Importance of Making Improvements to the Medicare Savings Programs

This amendment makes two modest, long overdue changes to Medicaid law that would help to stabilize and update important protections for low-income Medicare beneficiaries that are intended to reduce financial barriers to care. The amendment makes permanent the Qualified Individual program and requires annual indexing of the asset eligibility ceiling for all Medicare Savings Programs.

The Qualified Individual (QI) program was created in the Balanced Budget Act of 1997 to provide low-income seniors and people with disabilities with critical assistance by paying for their Medicare Part B premiums. Currently, the program is funded through time-limited grants to states to pay Part B premiums for beneficiaries with incomes between 120-135% of poverty, and assets below $4,000 for singles and $6,000 for couples. **The program is scheduled to expire again on September 30, 2007.**

The QI program has been very unstable in recent years, with reauthorizations made for short periods of time and often at the very last minute just before the program was scheduled to expire. Such instability causes havoc and uncertainty in the lives of those beneficiaries who rely on the benefit and runs counter to the goal of the Medicare program of providing health care security to those in greatest need. This amendment will stabilize the program by folding it into the Specified Low-Income Medicare Beneficiary (SLMB) program, which is a guaranteed Medicare Savings Program (MSP) not subject to a sunset, that pays Part B premiums for beneficiaries with incomes between 100-120% of poverty. The amendment would simply phase-in an increase in this threshold to 135% of poverty.

In addition, the amendment would provide a phase-in of a long-overdue index for MSP asset test. The absence of indexing over the past decades has meant that every year it has become more difficult to qualify for MSP protections. Not only has current law been penalizing responsible

beneficiaries for creating a small nest egg of savings during their working lives, it also has failed to keep up with the cost of living.

According to a June 2006 report of the National Academy of Social Insurance entitled *Improving the Medicare Savings Programs*: "Compared to all Medicare beneficiaries, those who are eligible for the Medicare Savings Programs are more likely to be old, female, black or Hispanic, and living alone. They are also more likely to be in fair or poor health. Thus, they not only have more limited means than other Medicare beneficiaries but a greater need for medical services."

As noted, Qualified Individuals have incomes under 135 percent of poverty – only $1,150 per month. These seniors and people with disabilities are routinely forced to make difficult decisions relating to life's necessities, such as whether to buy food, pay for heat or shelter, or expend their precious resources on medical care.

To that end, the impact that the program has on these individuals' lives cannot be overestimated. The Medicare Part B premium is currently $93.50 per month ($1,122 per year) – almost 10 percent of the total income for a QI eligible beneficiary. Premiums have increased by almost 60% over the past 4 years, and are expected to rise in January to over $100 per month.

But the QI benefit is worth even more than the amount of the Part B premium. QI status enables the recipient to receive the full Part D low-income subsidy – no premium, no deductible, no coverage gap and very low cost-sharing. CMS estimates the value of the full LIS to be about $3,300 for 2007. Without this amendment, beneficiaries currently receiving QI and LIS would lose QI in 2008 and would be required to apply separately for LIS.

This amendment is intended to make a modest policy extension and a modest policy change, both non-controversial, yet very important for a worthy, vulnerable population. Low-income Medicare beneficiaries need and deserve the assistance and security provided under these proposals.

Contact: Frederick Isasi 4-0164

Bingaman, Kerry, Salazar Amendment # 10 to CHIP Reauthorization

Improvements to Medicare Savings Programs (MSPs) to Provide Assistance to Low-income Seniors

Summary:
Makes critical improvements to Medicare Savings Programs (MSPs) to provide assistance to low-income seniors and other low-income Medicare beneficiaries with Medicare cost sharing requirements. Specifically, the amendment phases-in: 1) an increase in the threshold of the Specified Low Income Beneficiary (SLMB) program to 135 % of the Federal Poverty Level (i.e., would make the Qualified Individual (QI) program permanent) 2) an indexing of the asset test for MSPs by the Consumer Price Index (CPI).

Offset:
Increase in the drug rebate paid by pharmaceutical manufactures to State Medicaid programs

Note: this offset has passed the Senate this year as part of the Iraq Supplemental Appropriation. Specifically, a 4.9 percent increase in the rebate passed the Senate this year as part of the Iraq Supplemental Appropriations.

Background:

The Importance of Making Improvements to the Medicare Savings Programs

This amendment makes two modest, long overdue changes to Medicaid law that would help to stabilize and update important protections for low-income Medicare beneficiaries that are intended to reduce financial barriers to care. The amendment makes permanent the Qualified Individual program and requires annual indexing of the asset eligibility ceiling for all Medicare Savings Programs.

The Qualified Individual (QI) program was created in the Balanced Budget Act of 1997 to provide low-income seniors and people with disabilities with critical assistance by paying for their Medicare Part B premiums. Currently, the program is funded through time-limited grants to states to pay Part B premiums for beneficiaries with incomes between 120-135% of poverty, and assets below $4,000 for singles and $6,000 for couples. **The program is scheduled to expire again on September 30, 2007.**

The QI program has been very unstable in recent years, with reauthorizations made for short periods of time and often at the very last minute just before the program was scheduled to expire. Such instability causes havoc and uncertainty in the lives of those beneficiaries who rely on the benefit and runs counter to the goal of the Medicare program of providing health care security to those in greatest need. This amendment will stabilize the program by folding it into the Specified Low-Income Medicare Beneficiary (SLMB) program, which is a guaranteed Medicare Savings Program (MSP) not subject to a sunset, that pays Part B premiums for beneficiaries with incomes between 100-120% of poverty. The amendment would simply phase-in an increase in this threshold to 135% of poverty.

In addition, the amendment would provide a phase-in of a long-overdue index for MSP asset test. The absence of indexing over the past decades has meant that every year it has become more difficult to qualify for MSP protections. Not only has current law been penalizing responsible beneficiaries for creating a small nest egg of savings during their working lives, it also has failed to keep up with the cost of living.

According to a June 2006 report of the National Academy of Social Insurance entitled *Improving the Medicare Savings Programs*: "Compared to all Medicare beneficiaries, those who are eligible for the Medicare Savings Programs are more likely to be old, female, black or Hispanic, and living alone. They are also more likely to be in fair or poor health. Thus, they not only have more limited means than other Medicare beneficiaries but a greater need for medical services."

As noted, Qualified Individuals have incomes under 135 percent of poverty – only $1,150 per month. These seniors and people with disabilities are routinely forced to make difficult decisions relating to life's necessities, such as whether to buy food, pay for heat or shelter, or expend their precious resources on medical care.

To that end, the impact that the program has on these individuals' lives cannot be overestimated. The Medicare Part B premium is currently $93.50 per month ($1,122 per year) – almost 10 percent of the total income for a QI eligible beneficiary. Premiums have increased by almost 60% over the past 4 years, and are expected to rise in January to over $100 per month.

But the QI benefit is worth even more than the amount of the Part B premium. QI status enables the recipient to receive the full Part D low-income subsidy – no premium, no deductible, no coverage gap and very low cost-sharing. CMS estimates the value of the full LIS to be about $3,300 for 2007. Without this amendment, beneficiaries currently receiving QI and LIS would lose QI in 2008 and would be required to apply separately for LIS.

This amendment is intended to make a modest policy extension and a modest policy change, both non-controversial, yet very important for a worthy, vulnerable population. Low-income Medicare beneficiaries need and deserve the assistance and security provided under these proposals.

Contact: Frederick Isasi 4-0164

Bingaman, Kerry, Salazar Amendment # 11 to CHIP Reauthorization

Improvements to Medicare Savings Programs (MSPs) to Provide Assistance to Low-income Seniors

Summary:
Makes critical improvements to Medicare Savings Programs (MSPs) to provide assistance to low-income seniors and other low-income Medicare beneficiaries with Medicare cost sharing requirements. Specifically, the amendment phases-in: 1) an increase in the threshold of the Specified Low Income Beneficiary (SLMB) program to 135 % of the Federal Poverty Level (i.e., would make the Qualified Individual (QI) program permanent) 2) an indexing of the asset test for MSPs by the Consumer Price Index (CPI).

Offset:
Expands the Medicaid drug rebate paid by pharmaceutical manufactures to include Medicaid Manage Care Organizations (MCOs).

Background:

The Importance of Making Improvements to the Medicare Savings Programs

This amendment makes two modest, long overdue changes to Medicaid law that would help to stabilize and update important protections for low-income Medicare beneficiaries that are intended to reduce financial barriers to care. The amendment makes permanent the Qualified Individual program and requires annual indexing of the asset eligibility ceiling for all Medicare Savings Programs.

The Qualified Individual (QI) program was created in the Balanced Budget Act of 1997 to provide low-income seniors and people with disabilities with critical assistance by paying for their Medicare Part B premiums. Currently, the program is funded through time-limited grants to states to pay Part B premiums for beneficiaries with incomes between 120-135% of poverty, and assets below $4,000 for singles and $6,000 for couples. **The program is scheduled to expire again on September 30, 2007.**

The QI program has been very unstable in recent years, with reauthorizations made for short periods of time and often at the very last minute just before the program was scheduled to expire. Such instability causes havoc and uncertainty in the lives of those beneficiaries who rely on the benefit and runs counter to the goal of the Medicare program of providing health care security to those in greatest need. This amendment will stabilize the program by folding it into the Specified Low-Income Medicare Beneficiary (SLMB) program, which is a guaranteed Medicare Savings Program (MSP) not subject to a sunset, that pays Part B premiums for beneficiaries with incomes between 100-120% of poverty. The amendment would simply phase-in an increase in this threshold to 135% of poverty.

In addition, the amendment would provide a phase-in of a long-overdue index for MSP asset test. The absence of indexing over the past decades has meant that every year it has become more

difficult to qualify for MSP protections. Not only has current law been penalizing responsible beneficiaries for creating a small nest egg of savings during their working lives, it also has failed to keep up with the cost of living.

According to a June 2006 report of the National Academy of Social Insurance entitled *Improving the Medicare Savings Programs*: "Compared to all Medicare beneficiaries, those who are eligible for the Medicare Savings Programs are more likely to be old, female, black or Hispanic, and living alone. They are also more likely to be in fair or poor health. Thus, they not only have more limited means than other Medicare beneficiaries but a greater need for medical services."

As noted, Qualified Individuals have incomes under 135 percent of poverty – only $1,150 per month. These seniors and people with disabilities are routinely forced to make difficult decisions relating to life's necessities, such as whether to buy food, pay for heat or shelter, or expend their precious resources on medical care.

To that end, the impact that the program has on these individuals' lives cannot be overestimated. The Medicare Part B premium is currently $93.50 per month ($1,122 per year) – almost 10 percent of the total income for a QI eligible beneficiary. Premiums have increased by almost 60% over the past 4 years, and are expected to rise in January to over $100 per month.

But the QI benefit is worth even more than the amount of the Part B premium. QI status enables the recipient to receive the full Part D low-income subsidy – no premium, no deductible, no coverage gap and very low cost-sharing. CMS estimates the value of the full LIS to be about $3,300 for 2007. Without this amendment, beneficiaries currently receiving QI and LIS would lose QI in 2008 and would be required to apply separately for LIS.

This amendment is intended to make a modest policy extension and a modest policy change, both non-controversial, yet very important for a worthy, vulnerable population. Low-income Medicare beneficiaries need and deserve the assistance and security provided under these proposals.

The Importance of Including Medicaid MCOs in Medicaid Drug Rebate Program

The amendment also will ensure that Medicaid managed care plans will have access to the same "best price" as traditional Medicaid and has the potential to save the federal government billions of dollars over five years. Currently, the Medicaid drug rebate ensures that State Medicaid programs receive the best price for prescription drugs for their Medicaid beneficiaries. Unfortunately, health plans that serve over 10 million Medicaid beneficiaries cannot access the same discounts through the federal drug rebate program. As a result, States pay more for the acquisition of prescription drugs for these health plan enrollees than for beneficiaries in fee-for-service Medicaid – ultimately raising the costs to Federal and State governments.

Even with this price disadvantage, the total cost of prescription drugs for health plans is less on a per member per month basis because of health plans' greater use of generics and case management. Unfortunately, many states are considering carving prescription drugs out from health plans for the sole purpose of obtaining the rebate – thereby undermining plans' ability to

maintain a comprehensive care and disease management program that includes prescription drugs.

This amendment would undue these distortions that will lead to inefficiencies and wasted federal dollars by ensuring that Medicaid MCOs have access to the same pricing as fee-for-service Medicaid. In addition, the amendment would include provisions to preserve the ability of health plans to coordinate care, protect the 340B drug discount program against "double dipping," and allows plans to maintain positive formularies while ensuring that plans comply with rules governing formularies and utilization management. Under this amendment, Medicaid beneficiaries would have access to all FDA-approved drugs through a prior authorization process, just as they do in the fee-for-service programs.

Last year, the Congressional Budget Office and the CMS Actuary estimated that this policy change would save the Federal government approximately $2 billion over 5 years. The core policy described in this offset was offered as an amendment to the Deficit Reduction Act of 2005 and was accepted by the Senate on a vote of 54 – 45 (vote number 291).

Contact: Frederick Isasi 4-0164

Kerry

KERRY/SMITH/BINGAMAN/WYDEN/LINCOLN AMENDMENT #1
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry/Smith/Bingaman/Wyden/Lincoln Amendment 1

Short Title: **S-CHIP Mental Health Parity**

Amendment Description:

The Chairman's mark does not include a provision to ensure that all S-CHIP enrollees receive adequate mental health and substance abuse benefits. While enrollees in Medicaid expansion states enjoy the protections afforded by EPSDT, those in separately-administered state plans have benefits based on benchmarks that do not include equal treatment for mental and physical conditions.

This amendment would adopt the language of S.1337, the "Children's Mental Health Parity Act," sponsored by Senators Kerry, Smith, Kennedy, and Domenici. The amendment would prohibit discriminatory limits on mental health care in SCHIP plans by directing that any financial requirements or treatment limitations that apply to mental health or substance abuse services must be no more restrictive than the financial requirements or treatment limits that apply to other medical services. It would also eliminate a provision in current law that authorizes states to lower the amount of mental health coverage they provide to children in SCHIP down to 75 percent of the coverage provided in the benchmark plans listed in the statute as models for states to use in developing their SCHIP plans.

CBO estimates the cost of this amendment at $200 million over five years.

Offset: Additional increase in the tobacco tax necessary to make budget-neutral.

Contact: Chris Dawe (Direct: 4-4030)

KERRY/BINGAMAN AMENDMENT #2
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry/Bingaman Amendment 2

Short Title: **State Option to Cover Legal Immigrant Children and Pregnant Women**

Amendment Description:

This amendment would adopt the language of S.764, the "Legal Immigrant Children's Health Improvement Act of 2007." Under current law, legally present pregnant women and children who entered the United States since August 22, 1996 are barred from Medicaid and SCHIP benefits for five years. More than 20 states already use their own funds to provide health care to at least some immigrants who are ineligible for Medicaid or SCHIP because of the five year bar. Under this amendment, the federal government would provide matching funds to states that opt to extend Medicaid or SCHIP coverage to immigrant children who are lawfully residing in the U.S. and who are otherwise eligible under the income standards of the State programs. Before 1996, states had the option to provide Medicaid coverage to this population, but access to Medicaid and SCHIP remains restricted for these children.

More than 500 organizations support ICHIA across the country, including the National Governors Association and the National Conference of State Legislators. The cost of this amendment is estimated to be $1.5 billion over five years.

Offset: Increase minimum rebate for Medicaid prescription drugs to extent necessary to make budget-neutral

Contact: Chris Dawe (Direct: 4-4030)

KERRY AMENDMENT #3
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry Amendment 3

Short Title: **State Option to Allow Small Business S-CHIP Buy-in**

Amendment Description:

This amendment would clarify existing law by making explicit state reimbursement for administrative costs associated with full-cost S-CHIP buy-in for individuals/families employed by businesses with fewer than 51 workers.

Cost and offset: TBD

Contact: Chris Dawe (Direct: 4-4030)

KERRY AMENDMENT #4
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry Amendment 4

Short Title: **Creation of a Medicaid and CHIP Payment and Access Commission**

Amendment Description:

This amendment would adopt the language of Section 502 in S. 1224. Similar to the Medicare Payment Advisory Commission (MedPAC), the Medicaid and CHIP Payment and Access Commission (MACPAC) will be an independent federal body established by law to advise the U.S. Congress on issues affecting the Medicaid and CHIP programs. It will advise Congress on Medicaid and CHIP payments and also analyze access to care, quality of care, and other issues affecting Medicaid.

Cost and offset: Senator Kerry does not believe this amendment will result in additional costs.

Contact: Chris Dawe (Direct: 4-4030)

KERRY AMENDMENT #5
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry Amendment 5

Short Title: **Unfair Treatment of Individuals Making Allowable Transfers Correction Amendment**

Amendment Description:

This amendment provides detail to the current law based on the stated intent of Congress with regard to transfers made for purposes other than becoming eligible for Medicaid. Current law provides for an exception to the transfer penalty rule for gifts to churches or charitable organizations, or helping family members pay for medical or educational expenses. Hence, transfers made exclusively for purposes other than to qualify for Medicaid are not subject to a Medicaid transfer penalty period. This amendment clarifies the intent of Congress in current law by providing a list of gifts that do not create a penalty. Further, the amendment protects victims of dementia and fraud from unfair treatment.

Cost and offset: TBD

Contact: Chris Dawe (Direct: 4-4030)

KERRY AMENDMENT #6
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry Amendment 6

Short Title: **Meaningful Hardship Waivers Technical Correction Amendment**

Amendment Description:

This amendment provides detail to the current law based on the stated intent of Congress and clarifies that, after an individual shows that an imposition of a transfer penalty would deprive the individual of needed medical care, food, clothing, shelter, or other necessities of life, the state must—without further evidence—provide for a hardship and not impose a penalty that would cause ineligibility. Under the DRA, Congress codified a hardship provision to ensure that a person would not be deprived of needed care and necessities notwithstanding the penalties imposed by the DRA for uncompensated transfers. Despite the language of the statue and its legislative history, there is evidence that various states have or will make access to the hardship provision more restrictive than contemplated by the statute.

Cost and offset: TBD

Contact: Chris Dawe (Direct: 4-4030)

KERRY AMENDMENT #7
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry Amendment 7

Short Title: **Allowing for the Return of Gifts Technical Correction Amendment**

Amendment Description:

The proposed technical correction language clarifies that once a penalty period is imposed, a partial refund of the transferred assets will result in a reduction of the period of ineligibility. This will encourage the return of transferred assets when such a return is possible. It also clarifies that under DRA rules an individual does not need to be in a nursing home for a penalty period to begin running. Rather, the individual must be financially eligible and in need of such services and would be receiving them but for the penalty period. This prevents the necessity of an individual entering a nursing home solely to trigger a penalty period, instead of receiving care at home and then having to leave the nursing home because there is no payment source. It further clarifies the rule that once a period of ineligibility begins, it will not be tolled if an individual leaves a nursing home or remains in the nursing home while his or her care is being paid for. This will prevent the untenable situation of periods of ineligibility only running while an individual is in a nursing home with no payment being made for his or her care.

Cost and offset: TBD

Contact: Chris Dawe (Direct: 4-4030)

KERRY AMENDMENT #8
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry Amendment 8

Short Title: **To provide sufficient funding to cover half of all uninsured children**

Amendment Description:

This amendment would increase the amount of per capita bonus payments (e.g. $75 for first 2% excess of enrollment baseline) by 50%, and convert the bonus to a percent of state spending per child equivalent in aggregate to the amounts in the mark. The amendment would also replace the $3 billion initial appropriate with "such sums as necessary but not more than $15 billion over 5 years."

Additionally, this amendment would make improvements to Medicare Savings Programs (MSPs) to provide assistance to low-income Medicare beneficiaries with Medicare cost sharing requirements. Specifically, it would make permanent the QI1 program, increase the assets limit for the low-income subsidy program, and raise the income threshold for qualifying for full premium assistance

Offset: Over two years, phase-down the benchmark for Private Fee-for-Service plans under Medicare Advantage to 100% of fee-for-service. Additionally, it would reduce the benchmark for other Medicare Advantage plans to 120% while creating a pool of funds to reward high-performing plans as measured by NCQA.

Contact: Chris Dawe (Direct: 4-4030)

KERRY/BINGAMAN AMENDMENT #9
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry/Bingaman Amendment 9

Short Title: **To provide sufficient funding and incentive to enroll half of all uninsured children**

Amendment Description:

This amendment would increase the amount of per capita bonus payments (e.g. $75 for first 2% excess of enrollment baseline) by 50%, and convert the bonus to a percent of state spending per child equivalent in aggregate to the amounts in the mark. The amendment would also replace the $3 billion initial appropriate with "such sums as necessary but not more than $15 billion over 5 years."

The estimated cost of this amendment is $15 billion.

Offset: Apply Medicaid rebate to drugs dispensed through managed care; increase taxes on cigarettes by an additional 25 cents (including corresponding proportional increase on other tobacco products); and increase minimum rebate for Medicaid prescription drugs to extent necessary to make budget-neutral.

Contact: Chris Dawe (Direct: 4-4030)

KERRY/BINGAMAN AMENDMENT #10
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry/Bingaman Amendment 10

Short Title: **To provide sufficient funding and incentive to enroll half of all uninsured children**

Amendment Description:

This amendment would increase the amount of per capita bonus payments (e.g. $75 for first 2% excess of enrollment baseline) by 50%, and convert the bonus to a percent of state spending per child equivalent in aggregate to the amounts in the mark. The amendment would also replace the $3 billion initial appropriate with "such sums as necessary but not more than $15 billion over 5 years."

The estimated cost of this amendment is $15 billion.

Offset: An increase in the tobacco tax that is sufficient to keep the mark revenue neutral.

Contact: Chris Dawe (Direct: 4-4030)

16	Kerry #5	Unfair Treatment of Individuals Making Allowable Transfers Correction Amendment.	To be determined.
17	Kerry #6	Meaningful Hardship Waivers Technical Correction Amendment.	To be determined.
18	Kerry #7	Allowing for the return of gifts technical correction amendment.	to be determined.
19	Kerry #8	To provide sufficient funding to cover half of all uninsured children.	Over two years, phase-down the benchmark for Private Fee-for-Service plans under Medicare Advantage to 100% of fee-for-service. Additionally, it would reduce the benchmark for other other Medicare advantage plans to 120% while creating a pool of funds to reward high performing plans as measured by NCQA.
20	Kerry/Bingaman #9	To provide sufficient funding and incentive to enroll half of all uninsured children.	Apply Medicaid rebate to drugs dispensed through managed care; increase taxes on cigarettes by an additional 25 cents (including corresponding proportional increase on other tobacco products) and increase minimum rebate for Medicaid prescription drugs to extent necessary to make budget-neutral.
21	Kerry/Bingaman #10	To provide sufficient funding and incentive to enroll half of all uninsured children.	An increase in the tobacco tax that is sufficient to keep the mark revenue neutral.

KERRY AMENDMENT #11
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry Amendment 11

Short Title: **To provide sufficient funding and incentive to enroll half of all uninsured children**

Amendment Description:

This amendment would increase the amount of per capita bonus payments (e.g. $75 for first 2% excess of enrollment baseline) by 50%, and convert the bonus to a percent of state spending per child equivalent in aggregate to the amounts in the mark. The amendment would also replace the $3 billion initial appropriate with "such sums as necessary but not more than $15 billion/5 years."

The estimated cost of this amendment is $15 billion.

Offset: This amendment is offset by closing the following corporate tax loopholes:

1) Codify the economic substance doctrine ($13.6 billion over ten years)
2) Repeal section 199 deduction for major integrated oil companies for income attributable to domestic production of oil and natural gas ($9.4 billion)
3) Change the tax treatment of individuals that expatriate ($444 million over ten years)
4) Modify the effective date of leasing provisions of the American Jobs Creation Act of 2004 ($3.25 billion over ten years)
5) Revises the corporate inversion effective date and makes other changes ($1.3 over ten years)
6) Eliminate the distinction between foreign oil and gas extraction income and foreign oil related income. ($3.2 billion over ten years)

Contact: Chris Dawe (Direct: 4-4030)

KERRY/BINGAMAN AMENDMENT #12
to
The Children's Health Insurance Program Reauthorization Act of 2007

Kerry/Bingaman Amendment 12

Short Title: **To provide sufficient funding and incentive to enroll half of all uninsured children**

Amendment Description:

This amendment would add $15 billion in funding to the Chairman's mark. The additional funding will be used to increase payments to the incentive fund, raise the amount of per capita bonus payments for enrollment above the baseline, and cover the additional costs of new enrollees.

The estimated cost of this amendment is $15 billion.

Offset: An increase in the tobacco tax that is sufficient to keep the mark revenue neutral.

Contact: Chris Dawe (Direct: 4-4030)

Lincoln

Lincoln-Salazar-Roberts Amendment #1 to The Children's Health Insurance Reauthorization Act of 2007

Purpose: To require the Secretary of Health and Human Services to provide adequate pharmacy reimbursement under Medicaid by amending Section 1927(e) of the Social Security Act to revise the definition and use of "Average Manufacturer Price" (AMP) in establishing Federal upper reimbursement limits.

Description of Amendment:

A June 2007 Office of Inspector General (OIG) report shows that the new formula mandated by the Deficit Reduction Act of 2005 (DRA), based on lowest AMPs, may result in some Federal upper limit amounts that are below pharmacy acquisition costs. This could occur because for certain drugs the lowest AMPs may not reflect prices generally available in the marketplace. The OIG and GAO in 2007 both expressed concerns that this situation could adversely affect access to pharmacies for Medicaid beneficiaries.

Under this amendment, the Secretary would calculate the Federal upper reimbursement limit as no less than 250 percent of the weighted, rather than lowest, average of the most recent average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The definition of AMP would be amended to exclude sales to mail order pharmacies, nursing home pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies (e.g. 340B-covered entities), government pharmacies, and rebates paid by manufacturers to pharmacy benefit managers for sales associated with all drugs in mail order and the retail class trade. The amendment would change the definition of multiple-source drug to ensure there must be two other drug products rather than one before the Federal upper limit can be applied.

Offset: To be provided.

Contact: Ashley Ridlon (Lincoln, 4-4843)
Karen Howard (Salazar, 8-5435)
Jennifer Swenson (Roberts, 4-4774)

Lincoln-Snowe-Kerry-Salazar Amendment #2 to
The Children's Health Insurance Reauthorization Act of 2007

Purpose: Optimizing care of high risk infants to assure optimal growth and development, and to prevent the major causes of re-hospitalization in the first year of life

Description of Amendment: This amendment would add a new measure to the list of items from which the HHS Secretary would have to report on child health quality measures for use by states with respect to Medicaid and CHIP, health insurance issuers and managed care entities that enter into contracts under Medicaid and CHIP, and providers under those two programs.

Language: Proposed additional language is in bold.

Sec. 501 (a) Development of Child Health Quality Measures For Children Enrolled in Medicaid or CHIP.

With consultation with specific groups (identified below), the Secretary must identify existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time. Based on such measures, the Secretary publish an initial core set of child health quality measures that includes, but is not limited to, the following: (1) duration of insurance coverage over a 12-month period, (2) availability of a full range of preventive services, treatments, and services for acute conditions, and treatments to correct or ameliorate the effects of chronic physical and mental conditions, (3) availability of care in a range of ambulatory and inpatient settings, **["(4) data on the development of measures that promote healthy birth and reduce the rate of premature birth, and]** (5) measures that, taken together, can be used to estimate the overall national quality of health care for children and to perform

Contact: Tony McClain (Lincoln, 4-4843)
Amy Pellegrino (Snowe, 4-5344)
Chris Dawe (Kerry, 4-2742)
Karen Howard (Salazar, 4-5852)

Lincoln Amendment #3 to The Children's Health Insurance Reauthorization Act of 2007

Purpose: To express a sense of the Senate that legislation passed by the Congress to reauthorize the State Children's Health Insurance Program should include optometry as a basic service required in any benchmark equivalent coverage package as part of the scope of health insurance coverage provided.

Description of Amendment:

(a) The Senate makes the following findings:

(1) Millions of children in the United States suffer from vision problems, many of which go undetected. Because children with vision problems can struggle developmentally, resulting in physical, emotional, and social consequences, good vision is essential for proper physical development and educational progress.

(2) Vision problems in children range from common conditions such as refractive errors, amblyopia, strabismus, ocular trauma, and infections, to rare but potentially life- or sight-threatening problems such as retinoblastoma, infantile cataracts, congenital glaucoma, and genetic or metabolic diseases of the eye.

(3) Since many serious ocular conditions are treatable if identified in the preschool and early school-aged years, early detection provides the best opportunity for effective treatment and can have far-reaching implications for vision.

(4) Various identification methods, including vision screening and comprehensive eye examinations required by State laws, can be helpful in identifying children needing services. A child identified as needing services through vision screening should receive a comprehensive eye examination followed by subsequent treatment as needed. Any child identified as needing services should have access to subsequent treatment as needed.

(5) There is a need to increase public awareness about the prevalence and devastating consequences of vision disorders in children and to educate the public and health care providers about the warning signs and symptoms of ocular and vision disorders and the benefits of early detection, evaluation, and treatment.

(b) It is the Sense of the Senate that legislation passed by the Congress to reauthorize the State Children's Health Insurance Program should include optometry as a basic service required in any benchmark equivalent coverage package as part of the scope of health insurance coverage provided.

Contact: Tony McClain (4-4843)

Wyden

AMENDMENT

Wyden Amendment #1 to The Children's Health Insurance Reauthorization Act of 2007

Short Title: Relief from 10% Cap for Voluntary Programs to Encourage Education, Screening and Behavior Modifications That Will Reduce Type 2 Juvenile Diabetes and Childhood Obesity

Description of Amendment: Type 2 juvenile diabetes is a growing epidemic in the United States. As an increasing number of children and adolescents in the U.S. become overweight and lead inactive lifestyles, health providers are identifying more children and adolescents with Type 2 juvenile diabetes.

In order to promote voluntary efforts to assist in the prevention and reduction in type 2 juvenile diabetes and childhood obesity, State CHIP and Medicaid programs are encouraged to develop incentive programs to promote children's receipt of relevant screenings and improvements in healthy eating and physical activity. Programs could involve reductions in cost-sharing or premiums when children receive regular screening and reach certain benchmarks in healthy eating and physical activity. States could also provide financial bonuses for partnerships with entities, such as schools, which increase their education and efforts in this area. States could also devise incentives for providers serving children covered under Titles XIX and XXI to perform relevant screening and counseling regarding healthy eating and physical activity.

State expenditures on such programs (outside of any direct benefits provided through SCHIP) can be paid out of administrative expense funds, subject to the 10% administrative cap. Should a state reach its administrative cap, it could draw up to 1% of any unused allotments to fund these activities.

Contact Name and Phone Number: Nicole Tapay (202) 224-7163

Schumer

SCHUMER AMENDMENT #1
to The Children's Health Insurance Reauthorization Act of 2007

Short Title: Diabetes Screening and Treatment in the SCHIP Program

Description of Amendment:
Amend Sec. 1397jj(a) of Title 42 of the U.S. Code by inserting a new clause after (27):
"(28) Diabetes screening and treatment including medical nutrition therapy (as defined in section 1861 (vv)(1)) for individual with diabetes or at risk for diabetes (as defined in section 1861 (yy))."

This language would ensure that individuals at risk for diabetes, especially overweight children, have access to diabetes screening and subsequent treatment. According to the Kaiser Family Foundation, only four states currently cover diabetes screenings for at-risk children.

The amendment is offset by the requisite increase in the Medicaid rebate for pharmaceutical manufacturers.

Staff Contact: Heather Langdon
224-7458
Heather_Langdon@schumer.senate.gov

SCHUMER AMENDMENT #2
to The Children's Health Insurance Reauthorization Act of 2007

Short Title: Diabetes Screening and Treatment in the Medicaid Program

Description of Amendment:
This amendment would guarantee Medicaid coverage of diabetes screenings for patients who are at-risk. For patients who are diagnosed with diabetes, it would guarantee Medicaid coverage of a package of diabetes services which includes diabetes education, insulin, and podiatric visits. It would also ensure that these diabetes services would not be subject to cost-sharing requirements. It is based on S. 755, the bipartisan Diabetes Screening and Medicaid Savings Act of 2007.

The amendment is offset by the requisite increase in the Medicaid rebate for pharmaceutical manufacturers.

Staff Contact: Heather Langdon
224-7458
Heather_Langdon@schumer.senate.gov

SCHUMER AMENDMENT #3
to The Children's Health Insurance Reauthorization Act of 2007

Short Title: State Employee Coverage

Description of Amendment:
Remove the current restriction on eligibility of children who have access to State Health Benefits programs, to allow children of state employees and others with access to the state health benefits program to enroll in CHIP if otherwise eligible, and provide for federal financial participation for such children.

The amendment is offset by the requisite increase in the Medicaid rebate for pharmaceutical manufacturers.

Staff Contact: Heather Langdon
224-7458
Heather_Langdon@schumer.senate.gov

SCHUMER AMENDMENT #4
to The Children's Health Insurance Reauthorization Act of 2007

Short Title: Parity for Territories

- **Description of Amendment:**
Change the first two paragraphs of Section 104 under "Explanation of Provision" to read as follows:

From the national CHIP appropriation, the allotments to the territories are calculated as follows. For FY2008, each territory's allotment is its highest annual federal CHIP spending between FY1998 and FY2007, plus the annual adjustment for health care cost growth and national child population growth. FY2007 spending will be determined by the Secretary based on the most timely and accurate published estimates of the Census Bureau. For FY2009 through FY2012, each territory's allotment is **110% of** the prior year's allotment, plus the annual adjustment for health care cost growth and national child population growth, **provided that the territory's projected CHIP expenditures for FY2009 to FY2012 are at least 10% more than the last year's allotment. The territory must submit to the Secretary by August 31 before the fiscal year information that the Secretary may require for the territory to demonstrate the need for the increase in the territory's allotment.**

~~For FY2008 and each fiscal year thereafter, federal matching payments for specified data reporting systems (i.e., the design, development, and operations of claims processing systems and citizenship documentation data systems) in each of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa would~~ **receive 90% reimbursement for costs attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement name and SSN validation, implementation of PERM requirements and other requirements of the S-CHIP and 75% for the operation of such systems,** without regard to the specified spending caps.

The amendment is offset by the requisite increase in the Medicaid rebate for pharmaceutical manufacturers.

Staff Contact: Heather Langdon
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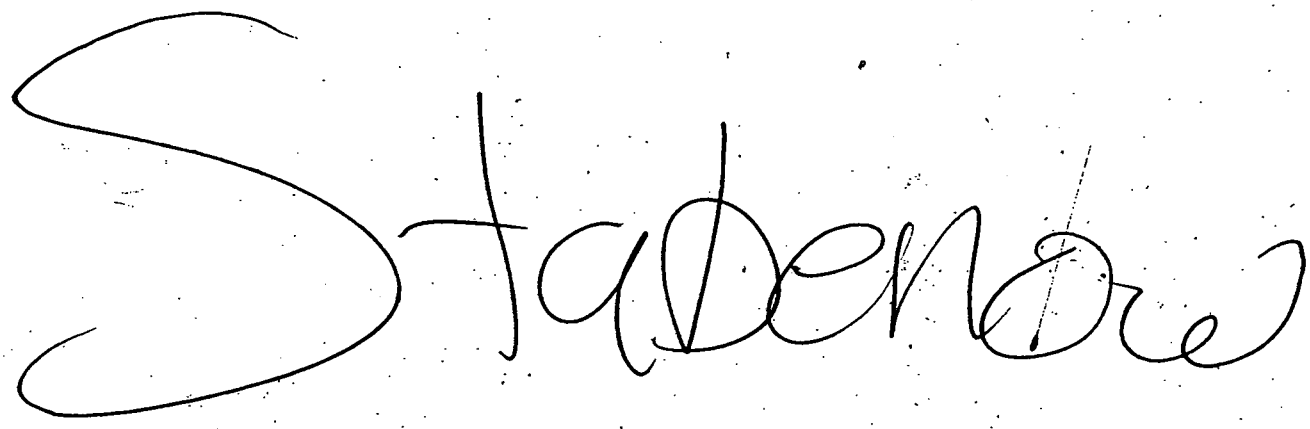


Stabenow Amendment #1 to the Reauthorization of the State Children's Health Insurance Program Act of 2007

Short title/purpose: To ensure parity for all waivers

Description of Amendment: This amendment would strike all dates in Section 106 as related to waivers for childless adult populations and replace them by moving the dates two years later. Applicable States would have to meet the same benchmarks required of States to retain parent coverage in FY10.

Offset: To the extent necessary, Medicaid drug rebates would be increased

Contact: Oliver Kim (4-2166)

Stabenow/Salazar/Bingaman/Wyden/Kerry Amendment #2 to the Reauthorization of the State Children's Health Insurance Program Act of 2007

Short title/purpose: To define the term "school based health centers" within the Social Security Act for recognition under the Medicaid and SCHIP provisions

Description of Amendment: The amendment would create a definition of "school based health center" within Titles XIX and XXI of the Social Security Act as a provider that 1) is located in or near a school facility of a school district or board or of an Indian tribe or tribal organization; 2) provides primary care services; 3) has an established referral link for specialty services with a hospital, community health center, Urban Indian Health Center, or similar provider; 4) and is certified by the State to deliver such services in compliance with any appropriate State laws or standards on scope of practice. SBHCs certified by a State are eligible for reimbursement in a State's Medicaid and SCHIP programs.

The amendment would also require the State plan to describe procedures to pay for medical assistance furnished in a SBHC certified by the State if payment would be made under the State plan for the same items and services if furnished in a physician's office or other outpatient clinic.

Offset: To the extent necessary, an increase in Medicaid drug rebates

Contact: Oliver Kim (4-2166)

Stabenow Amendment #3 to the Reauthorization of the State Children's Health Insurance Program Act of 2007

Purpose: To increase appropriations for pediatric health quality and information technology demonstration projects to develop a model electronic health record

Description of Amendment: This amendment would provide an additional appropriation of $20 million annually from FY10 through FY12 for Section 501 for the purpose of implementing a model electronic health record as described in Section 501(e).

In developing and disseminating a model electronic health record format for children, the Secretary of Health and Human Services shall award no more than 10 demonstration grants to State applicants beginning FY10. At least 4 of the grants must be awarded to States that intend to establish personal health records in rural areas; 1 of the grants must be awarded to a State that will coordinate with an Indian tribe; and 1 of the grants must be awarded to a State with an existing public health authority created by an agreement between a metropolitan city, a county and a state that is charged with developing strategies to strengthen the safety net and has a goal of finding a primary care clinic (medical home) for children on Medicaid or SCHIP.

The Secretary of Health and Human Services would be instructed to give preference to States that have selected an area with demonstrable coordination among State and local officials and health care providers or has an existing community consortium that can demonstrate past successful community-wide efforts to improve the quality of care provided and the coordination of care for the medically underserved. In addition, preference would be given to those States or community consortiums that plan to use electronic health record information to reduce the incidence and effects of chronic childhood conditions such as obesity, diabetes, hypertension, and asthma.

The State must define the geographic area or areas within the State that would establish personal health records for children; identify a nonprofit or public entity to maintain the personal health records; provide evidence that local providers are committed to participating in the program; and assure that any standards related to interoperability adhere to standards recognized or adopted by the Secretary of HHS. Additionally, the State must allow families to opt out of the program at any time and must provide families with a plain language explanation of their privacy rights with respect to their personal health records. The electronic health record must meet all security and privacy laws of the State in which the demonstration program is conducted and federal HIPAA security and privacy standards. States would be required to establish a procedure to notify a family if a child's health information is wrongly disclosed.

Personal health records must contain the following information: allergies and adverse drug reactions; current medications; illnesses for which the child sought medical care or outpatient care; surgeries or other inpatient or outpatient medical procedures; vaccinations; lab results and family medical history. At State option, the personal health

record may also include additional information to allow a State agency to access the record to determine eligibility for public programs.

A community consortium is a consortium whose principal purpose is to provide a broad range of coordinated health care services to a community and includes, at least, a FQHC, a hospital with a low-income utilization that is greater than 25 percent, a public health department, and an interested public or private health care provider or an organization that has traditionally served the medically underserved.

The HHS Secretary would be required to provide for an ongoing, independent, evaluation of the demonstration program and submit annual reports to Congress that includes information on the number of children participating in the program, the ability of health care workers to access the personal health records, and the extent to which the use of personal health records reduced health care costs.

This amendment also includes a Sense of the Senate Resolution that not later than September 30, 2017 every child enrolled in Medicaid and SCHIP should have an electronic health record.

Offset: To the extent necessary, an increase in Medicaid drug rebates

Contact: Oliver Kim (4-2166)

Salazar

Salazar/Bingaman Amendment #1 to the Children's Health Insurance Reauthorization Act of 2007

Purpose: To require the Secretary of Health and Human Services to conduct a demonstration project under section 1115 of the Social Security Act to provide nurse home visitation services under Medicaid and CHIP. Also requires the Department of Health and Human Services to conduct a study regarding the cost- effectiveness of nurse home visitation programs.

Description of Amendment: This amendment is based on the Healthy Children and Families Act (S. 1052). It would allocate $100M/5years to award grants to states to implement and/or expand evidence-based nurse home visitation programs for first-time, low-income pregnant women. The amendment would require the Secretary to conduct a study on the cost-effectiveness of the program. Nurse home visitation programs provide low-income pregnant women and their children with visits from trained registered nurses from early in the mother's pregnancy through the child's second birthday. The nurses counsel their clients on prenatal care, child health and development, nutrition, parenting skills, healthy family relationships, educational development and a variety of other services to promote healthy children and families.

A Rand Corporation study recently found that for every $1 spent on evidence-based nurse home visitation programs, society saved $5.70 in reduced emergency room expenditures and criminal justice and social costs. Studies have shown that evidence-based nurse home visitation programs result in:

- Better pregnancy outcomes, including 79% reduction in preterm delivery for women who smoke and reductions in high-risk pregnancies as a result of greater intervals between first and subsequent births;
- 48% reduction in child abuse and neglect;
- 59% reduction in child arrests;
- 61% fewer arrests of the mother;
- 72% fewer conviction for the mother;
- 46% increase in father presence in household;
- 32% fewer subsequent pregnancies;
- 50% reduction in language delays of child age 21 months;
- 67% reduction in behavioral/intellectual problems at age 6.

Offset: Increase pharmaceutical rebate under Medicaid and/or expand Medicaid drug rebate paid by manufacturers to include managed Care Organizations

Contact: Karen Howard (8-5435)
Ashley Wheeland (8-5434)

Salazar/Roberts/Bingaman Amendment #2 to the Children's Health Insurance Act of 2007

Purpose: Under the State Children's Health Insurance Program (SCHIP) expansion programs, Federally Qualified Health Centers (FQHC) are reimbursed under the FQHC Medicaid Prospective Payment System (PPS). However, under SCHIP separate and combination programs, FQHCs are reimbursed on a fee-for-service basis. Fee-for-service reimbursements are typically lower than the Medicaid Prospective Payment System, resulting in financial losses to health centers. Currently, FQHCs in 16 states receive fee-for-service reimbursements. The payment disparity has resulted in financial losses to the FQHCs in 16 states of $20 million annually.

Description of Amendment: This amendment would establish a Federally Qualified Health Center prospective payment system in SCHIP similar to the payment system established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) for FQHC services provided under Medicaid. Under the amendment, states that operate separate and/or combination SCHIP programs will be required to reimburse FQHCs based on the Medicaid Prospective Payment System.

Offset: Increase in the Medicaid pharmaceutical drug rebate

Contact: Karen Howard (8-5435)
Ashley Wheeland (8-5434)

Salazar Amendment #3 to the Children's Health Insurance Reauthorization Act of 2007

Purpose: The Centers for Medicare and Medicaid Services (CMS) recently changed its long-standing interpretation of the rehabilitation option under Medicaid law to disallow reimbursement for services that allow disabled beneficiaries to attain their highest functioning ability under the argument that Medicaid covers only those services that "restore" a person's abilities. CMS' new interpretation of the rehabilitation option deprives Medicaid beneficiaries, particularly beneficiaries who are mentally ill and developmentally disabled, comprehensive services that enable them to function and live independently. CMS has recently announced its intention to promulgate rulemaking to codify its new interpretation. This amendment would clarify statutory language that rehabilitation services include services to restore, retain and attain independent functioning.

Description of Amendment: This amendment would change the statutory language for Medicaid rehabilitative services for billing assessments to include services to restore, retain or attain independent functioning.

Offset: To be decided

Contact: Karen Howard (8-5435)
Ashley Wheeland (8-5434)

Salazar Amendment #4 to the Children's Health Insurance Reauthorization Act of 2007

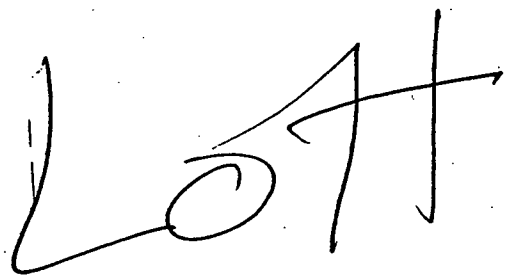
Purpose: The Centers for Medicare and Medicaid Services (CMS) has announced its intention to promulgate two new regulations that restrict the type of community-based services typically provided to people with disabilities through the rehabilitative services option and eliminate certain school-based services provided to children with mental and physical disabilities. The purpose of this amendment is to impose a one-year moratorium on CMS's rulemaking in order to permit the Senate Committee on Finance to exercise its jurisdiction over this important issue.

Description of Amendment: This amendment imposes a one-year moratorium on CMS from taking any action (through promulgation of regulation, issuance of regulatory guidance, use of federal payment audit and disallowance procedures, or other administrative action, policy or practice) to –

(1) finalize or otherwise implement regulations with respect to the rehabilitative services described in Section 1905(a)(13) under title XIX of the Social Security Act
(2) place restrictions on coverage of or payment for school-based administration, transportation or medical services under title XIX of such Act.

Offset: To be provided

Contact: Karen Howard (8-5435)
Ashley Wheeland (8-5434)



Lott Amendment #1 to the Children's Health Insurance Program Reauthorization Act of 2007

Short Title: An amendment to re-focus SCHIP resources on children and assist in providing families the resources to provide for their children's health and well-being

Description of Amendment: The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would also strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP" as they pertain to enrollment of adults. The amendment would increase the child tax credit (IRC section 24) to $1,080 for 2008. [Adjustments will be made, if necessary, to conform with revenue-neutrality.]

Contact: King Mueller (4-6584) and John O'Neill (4-0721)

Lott Amendment #2 to the Children's Health Insurance Program Reauthorization Act of 2007

Short Title: An amendment to re-focus SCHIP resources on children and assist in providing families the resources to provide for their children's health and well-being

Description of Amendment: The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would also strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP" as they pertain to enrollment of adults. The amendment would extend the college tuition deduction (IRC section 222) through the end of 2008. [Adjustments will be made, if necessary, to conform with revenue-neutrality.]

Contact: King Mueller (4-6584) and John O'Neill (4-0721)

Lott Amendment #3 to the Children's Health Insurance Program Reauthorization Act of 2007

Short Title: An amendment to re-focus SCHIP resources on children and assist in providing families the resources to provide for their children's health and well-being

Description of Amendment: The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would also strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP" as they pertain to enrollment of adults. The amendment would reduce the 10 percent income tax bracket to 9.6 percent for 2008. [Adjustments will be made, if necessary, to conform with revenue-neutrality.]

Contact: King Mueller (4-6584) and John O'Neill (4-0721)

Lott Amendment #4 to the Children's Health Insurance Program Reauthorization Act of 2007

Short Title: An amendment to re-focus SCHIP resources on children and assist in providing families the resources to provide for their children's health and well-being

Description of Amendment: The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would also strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP" as they pertain to enrollment of adults. The amendment would allow the personal exemption to be claimed under the Alternative Minimum Tax with respect to children. [Adjustments will be made, if necessary, to conform with revenue-neutrality.]

Contact: King Mueller (4-6584) and John O'Neill (4-0721)

Lott Amendment #5 to the Children's Health Insurance Program Reauthorization Act of 2007

Short Title: An amendment to re-focus SCHIP resources on children and assist in providing families the resources to provide for their children's health and well-being

Description of Amendment: The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would also strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP" as they pertain to enrollment of adults. The amendment would reduce the tobacco excise tax by 3 percent of the otherwise applicable tax. [Adjustments will be made, if necessary, to conform with revenue-neutrality.]

Contact: King Mueller (4-6584) and John O'Neill (4-0721)

Lott Amendment #6 to the Children's Health Insurance Program Reauthorization Act of 2007

Short Title: An amendment to re-focus SCHIP resources on children and assist in providing families the resources to provide for their children's health and well-being

Description of Amendment: The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would also strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP" as they pertain to enrollment of adults. The amendment would eliminate the increase in the excise tax on "large cigars" under the Chairman's Mark. [Adjustments will be made, if necessary, to conform with revenue-neutrality.]

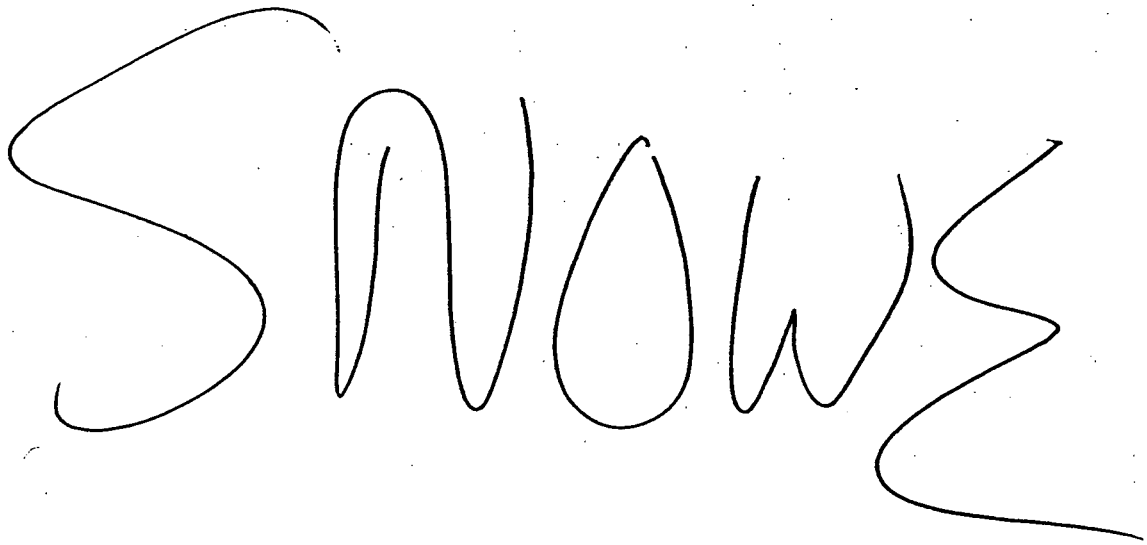
Contact: King Mueller (4-6584) and John O'Neill (4-0721)

Lott Amendment #7 to the Children's Health Insurance Program Reauthorization Act of 2007

Short Title: An amendment to re-focus SCHIP resources on children

Description of Amendment: The amendment would apply the provisions of section 106 of the Chairman's Mark for non-pregnant childless adults to all non-pregnant adults. The amendment would also strike the provisions under section 301 of the Chairman's Mark with respect to the "verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP" as they pertain to enrollment of adults. The amendment would apply any savings from reduced outlays to deficit reduction. [Adjustments will be made, if necessary, to conform with revenue-neutrality.]

Contact: King Mueller (4-6584) and John O'Neill (4-0721)


SNOWS

Snowe Amendment #1

Childhood Obesity Demonstration Project

Summary:

The Secretary of Health and Human Services is given the authority to conduct a demonstration project in order to develop a comprehensive and systematic plan for reducing childhood obesity. For purposes of this section, $125 million ($25 million for each of fiscal years 2008-2012) is authorized to be appropriated.

Offset:

Background:

The Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such project. The model will --

- Identify behavioral risk factors for obesity among children;
- Identify needed clinical preventive and screening benefits among those children identified as target individuals on the basis of such risk factors;
- Provide ongoing support to such target individuals and their families to reduce risk factors and promote the appropriate use of preventive and screening benefits; and
- Be designed to improve health outcomes, satisfaction, quality of life, and appropriate use of items and services for which medical assistance is available under S-CHIP and Medicaid

Eligible Entities: Eligibility entities include a city, county, or Indian tribe; a local or tribal educational agency; an accredited university, college, or community college; a federally-qualified health center; a local health department; a health care provider; a community-based organization; or any other entity determined appropriate by the Secretary, including a consortia or partnership An eligible entity awarded a grant under this section shall use the funds made available under the grant to--

1. **Carry out community-based activities related to reducing childhood obesity, including**

- forming partnerships with entities, including schools and other facilities providing recreational services, to establish programs for after school and weekend community activities that are designed to reduce childhood obesity;
- forming partnerships with daycare facilities to establish programs that promote healthy eating behaviors and physical activity; and
- developing and evaluating community educational activities targeting good nutrition and promoting healthy eating behaviors.

2. Carry out age-appropriate school-based activities that are designed to reduce childhood obesity, including by-

- developing and testing educational curricula and intervention programs designed to promote healthy eating behaviors and habits in youth

- providing education and training to educational professionals regarding how to promote a healthy lifestyle and a healthy school environment for children;

- planning and implementing a healthy lifestyle curriculum or program with an emphasis on healthy eating behaviors and physical activity; and

- planning and implementing healthy lifestyle classes or programs for parents or guardians, with an emphasis on healthy eating behaviors and physical activity for children;

3. Carry out activities through the local health care delivery systems including --

promoting healthy eating behaviors and physical activity services to treat or prevent eating disorders, being overweight, and obesity;

providing patient education and counseling to increase physical activity and promote healthy eating behaviors;

training health professionals on how to identify and treat obese and overweight individuals which may include nutrition and physical activity counseling; and

providing community education by a health professional on good nutrition and physical activity to develop a better understanding of the relationship between diet, physical activity, and eating disorders, obesity, or being overweight; and

4. Provide, through qualified health professionals, training and supervision for community health workers to--

Educate families regarding the relationship between nutrition, eating habits, physical activity, and obesity;

educate families about effective strategies to improve nutrition, establish healthy eating patterns, and establish appropriate levels of physical activity; and

educate and guide parents regarding the ability to model and communicate positive health behaviors.

Report to Congress- Not later than 3 years after the date the Secretary implements the demonstration project under this section, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates the beneficiary satisfaction under the project, and includes any such other information as the Secretary determines to be appropriate.

Staff contact: Amy Pellegrino (4-8673)

Snowe / Bingaman Amendment #1
SCHIP Dental and Mental Health Mandate and Dental Wrap

Summary: Requires benefits provided under SCHIP (title XXI) to include dental and mental health services to the level provided under Medicaid. In addition, would permit, at a state option, the provision of dental health coverage to children enrolled in private insurance that does not include such benefits (i.e., "wrap around" SCHIP coverage of dental services.)

Offset: Increase the minimum Medicaid drug rebate to the extent necessary

Background:

Overview of the Need for Children's Dental Mandate and Wrap in SCHIP

Dental caries (tooth decay) remains the most prevalent chronic disease of U.S. children. The disease is infectious and preventable and left untreated it can impede a child's ability to eat, speak, smile and learn. Minority, low-income, and geographically isolated children suffer disproportionately from dental caries – in fact, 80 percent of all tooth decay is found in 25 percent of children. Low-income children who have their first preventive visit by age one are not only less likely to have subsequent restorative or emergency room visits, but their average dentally related costs are almost 40 percent lower ($263 compared to $447) over a five year period than children who receive their first preventive visit after age one.[i]

Despite the magnitude of need, dental coverage remains an optional benefit in SCHIP. States have recognized that poor oral health affects children's general health and have opted to provide dental coverage, Tennessee recently dropped their benefit to become the only state currently that does not have a dental benefit in SCHIP. A 2000 report referenced by the US Surgeon General estimates that 20 percent more children lack dental than medical coverage.[ii]

Children who receive medical benefits through their parent's employer-sponsored plan are not eligible for dental coverage through SCHIP, even if they meet the income and other eligibility standards. Although SCHIP funds can be used to help pay for employer-based coverage, SCHIP cannot provide supplemental dental coverage.

Overview of the Need for Children's Mental Health Mandate in SCHIP[1]

Mental disorders affect about one in five American children and five to nine percent experience serious emotional disturbances that severely impair their functioning. Children from low-income households are at increased risk of mental health problems and research has indicated that children in Medicaid and SCHIP have a much higher prevalence of mental health problems than other insured children or even uninsured children. Tragically, a large majority of children struggling with these mental disorders (79% by some estimates) do not receive the mental health services they need. Not surprisingly, uninsured children have a higher rate of unmet need than children with public or private insurance.

More than just a problem for the uninsured, children covered by private or public health plans have serious coverage gaps that prevent them from obtaining needed mental health services. For instance, private health

[1] From the testimony of Chris Koyanagi, Policy Director, Bazelon Center for Mental Health Law. US. House Energy and Commerce Committee, March 27,2007.

plans set arbitrary limits on mental health coverage, such as caps on the number of times a child may be seen by a therapist over the course of a year. Approximately 68% of Americans under the age of 18 are covered by private insurance, while public programs (such as Medicaid and SCHIP) cover about 19 percent.

Within the public sector, discriminatory limits on mental health services in SCHIP that would not be permissible in Medicaid have restricted access to care for children and adolescents. Additionally, current Administrative activities that restrict reimbursement under the Medicaid rehabilitative services option limit access to a range of critical community-based services for children and adults that help them remain in the community—a goal supported by the President's Commission on Mental Health. Without early and effective identification and intervention, childhood mental disorders can lead to a downward spiral of school failure, poor employment outcomes, and, later poverty in adulthood. Untreated mental illness may also increase a child's risk of coming into contact with the juvenile justice system, and children with mental disorders are a much higher risk of suicide. According to the Surgeon General, an estimated 90% of children who commit suicide have a mental disorder.

Fortunately, poor outcomes for children with mental health needs can be prevented with access to appropriate services. SCHIP has generally been very successful in expanding health care coverage to millions of previously uninsured children, and states that simply expanded their Medicaid programs to cover these additional children offer comprehensive mental health services. However, states have the option to establish stand-alone SCHIP plans that are separate from their Medicaid programs and modeled after private insurance benchmark plans. Unfortunately, many states have adopted limits on mental health services that would not be permissible in Medicaid, including caps on inpatient and outpatient care.

A study of SCHIP managed care plans found wide variations in the scope and limits of mental health treatment, with many states limiting outpatient services to 20 visits and inpatient days to 30 or less. These limits are not based on the medical needs of beneficiaries or best practice guidelines and result in coverage that is wholly inadequate for children with mental disorders. Another study found that children with complex mental health needs would have access to full coverage of needed services in only approximately 40 percent of states due to limited benefits in SCHIP plans.

Furthermore, language in the SCHIP statute even allows states to provide significantly less mental health coverage in their separate SCHIP plans than is covered in the benchmark plan they select. The law allows states that opt to create a separate plan to reduce the actuarial value of the mental health benefit by 25 percent—that is, the mental health benefit in SCHIP need only be actuarially equivalent to 75% of the benefit in the benchmark plan itself. This statutory provision authorizes states to establish SCHIP benefit packages that are totally inadequate for treating the great majority of childhood mental disorders. This provision allowing the reduction of mental health benefits to 75 percent of the mental health benefits in the benchmark plans must be eliminated,

Contact: Amy Pellegrino 4-5344 and Frederick Isasi 4-0164

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[i] Savage Matthew, Lee Jessica, Kotch Jonathan, Vann Jr. William. Early Preventive Visits: Effects on Subsequent Utilization and Costs. Pediatrics114: 418-423, 2004.

[ii] Vargas CM, Isman RE, Crall JJ. Comparison of children's medical and dental insurance coverage, United States 1995. Journal of Public Health Dentistry. 2002; 62(1):38-44.

Snowe / Bingaman Amendment #2
SCHIP Dental and Mental Health Mandate and Dental Wrap

Summary: Requires benefits provided under SCHIP (title XXI) to include dental and mental health services to the level provided under Medicaid. In addition, would permit, at a state option, the provision of dental health coverage to children enrolled in private insurance that does not include such benefits (i.e., "wrap around" SCHIP coverage of dental services.)

Offset: Expand the Medicaid drug rebate paid by pharmaceutical manufactures to include Medicaid Manage Care Organizations (MCOs).

Background:

Overview of the Need for Children's Dental Mandate and Wrap in SCHIP

Dental caries (tooth decay) remains the most prevalent chronic disease of U.S. children. The disease is infectious and preventable and left untreated it can impede a child's ability to eat, speak, smile and learn. Minority, low-income, and geographically isolated children suffer disproportionately from dental caries – in fact, 80 percent of all tooth decay is found in 25 percent of children. Low-income children who have their first preventive visit by age one are not only less likely to have subsequent restorative or emergency room visits, but their average dentally related costs are almost 40 percent lower ($263 compared to $447) over a five year period than children who receive their first preventive visit after age one.[i]

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Mental disorders affect about one in five American children and five to nine percent experience serious emotional disturbances that severely impair their functioning. Children from low-income households are at increased risk of mental health problems and research has indicated that children in Medicaid and SCHIP have a much higher prevalence of mental health problems than other insured children or even uninsured children. Tragically, a large majority of children struggling with these mental disorders (79% by some estimates) do not receive the mental health services they need. Not surprisingly, uninsured children have a higher rate of unmet need than children with public or private insurance.

[1] From the testimony of Chris Koyanagi, Policy Director, Bazelon Center for Mental Health Law. US. House Energy and Commerce Committee, March 27,2007.

More than just a problem for the uninsured, children covered by private or public health plans have serious coverage gaps that prevent them from obtaining needed mental health services. For instance, private health plans set arbitrary limits on mental health coverage, such as caps on the number of times a child may be seen by a therapist over the course of a year. Approximately 68% of Americans under the age of 18 are covered by private insurance, while public programs (such as Medicaid and SCHIP) cover about 19 percent.

Within the public sector, discriminatory limits on mental health services in SCHIP that would not be permissible in Medicaid have restricted access to care for children and adolescents. Additionally, current Administrative activities that restrict reimbursement under the Medicaid rehabilitative services option limit access to a range of critical community-based services for children and adults that help them remain in the community—a goal supported by the President's Commission on Mental Health. Without early and effective identification and intervention, childhood mental disorders can lead to a downward spiral of school failure, poor employment outcomes, and, later poverty in adulthood. Untreated mental illness may also increase a child's risk of coming into contact with the juvenile justice system, and children with mental disorders are a much higher risk of suicide. According to the Surgeon General, an estimated 90% of children who commit suicide have a mental disorder.

Fortunately, poor outcomes for children with mental health needs can be prevented with access to appropriate services. SCHIP has generally been very successful in expanding health care coverage to millions of previously uninsured children, and states that simply expanded their Medicaid programs to cover these additional children offer comprehensive mental health services. However, states have the option to establish stand-alone SCHIP plans that are separate from their Medicaid programs and modeled after private insurance benchmark plans. Unfortunately, many states have adopted limits on mental health services that would not be permissible in Medicaid, including caps on inpatient and outpatient care.

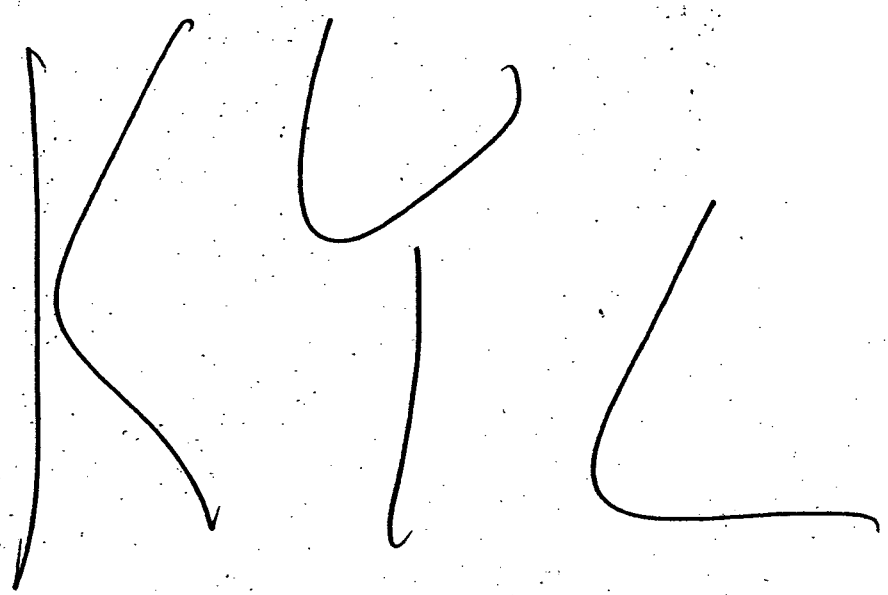
A study of SCHIP managed care plans found wide variations in the scope and limits of mental health treatment, with many states limiting outpatient services to 20 visits and inpatient days to 30 or less. These limits are not based on the medical needs of beneficiaries or best practice guidelines and result in coverage that is wholly inadequate for children with mental disorders. Another study found that children with complex mental health needs would have access to full coverage of needed services in only approximately 40 percent of states due to limited benefits in SCHIP plans.

Furthermore, language in the SCHIP statute even allows states to provide significantly less mental health coverage in their separate SCHIP plans than is covered in the benchmark plan they select. The law allows states that opt to create a separate plan to reduce the actuarial value of the mental health benefit by 25 percent—that is, the mental health benefit in SCHIP need only be actuarially equivalent to 75% of the benefit in the benchmark plan itself. This statutory provision authorizes states to establish SCHIP benefit packages that are totally inadequate for treating the great majority of childhood mental disorders. This provision allowing the reduction of mental health benefits to 75 percent of the mental health benefits in the benchmark plans must be eliminated,

Contact: Amy Pellegrino 4-5344 and Frederick Isasi 4-0164

Savage Matthew, Lee Jessica, Kotch Jonathan, Vann Jr. William. Early Preventive Visits: Effects on Subsequent Utilization and Costs. Pediatrics114: 418-423, 2004.

Vargas CM, Isman RE, Crall JJ. Comparison of children's medical and dental insurance coverage, United States 1995. Journal of Public Health Dentistry. 2002; 62(1):38-44.



KYL AMENDMENT #1
The Children's Health Insurance Reauthorization Act of 2007

Short Title: Preventing the Erosion of Private Health Coverage

Amendment Description: Prior to the effective date of the Act, the Congressional Budget Office must certify that the bill will not result in a "crowd out" effect (i.e. a reduction in private coverage due to SCHIP) of greater than 20 percent.

Effective date: Upon enactment.

Cost: A cost estimate is not available.

Contact Name and Phone Number: Jennifer M. Romans, 224-2176

KYL AMENDMENT #2
The Children's Health Insurance Reauthorization Act of 2007

Short Title: Protecting Children's Health Coverage

Amendment Description: Prior to the effective date of the Act, the Congressional Budget Office must certify that the bill would not result in reduced enrollment or a change in covered benefits from fiscal year 2013 through fiscal year 2017.

Effective date: Upon enactment.

Cost: A cost estimate is not available.

Contact Name and Phone Number: Jennifer M. Romans, 224-2176

KYL AMENDMENT #3
The Children's Health Insurance Reauthorization Act of 2007

Short Title: Repeal of the Alternative Minimum Tax

Amendment Description: To repeal the individual Alternative Minimum Tax.

Effective date: January 1, 2007

Cost: No offset will be provided.

Contact Name and Phone Number: Lisa Wolski, 224-4521

KYL AMENDMENT #4
The Children's Health Insurance Reauthorization Act of 2007

Short Title: Waiving AMT Penalties and Interest

Amendment Description: To waive any penalties and interest that would be imposed on taxpayers for the 2007 tax year if Congress fails to extend the current individual Alternative Minimum Tax exemption levels, indexed for inflation, and other AMT hold-harmless provisions.

Effective date: January 1, 2007

Cost: No offset will be provided.

Contact Name and Phone Number: Lisa Wolski, 224-4521

KYL AMENDMENT #5
The Children's Health Insurance Reauthorization Act of 2007

Short Title: Small Cigars Modification

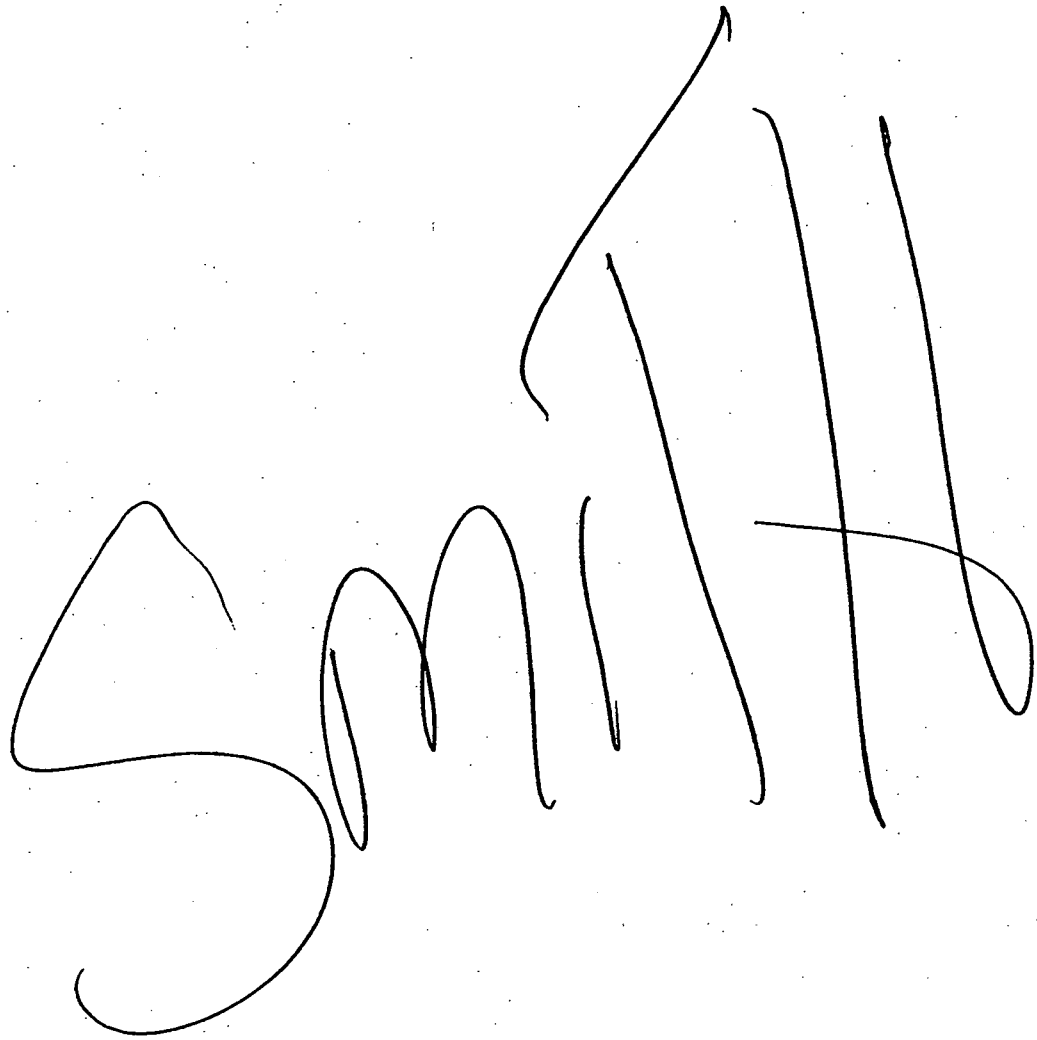
Amendment Description: To modify the tax imposed on "small cigars" so that the tax increase for small cigars is proportional to the tax increase proposed for small cigarettes. The modification would only apply to small cigars that are certified as traditional small cigars.

The tax on small cigarettes is proposed to increase from $19.50 per thousand to $50 per thousand—a 156.4% increase. The amendment would increase the current tax on small cigars by 156.4%, rather than by the amount proposed in the Chairman's Mark.

Effective date: January 1, 2008

Cost: No offset will be provided.

Contact Name and Phone Number: Lisa Wolski, 224-4521



Smith Amendment #1 to
The Children's Health Insurance Program Reauthorization Act of 2007

Short Title: Ensuring seamless transition to new citizen documentation system

Description of Amendment: To amend Section 301 of the bill to require the Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA) to work with states to develop a seamless transition to the new citizen documentation process, phased-in over a six month period.

Offset: Senator Smith does not believe this policy will result in additional costs.

Contact: Catherine Finley, 224-8325

Smith Amendment #2 to
The Children's Health Insurance Program Reauthorization Act of 2007

Short Title: Family and Small to Medium Sized Business Premium Assistance Purchasing Pool

Description of Amendment: To allow states under premium assistance to organize a pooling arrangement for SCHIP-eligible families and employers who have SCHIP-eligible employees or their children to purchase from at least two privately delivered health insurance policies and receive an SCHIP subsidy for eligible persons.

Offset: Senator Smith does not believe this policy will result in additional costs.

Contact: Catherine Finley, 224-8325

Smith Amendment #3 to
The Children's Health Insurance Program Reauthorization Act of 2007

Short Title: Supplemental Security Income (SSI) Extension for Elderly and Disabled Asylees and Refugees

Description of Amendment: To extend SSI benefits for an additional two years, with a potential third year for those awaiting a pending naturalization claim, for disabled and elderly refugees, asylees and other qualified humanitarian immigrants, including those whose benefits have expired in the recent past.

The amendment is based upon language included in S.821 and H.R. 2608, the "SSI Extension for Elderly and Disabled Refugees Act," of the 110th Congress.

Offset: Reduction of Federal tax refunds to recover unemployment insurance debts due to fraud.

Contact: Lindsay Morris, 224-8710

Smith Amendment #4 to
The Children's Health Insurance Program Reauthorization Act of 2007

Short Title: Early Treatment for HIV Medicaid Demonstration Projects

Description of Amendment: Directs the Secretary of Health and Human Services to establish state-based demonstration projects to provide Medicaid coverage to certain low-income, HIV-infected individuals. The cost of the projects could not exceed $500 million over five years, the amount authorized in the Fiscal Year 2008 Budget Resolution.

The amendment is based upon language included in S.860, "Early Treatment for HIV Act of 2007" of the 110th Congress.

Offset: To be provided.

Contact: Matt Canedy, 224-5100

Smith Amendment #5 to
The Children's Health Insurance Program Reauthorization Act of 2007

Short Title: Pathways to Independence Act of 2007

Description of Amendment: To give states more flexibility to meet work participation standards in the Temporary Assistance for Needy Families (TANF) program for individuals with disabilities that will help move them toward gainful employment, including individuals with mental and physical impairments, including substance abuse or addiction.

The amendment is based upon language included in S. 1730, Pathways to Independence Act of 2007, 110th Congress.

Offset: There is no cost associated with this amendment.

Contact: Jill Canino, 224-8699

Smith (Bingaman) Amendment #6 to
The Children's Health Insurance Program Reauthorization Act of 2007

Short Title: Home and Community-Based Services Copayment Equity Act

Description of Amendment: The amendment waives Medicare Part D cost-sharing for dual eligible beneficiaries who receive long-term care services in home and community based settings.

The amendment is based upon language included in S.1107, 110th Congress.

Offset: To be provided.

Contact: Matt Canedy, 224-5100

Smith (Bingaman) Amendment #7 to
The Children's Health Insurance Program Reauthorization Act of 2007

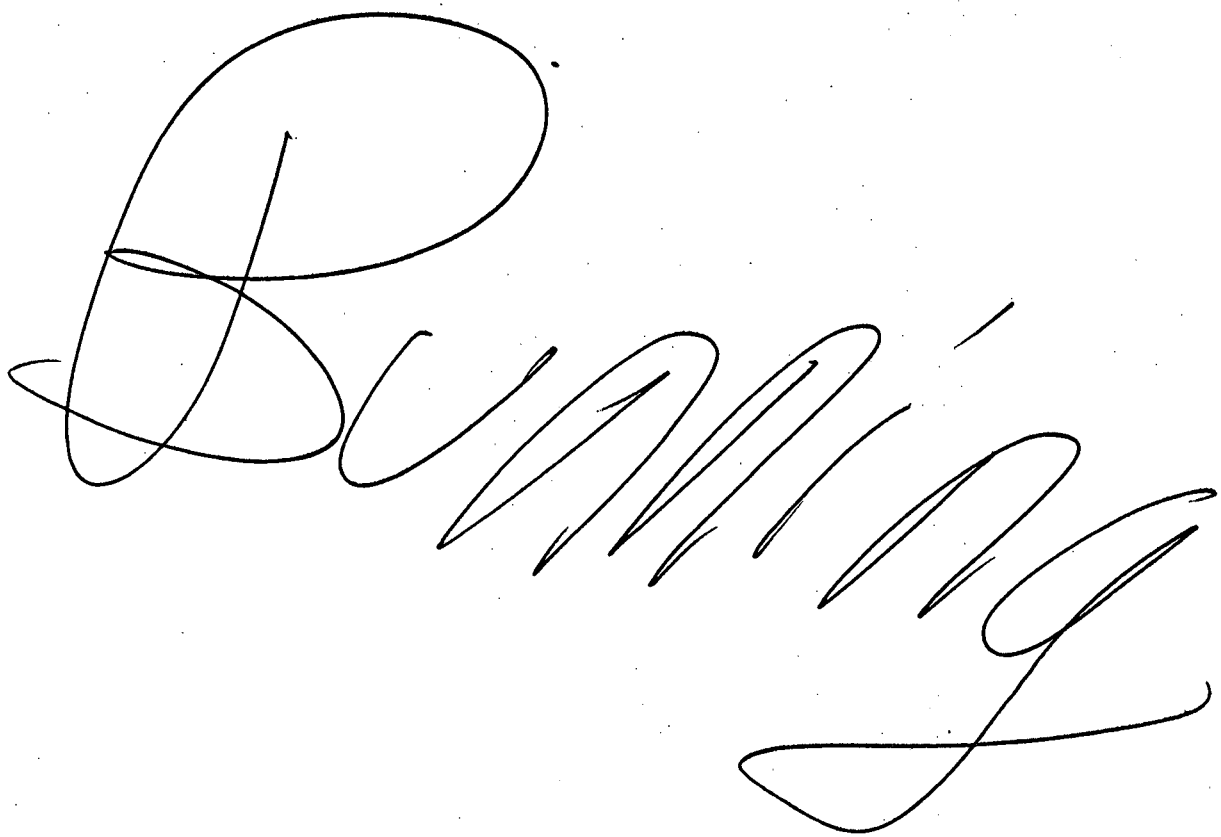
Short Title: Medicare Part D Outreach and Enrollment Enhancement Act

Description of Amendment: The amendment creates a special enrollment period for all Medicare beneficiaries receiving extra help with their drug costs; waives their late enrollment penalty; and provides additional SHIP funding for outreach activities.

The amendment is based upon language included in S.1108, 110th Congress.

Offset: To be provided.

Contact: Matt Canedy, 224-5100



Bunning Amendment #1 to the Children's Health Insurance Program Reauthorization Act of 2007

Title: Eliminate the exemption for covering children above 300% of poverty at the SCHIP matching rate.

The underlying bill has a provision that places a limitation on matching rates for states that propose to cover children with family incomes that exceed 300% of the poverty level. These states would be reimbursed at the Medicaid matching rate level, instead of the SCHIP matching level, for these children.

However, the bill provides an exemption for any state that, on the date of the bill's enactment, has an approved State plan amendment or waiver or has enacted a state law to submit a state plan amendment or waiver to cover children above 300% of the federal poverty level.

Bunning Amendment #1 would strike the provision allowing an exemption. The money saved from this amendment would be provided to the outreach and enrollment grants.

Staff: Holly Santry 4-1163

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ENSIGN

Ensign Amendment #1 to The Children's Health Insurance Reauthorization Act of 2007

Short Title: Disease Prevention and Treatment Research Amendment

Purpose: To ensure that the revenue title of this bill will be used to fund the "Disease Prevention and Treatment Research Trust Fund" which will provide funds for research activities at the National Institute of Health (NIH) to help prevent and treat debilitating diseases.

Explanation of Amendment:

The amendment establishes a trust fund within the Treasury of the United States that will be known as the "Disease Prevention and Treatment Research Trust Fund." The amendment will transfer the revenue generated from increases in tobacco excise tax rates in Title VII of the underlying bill to the Disease Prevention and Treatment Research Trust Fund. The amounts in the Disease Prevention and Treatment Research Trust Fund will be made available for disease prevention and treatment research at the National Institute of Health. Disease prevention and treatment research activities shall include but not be limited to activities relating to:

1) Cancer - Disease prevention and treatment research in this category shall include but not be limited to activities relating to the following types of cancers: pediatric, lung, breast, ovarian, prostate, oral, kidney, liver, stomach, bladder, thyroid, and pancreas. Priority in this category shall be given to disease prevention and treatment research of pediatric cancers.

2) Respiratory Diseases – Disease prevention and treatment research in this category shall include but not be limited to activities relating to: Chronic obstructive pulmonary disease, bronchitis, asthma, and emphysema.

3) Cardiovascular Diseases – Disease prevention and treatment research in this category shall include but not be limited to activities relating to: Peripheral arterial disease, heart disease, stroke, and hypertension.

4) Other Diseases, Conditions, and Disorders – Disease prevention and treatment research in this category shall include but not be limited to activities relating to: Autism, Diabetes (Type I Diabetes, also known as Juvenile Diabetes, and Type II Diabetes), Muscular Dystrophy, Alzheimer's Disease, Parkinson's Disease, Multiple Sclerosis, Amyotrophic lateral sclerosis, Cerebral palsy, Cystic Fibrosis, Spinal Muscular Atrophy, Osteoporosis, Tuberculosis, HIV/AIDS, depression and other mental disorders, infertility, Arthritis, Anaphylaxis, Lymphedema, Psoriasis, Eczema, Lupus, cleft lip and palate, Fibromyalgia, Chronic Fatigue and Immune Dysfunction Syndrome, Alopecia Areata, and Sepsis.

The funds provided to the National Institutes of Health through the Disease Prevention and Treatment Research Trust Fund will be in addition to any funds provided by appropriations Acts.

Contact Name and Phone Number: Michelle Spence 224-6244

Ensign Amendment #2 to The Children's Health Insurance Reauthorization Act of 2007

Short Title: SCHIP is for Kids Amendment

Purpose: To ensure that SCHIP funds are used to provide health assistance to children.

Explanation of Amendment:

The amendment prohibits SCHIP funds from being used to provide health assistance to any non-pregnant adult. Any savings generated from this change shall be used for outreach and coverage of low-income children at or below 200 percent of the Federal Poverty level.

Contact Name and Phone Number: Michelle Spence 224-6244

Ensign Amendment #3 to The Children's Health Insurance Reauthorization Act of 2007

Short Title: Cover Kids First Amendment

Purpose: To prohibit a State from using SCHIP funds on non-pregnant adults until the State first demonstrates that it has adequately covered its SCHIP-eligible population as defined in current law.

Explanation of Amendment:

The amendment would prohibit a State from providing SCHIP to any non-pregnant adult unless the State can prove that it has enrolled 95 percent of its targeted low-income child SCHIP-eligible population as defined in current law.

Contact Name and Phone Number: Michelle Spence 224-6244

Ensign Amendment #4 The Children's Health Insurance Reauthorization Act of 2007

Short Title: Cover Low-Income Kids First Amendment

Purpose: To prohibit States from providing SCHIP coverage to individuals above 200 percent of the Federal Poverty Level unless the State has demonstrated that it has enrolled 95 percent of SCHIP-eligible children.

Explanation of Amendment:

The amendment would prohibit a State from providing SCHIP to individuals whose gross family income exceeds 200 percent of the Federal Poverty Level unless the State has demonstrated that it has enrolled 95 percent of its SCHIP-eligible children at or below 200 percent of the Federal Poverty Level.

Contact Name and Phone Number: Michelle Spence 224-6244

Ensign Amendment #5 to The Children's Health Insurance Reauthorization Act of 2007

Short Title: Removing the Incentive to Cover Children at Higher Income Levels Rather than Lower Income Levels Amendment

Purpose: To eliminate the financial incentive provided by the Federal Government which encourages States to provide health care assistance to individuals at higher income levels rather than lower income levels.

Explanation of Amendment:

The amendment would eliminate the enhanced SCHIP Federal matching assistance percentage and replace it with the Federal medical assistance percentage.

Contact Name and Phone Number: Michelle Spence 224-6244

Ensign Amendment #6 to The Children's Health Insurance Reauthorization Act of 2007

Short Title: Personal Empowerment Through Individual Responsibility Amendment

Purpose: To require cost-sharing requirements in SCHIP.

Explanation of Amendment:

This amendment would require States to submit State Plan Amendments to implement cost-sharing for SCHIP eligibles under both separate SCHIP and Medicaid expansion programs. Cost-sharing levels for separate SCHIP and Medicaid expansion SCHIP shall be consistent with limitations under DRA.

Contact Name and Phone Number: Michelle Spence 224-6244

Ensign Amendment #7 to The Children's Health Insurance Reauthorization Act of 2007

Short Title: Improving Access to Affordable Health Insurance Options Amendment

Purpose: To improve access to affordable health care.

Explanation of Amendment:

The Ensign amendment will ensure that qualified employer sponsored coverage, referenced in Section 401 of the bill, shall include a high deductible health plan purchased in conjunction with a health savings account as defined in the Internal Revenue Code of 1986.

Contact Name and Phone Number: Michelle Spence 224-6244

Markup Statement of Senator Max Baucus (D-Mont.)
Regarding renewal of the State Children's Health Insurance Program

The Psalmist sang: "Out of the mouth of children and infants, You have ordained strength."

Today, we meet to add strength to a program that helps children and infants, the State Children's Health Insurance Program — CHIP.

CHIP works. Since the program began ten years ago, CHIP has cut the number of children without health insurance by more than one-third.

Health insurance matters. Children with health coverage are more likely to get the care that they need, when they need it. Because of CHIP, millions of children get checkups. They see doctors when they are sick. They get the prescription medicines that they need.

Uninsured children suffer. Uninsured kids are less likely to get care for sore throats, earaches, and asthma. When care is delayed, small problems can become big problems. Nearly half of uninsured children have not had a checkup in the past year. Uninsured children are twice as likely to miss out on doctor visits and checkups.

CHIP makes sense as an investment. A child who's healthy can go to school. A child who's healthy in school is more likely to do well. A child who does well in school is more likely to get a job. And people with jobs are less likely to end up in jail or on public assistance.

Thus, CHIP helps America to compete. Ensuring that kids have health coverage is an investment in America's future.

CHIP helps. CHIP helps more than six million children whose parents work but cannot afford insurance on their own. These low-income working families are not poor enough for Medicaid. And they are not rich enough to afford private health insurance. Ninety-one percent of children covered by CHIP live in families making less than twice the poverty level.

It's time to strengthen CHIP. Millions of children have no health insurance. There are more kids without health insurance than there are kids in the first and second grades. Americans overwhelmingly support getting kids covered.

Today, we will start to do more. Today, we will consider legislation to keep coverage for all children currently in the program. And today, we will start to reach more than three million additional uninsured, low-income kids.

We keep CHIP focused on kids. Childless adults who are covered today will transition off of the program. No new waivers will be allowed for CHIP coverage of childless adults.

Coverage of low-income parents will transition to separate block grants, at a lower match rate. No new waivers will be allowed for CHIP coverage of parents.

We build in flexibility. States will be able to designate CHIP funds to help families afford private coverage offered by employers or other sources.

And we pay for what we do. When Congress created CHIP in 1997, we paid for it with a cigarette tax. We continue that funding source. We increase the Federal tax on cigarettes by 61 cents. And we make proportional increases for other tobacco products.

Increasing the cigarette tax will discourage smoking, particularly among teens. And that will be good for kids, too.

CHIP is the legacy of work by Senators of good will from across the political spectrum. Much of that work occurred right here in this room. Much of that work was done by our Colleagues Jay Rockefeller and Orin Hatch.

This year, Chuck Grassley and I worked with Jay and Orin to craft the consensus package before us today. I believe that we have produced a bill of which the Committee can be proud. I thank my Colleagues for their hard work, their patience, and their commitment to getting something done.

CHIP is not new. CHIP is tried and true. It has worked successfully for ten years. And four out of five Americans would like to see Congress add new funds to CHIP.

Now it's time for us to act. For the benefit of children and infants, let us provide strength. For the benefit of children, let us extend health care coverage. For the benefit of children, let us pass this CHIP bill.

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Statement of
The Honorable Orrin G. Hatch
Mark-up of the Children's Health Insurance Program
Reauthorization Act of 2007

July 19, 2007

Mr. Chairman,

As the original author of the 1997 CHIP legislation with Chairman Kennedy, Chairman Rockefeller, and of course Senator John Chafee, I am tremendously proud of what we have achieved in the past decade. I believe the bill we consider today captures the true essence of the 1997 law and builds on that foundation to insure even more children.

That, indeed, should be our purpose.

You, Chairman Baucus, and you, Senator Grassley, deserve great credit as well.

The bill today is the very essence of compromise.

To be fair, it does not make any of us Republicans comfortable to face a veto threat from our President.

It does not make me comfortable to face a veto threat issued by my colleague from Utah, Secretary Leavitt.

It does not make me comfortable to advocate for such a large sum in new spending.

At the same time, I know none of you on the other side of the aisle are comfortable with the fact that we did not authorize spending up to the $50 billion limit in the budget resolution. Many of my Democrat colleagues made sacrifices in endorsing this bill and in sacrificing program expansions they so dearly advocated.

Senator Kennedy and I often like to joke with each other that if neither side is totally comfortable with one of our compromises, we must have done a good job.

And in that spirit, I say to my colleagues, we must have done a good job.

This bill will makes it all about the kids. That was our goal, and we achieved it. Our bill will provide health coverage to 2.7 million of the 6 million currently uninsured, low-income children who are 200% of the federal poverty level and below.

I want to circle back to the cost of this bill.

I remember so well my conversations with my colleagues in 1997 about the cost of this bill and the precedent it could represent.

We must recognize that we have covered the kids who are easy to find. Six million of them to be exact.

We can all be proud of that.

But one of the lessons we have learned along the way is that it will cost proportionately more to cover the remaining children. They are harder to find and thus harder to cover.

This is what CBO told us.

So you can't do the simple math and say "It cost $40 billion to cover 6 million kids, so it should cost $40 billion to cover the remaining 6 million kids." It doesn't work that way.

CBO told us that we need to give states more money to cover these new uninsured children and that is what we have done.

We have made a number of other important decisions in this bill.

We have restored the program back to its intent – to cover children, not adults. This was a hard decision for Senators from states with adult waivers, and I commend them for their commitment to the children.

The legislation before the Committee removes childless adults from the CHIP program by the end of FY09 and afterwards, gives the states the option of covering these individuals through Medicaid.

It also prohibits the approval of any new state waivers for parents to be covered through CHIP.

Only parents living in states with approved parent waivers will be eligible for health coverage through the CHIP program.

The next tough issue was the coverage of pregnant women. While I was not opposed to this in theory, in practice we all know that the cost of one delivery could fund insurance for three or four children. That is why I oppose this coverage in 1997.

I have been convinced that states should have the option of covering pregnant women through the CHIP program. This was a difficult decision for me and, again, a true compromise.

Third, we included money for outreach and enrollment. This is key for enrollment, but as we found out, it is very expensive. So we made the decision to place a limit on the amount of money dedicated to these efforts.

Fourth, our legislation includes premium assistance through CHIP for coverage through private plans. And if it is determined that family coverage would be more cost efficient, the entire family would be covered through this health plan.

This is something that was very important to me and Senator Grassley. Utah has started such a program with the hopes of providing affordable coverage to an entire family.

Fifth, our legislation includes a cap of 300% of the federal poverty level for eligibility in CHIP. If a state provides CHIP coverage above that level, it will not receive the enhanced match. States with higher eligibility levels when this legislation becomes law would be grandfathered-in.

Finally, I am pleased that this bill changes the name SCHIP back to CHIP, the way it was before the House added the superfluous S.

Mr. Chairman, this is a good bill. It accomplishes what we have set out to do – to take care of the children.

Yes, I wish it did not cost what it does, but I am persuaded this is necessary spending when I think of the six million American children who are leading healthier lives because of our vision and commitment.

We should not let the opportunity pass us buy to build on that solid foundation and do even more good for the children, our future.

Senator Debbie Stabenow
Opening Statement
CHIP reauthorization

I want to thank Chairman Baucus, Ranking Member Grassley, and Senators Rockefeller and Hatch and their staff for their hard work on producing a document to reauthorize the Children's Health Insurance Program.

This is a step forward for our nation's uninsured children, the vast majority of whom—78 percent—live in working families.

I know in my home state, CHIP and Medicaid have made a huge difference in families' lives.

According to a study by the University of Michigan, the number of uninsured children in Michigan grew between 2000 and 2004 to about 7% of the state's children. At the same time, the lack of affordable private and employer-based coverage is forcing more and more families to rely on public programs, such as Medicaid and MIChild (our CHIP program) for coverage.

As of February 2006, almost 1 out of every 3 children in Michigan relied on Medicaid or MIChild for health care coverage. For those who do have coverage, about three quarters of these children have at least one working parent.

I want to commend many of the positive things that the Chairman's mark will do. First, the mark will increase the amount of funding available to states. Michigan would face a shortfall in the next fiscal year without additional resources.

Second, I am pleased that the mark also recognizes the need to have more quality measures and improved health information technology as they relate to children. I thank the Chairman for accepting language I and Senator Snowe suggested on testing the use of electronic medical records for children. This will get better data on what methods work best to find, enroll, and treat children. This data will be critical for our next reauthorization.

Third, this bill makes it easier for states to cover pregnant women. This option is critically important to me because Michigan has the third worst infant mortality rate in the nation.

I am also glad that the Chairman was able to include some improvements for dental and mental health benefits. While these are not as substantial as I know many of us pushed for, they will make a difference in many children's lives. Further, adding these benefits will have a long-lasting impact on children as they grow into adulthood, reducing future health care costs.

Finally, it is great that there are incentives for states to do outreach and enroll more children. We all know that there is a hesitation to do enroll children if the resources are not there.

I also urge my colleagues not to listen to the negative attacks on this carefully crafted compromise as we move forward.

We all made compromises on moving CHIP forward. For example, I want to work out something that keeps my state whole, but I recognize the need to continue to work in the bipartisan spirit that created CHIP in the first place.

CHIP is a great success story that we can all be proud of.

This analysis represents how much money is needed to have the purchasing power of 200% FPL ($33,200 for a family of 3 in 2006) adjusted by the cost-of-living in different areas of the country.
(Prepared for staff by the Georgetown University Center for Children and Families)

Differences in the Cost of Living, 2006

Metro Area	How much does it cost to buy the same goods and services in different urban areas?	
	$	% FPL
Durham, NC	$28,552	172%
Omaha, NE	$29,681	179%
Houston, TX	$29,946	180%
Des Moines, IA	$30,079	181%
Charleston, WV	$30,810	186%
Wichita, KS	$31,241	188%
Boise, ID	$31,706	191%
Spokane, WA	$32,337	195%
Milwaukee, WI	$33,200	200%
St. Louis, MO	$33,233	200%
Cleveland, OH	$33,399	201%
Salt Lake City, UT	$33,532	202%
Phoenix, AZ	$33,798	204%
Tacoma, WA	$35,989	217%
Las Vegas, NV	$36,055	217%
Flagstaff, AZ	$38,479	232%
Burlington, VT	$39,242	236%
Baltimore, MD	$40,072	241%
Philadelphia, PA	$41,732	251%
Newark, NJ	$42,463	256%
Boston, MA	$46,314	279%
San Jose, CA	$51,128	308%

Source: Center for Children and Families analysis of 2006 ACCRA data (June 2007).

Notes:
(1) Data come from ACCRA Cost of Living Index: Comparative Data for 289 Urban Areas; Data for Third Quarter 2006 (Published November 2006). Note that data is available only for areas that participate in the survey.
(2) This analysis represents how much money will be needed to have the purchasing power of 200% FPL ($33,200 for a family of 3 in 2006) adjusted by the cost-of-living. Since the dollar amount set by the FPL is a national average for the 48 contiguous states, a metropolitan area with an average cost of living will have the same purchasing power as the dollar amount set at 200% FPL. [i.e., $33,200 x adjustment factor].