Senate Committee on Finance
U.S. Senator Orrin Hatch (R-UT), Chairman
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Discussion Draft: Extending Funding for the State Children's Health Insurance Program

Overview of Policies

Title

Extend SCHIP Funding and Retain Current Allotment Funding Formula.
This provision eliminates the funding cliff established by the Patient Protection and Affordable Care Act (PPACA) by extending SCHIP funding through additional annual appropriations. During the discussion phase, the committee is requesting feedback on the duration of the extension of SCHIP funding. Governors have overwhelmingly indicated that the current formula for allocating federal SCHIP funds for states works well. Thus, this provision maintains the current allotment formula. States have two years to use their federal SCHIP allotments. Under current policy, after two years any unused SCHIP allotments are redistributed to shortfall states—states that will not have enough money to meet projected costs in the current year after counting the state's current year allotment and unspent funds from the state's prior year's allotment. The bill would also preserve the current procedures for the redistribution of unused SCHIP allotments to shortfall states.

Give States Flexibility To Move Kids Into SCHIP.
PPACA required states move children ages 6 to 18 in families with income between 100% and 133% of the federal poverty level (FPL) onto Medicaid – a requirement that negatively impacted SCHIP programs and American families by forcing children off of SCHIP and into Medicaid. This provision would eliminate the requirement imposed by PPACA and provide states with the flexibility to transition these children back to SCHIP.

Save Taxpayer Dollars While Preserving High-Quality Coverage for Children.
PPACA included a 23 percent increase in federal SCHIP matching funds over the current enhanced match for the children's health program. However, Democrats and Republicans in Congress – and governors of both parties – have hailed SCHIP as a success at the current match rate. CBO also estimates that no new net enrollment will result from maintaining the 23 percent funding increase. Therefore, there is no policy justification to continue to direct federal taxpayer dollars to efforts that do not impact coverage for low-income children.

Reclaim SCHIP's Mission of Serving Low-Income Families.
The federal medical assistance percentage (FMAP) is the state-specific percentage of Medicaid service expenditures paid by the federal government. It is based on a formula that provides higher reimbursement rates to states with lower per capita incomes relative to the national average (and vice versa). It has a statutory minimum of 50 percent and maximum of 83 percent. The enhanced FMAP (E-FMAP) for SCHIP reduces the state's share under the regular FMAP by 30 percent. The E-FMAP has a statutory minimum of 65 percent and maximum of 85 percent. When SCHIP was created with bipartisan support in the Balanced Budget Act of 1997, SCHIP was intended to provide health insurance coverage for low-income children in families with incomes at or below 200 percent of the federal poverty level ($48,500 for a family of 4). The bipartisan SCHIP reauthorization passed in 2007 (H.R. 3963) prohibited

coverage under SCHIP for families with incomes above 300 percent FPL ($72,750 for a family of 4). That bipartisan policy was dropped in CHIPRA, the reauthorization of SCHIP in 2009. Currently 18 states and the District of Columbia have upper income eligibility levels that exceed 300 percent FPL and New York has an upper income level over 400 percent FPL ($97,000 for a family of 4). Given numerous changes in our health care system in recent years, the focus of SCHIP should be recovered—providing additional help to lower-income families. Under this policy, the enhanced match for low-income families, defined in statute as families with incomes at or below 200 percent of FPL is maintained. Consistent with the goal of returning SCHIP to its original purpose and consistent with bipartisan proposals in the past, the enhanced match for families with incomes at or above 250 percent FPL will be reduced and federal financial participation in SCHIP for families with incomes over 300 percent FPL will be ended.

Normalize the E-FMAP for Certain Services for ESL Populations.
The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included increased federal funding for certain translation and interpretation services for the enrollment and retention of populations for whom English is a second language (ESL). The bill did this by providing an increased match rate for certain ESL services, higher than the already-enhanced SCHIP matching rate. This provision would return the federal matching rate for these services to pre-CHIPRA levels, namely the normal enhanced SCHIP matching rate.

Extend the Qualifying State Option.
When SCHIP was created in the Balanced Budget Act of 1997, the statute included a maintenance-of-effort provision so states could not draw federal SCHIP funds for child populations already covered under Medicaid. States that had expanded Medicaid coverage to higher income children prior to SCHIP viewed this provision as a penalty against their early expansion efforts. Accordingly, a provision was added later in SCHIP to permit 11 early expansion "qualifying states" to use up to 20 percent of their SCHIP allotment to fund the difference between Medicaid and SCHIP matching rates for the cost for Medicaid children above 150 percent of poverty. CHIPRA in 2009 permitted this spending for Medicaid children above 133 percent of poverty, and without the 20 percent limitation. Since the purpose of SCHIP is to serve the most vulnerable lower-income families, this policy extends the qualifying state option by allowing the early expansion states to use federal SCHIP funds for Medicaid children between 133 percent and 250 percent of poverty.

Give States More Flexibility By Ending a Restrictive Maintenance-of-Effort Mandate.
PPACA reduced states' flexibility to manage their SCHIP programs by requiring states, as a condition of receiving federal Medicaid funding, to maintain income eligibility levels for children in Medicaid and SCHIP through September 30, 2019. States have identified a number of problems with this policy. This provision would give states flexibility to make commonsense changes to Medicaid and SCHIP by repealing PPACA's maintenance of effort requirement.

Give States More Tools to Reduce the Crowd-Out of Private Coverage.
The incidence of crowd-out in public programs has been a long-standing concern. Crowd-out occurs when families give up or do not take private health insurance in lieu of enrolling in public coverage. A high incidence of crowd-out is problematic as it makes it more difficult for employers to offer health insurance coverage and it inappropriately uses taxpayer dollars to fund coverage that could have been provided by an employer. The Congressional Budget Office has previously noted that crowd-out is a particularly acute problem in SCHIP because crowd-out occurs more frequently at higher income levels. The report also concludes that, "in general, expanding the program to children in higher-income families is likely to generate more of an offsetting reduction in private coverage… than expanding the program to more children in low-income families." CBO estimates that "the reduction in private coverage among children is between a quarter and a half of the increase in public coverage resulting from SCHIP. In other words, for every 100 children who enroll as a result of SCHIP, there is a corresponding reduction in private coverage of between 20 and 50 children." A number of policies to reduce crowd-out were included in the bipartisan CHIPRA I in 2007 (H.R. 976) and CHIPRA II also in 2007 (H.R. 3963), but were not included in the 2009 bill. One tool states have used to reduce the incentive for families to seek

SCHIP coverage instead of private coverage is to impose waiting periods. However, HHS regulations issued in 2013 limited states use of waiting periods to a maximum of 90 days. In order to provide states flexibility to address the issue of crowd out, this provision would return to policies adopted in 2007 on a bipartisan basis by permitting states to establish waiting periods of no more than 12 months for families who have private insurance.

Exempt State-Funded SCHIP-Equivalent Coverage From Individual Mandate.
PPACA imposed penalties on individuals who are not covered by health insurance that qualifies as minimum essential coverage. While the law specified that enrollment in SCHIP qualified as minimum essential coverage, the Centers for Medicare and Medicaid Services (CMS) has determined that at least one state's insurance program that provides *identical* coverage to the state's SCHIP program—yet is *exclusively* funded with state dollars—does not qualify as minimum essential coverage. As a result, individuals in this state-funded program may be forced to change health coverage or pay a penalty. CMS's actions are incoherent, since the coverage is equivalent to that of SCHIP, which meets the minimum essential coverage under the law. This provision will correct this inequity and protect families by considering any state program that is funded exclusively with state dollars that provides benefits equivalent to the state's SCHIP program as minimum essential coverage.

Reaffirm the State-Based Nature of the Program.
One of the hallmarks of the State Children's Health Insurance Program is that it is a state-based program, providing states with considerable flexibility to design and manage their individual programs to best serve the citizens of the state. This provision reclaims the state-based nature of the program in the program description, by repealing a provision of CHIPRA which allowed for the program to be referred to as "CHIP" and instead refer to the program as "SCHIP."

Reduce Medicaid and CHIP Fraud in the U.S. Territories.
Under current law, State Medicaid Fraud Control Units (MFCU) investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. Under federal law, the Office of Inspector General at the U.S. Department of Health and Human Services (HHS OIG) certifies, and annually recertifies, each MFCU. According to the HHS OIG, in fiscal year 2013, MFCUs recovered over $2.5 billion. Federal law also requires territories to maintain a certified MFCU as part of a State Medicaid program—unless the Secretary determines that operation of a MFCU would not be cost-effective and that other safeguards are in place. Because funding for MFCUs would currently count against the territories' capped federal funding for Medicaid, the territories do not currently have MFCUs. The absence of rigorous auditing and independent reviews from MFCUs in the territories may allow federal taxpayer dollars to be lost to waste, fraud, or abuse. Accordingly, this policy builds on the president's FY2015 budget request and would encourage territories to create MFCUs by exempting federal funding for the fraud control units from territories' cap on Medicaid funding and by exempting territories from the statutory ceiling on quarterly federal payments for the units.