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*MEDICAID AND THE STATE CHILDREN'S HEALTH  
INSURANCE PROGRAM (SCHIP): PROVISIONS IN THE  
CONSOLIDATED APPROPRIATIONS ACT FOR FY2000*

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Updated January 5, 2000

**Abstract.** This report summarizes the Medicaid and SCHIP provisions of H.R. 3426, the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 99) that was incorporated by reference into the conference agreement (H.R. 3194) on the Consolidated Appropriations Act for FY2000 (P.L. 106-113). While the majority of the provisions of BBRA 99 are intended to mitigate the impact of Medicare provisions in the Balanced Budget Act of 1997 (BBA 97) on health care providers, the new law includes a number of changes to Medicaid and SCHIP.

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## Medicaid and the State Children's Health Insurance Program (SCHIP): Provisions in the Consolidated Appropriations Act for FY2000

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## **ABSTRACT**

This report summarizes the Medicaid and SCHIP provisions of H.R. 3426, the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 99) that was incorporated by reference into the conference agreement (H.R. 3194) on the Consolidated Appropriations Act for FY2000 (P.L. 106-113). While the majority of the provisions of BBRA 99 are intended to mitigate the impact of Medicare provisions in the Balanced Budget Act of 1997 (BBA 97) on health care providers, the new law includes a number of changes to Medicaid and SCHIP. For more information on the Medicare provisions of BBRA 99 see CRS Report (RL30347) Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP): Changes to Balanced Budget Act of 1997 (BBA 97, P.L. 105-33).

# Medicaid and the State Children's Health Insurance Program (SCHIP): Provisions in the Consolidated Appropriations Act for FY2000

## Summary

On November 19, 1999, the Senate voted to pass the *Consolidated Appropriations Act for FY2000* (H.R. 3194) that includes by reference the *Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999* (BBRA 99; H.R. 3426). The House passed the same bill on November 18, 1999 and the President signed the measure on November 29, 1999 (P.L. 106-113). While BBRA 99 is largely comprised of Medicare provisions, the new law includes a number of changes to Medicaid and the State Children's Health Insurance Program (SCHIP).

In addition to technical amendments to the Balanced Budget Act of 1997, the Medicaid changes include provisions allowing for increased disproportionate share payments to hospitals for certain states and the District of Columbia, and for extended access to a special \$500 million fund to pay for Medicaid eligibility determinations resulting from welfare reform for a longer period of time than allowed under previous law. BBRA 99 also modifies the schedule for phasing out cost-based reimbursement for Federally Qualified Health Centers and Rural Health Clinics that had been included in the Balanced Budget Act of 1997.

Included among the SCHIP changes are provisions to improve state-level data collection; to evaluate the SCHIP (and Medicaid) programs with respect to outreach and enrollment practices; and to create a clearinghouse to coordinate and consolidate federal databases and reports on children's health. In addition, BBRA 99 includes a number of changes to the formula used to distribute federal SCHIP funds among the states, increases in the amounts available for U.S. territories, and minor technical changes.

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# Medicaid and the State Children's Health Insurance Program (SCHIP): Provisions in the Consolidated Appropriations Act for FY2000

## Introduction

Medicaid is a joint federal-state entitlement program that pays for medical assistance primarily for low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children. Within broad federal guidelines, each state designs and administers its own program. Total program outlays in FY1998 were \$177.4 billion. Federal outlays were \$100.2 billion and state outlays were approximately \$77.2 billion. The federal government shares in a state's Medicaid costs by means of a statutory formula based on a state's per capita income, adjusted annually. In FY1998, federal matching rates ranged from 50% to 77% of a state's expenditures for Medicaid items and services. Overall, the federal government finances about 57% of all Medicaid costs.

The 105<sup>th</sup> Congress made important changes to the Medicaid program through the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33).<sup>1</sup> BBA 97 included provisions to achieve net Medicaid savings of about \$13 billion between FY1998 and FY2002, largely from reductions in supplemental payments to hospitals that serve a disproportionate share of Medicaid and low-income patients. BBA 97 also significantly increased the flexibility that states have to manage their Medicaid programs. In particular, it gave states the option of requiring most beneficiaries to enroll in managed care plans without seeking a federal waiver, and replaced federal reimbursement requirements imposed by the Boren amendments with a public notice process for setting payment rates for institutional services. The Act also required that the previously existing cost-based reimbursement system for Federally Qualified Health Centers and Rural Health Clinics be phased out over a 6-year period. Spending items in the Act included Medicaid coverage for additional children, and increased assistance for low-income individuals to pay Medicare Part B premiums.

BBA 97 also included provisions establishing SCHIP under a new Title XXI of the Social Security Act. SCHIP represents the second largest federal effort to provide health insurance coverage to uninsured, low-income children since the enactment of Medicaid in 1965. The program began in October 1997 with total federal funding authorization of \$39.7 billion for the period FY1998 through FY2007.

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<sup>1</sup> For a detailed description of the changes to Medicaid under BBA 97, see CRS Report 98-132, *Medicaid: 105<sup>th</sup> Congress*, by Melvina Ford and Richard Price.

Generally, SCHIP is targeted at uninsured children who live in families with income below twice the federal poverty level. States may use SCHIP funds to provide coverage through health insurance that meets specific standards for benefits and cost-sharing (known as separate state programs), or through expansions of eligibility under Medicaid, or through a combination of both options.

Not all targeted low-income children will necessarily receive medical assistance under SCHIP for two reasons. First, the law does not establish an individual's entitlement to the benefits of SCHIP. Instead it entitles states with approved SCHIP plans to pre-determined, annual federal allotments based on a distribution formula set in law. Second, each state has flexibility to define the group of targeted, low-income children who are eligible for its SCHIP. Eligibility criteria may include, for example, geography, age, income and resources, residency, disability status, access to other health insurance, and duration of eligibility for other health insurance.

As of December 1, 1999, all 50 states, the District of Columbia and all five territories had approved SCHIP plans. Among these, 25 are Medicaid expansions, 16 are new or expanded separate state programs, and 15 will use both a Medicaid expansion and a separate state program. Federal spending in FY1998 totaled less than \$500 million. Recently, the Congressional Budget Office (CBO)<sup>2</sup> estimated that federal SCHIP spending will total approximately \$1 billion for FY1999. These spending projections fall well below total annual federal authorization levels of \$4.3 billion for each fiscal year. However, since annual state allotments are available for a period of 3 years, states may eventually claim their full FY1998 and FY1999 federal SCHIP funding. These initial spending projections are consistent with preliminary enrollment estimates of 1.3 million children nationwide through June of 1999. Subsequent to enactment of BBA 97, CBO estimated that SCHIP would cover an average of 2.3 million children per year after 1999.<sup>3</sup> The Administration's goal is to enroll 5 million children by FY2002.

## Recent Legislative Activity

On October 26, 1999, the Senate Finance Committee ordered reported the *Medicare, Medicaid and SCHIP Adjustment Act of 1999* (S. 1788). On November 5, 1999, the House passed an expanded version of a bill originally introduced with changes to Medicare only. The expanded version, retitled the *Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999* (H.R. 3075), added provisions modifying Medicaid and SCHIP.

On November 17, 1999, House and Senate negotiators reached agreement on the Medicare, Medicaid and SCHIP provisions. The agreement was introduced as H.R. 3426, the *Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999*. It was incorporated by reference into the conference agreement (H.R. 3194)

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<sup>2</sup> U.S. Congressional Budget Office. *The Economic and Budget Outlook: An Update*. July 1, 1999. Washington, GPO, 1999.

<sup>3</sup> U.S. Congressional Budget Office. *Expanding Health Insurance Coverage for Children Under Title XXI of the Social Security Act* (CBO Memorandum), February 1998. Washington, GPO, 1998.

on the *Consolidated Appropriations Act for FY2000*. The House passed the measure on November 18, 1999. The Senate also passed the bill on the following day. The President signed this legislation on November 29, 1999 (P.L. 106-113).

CBO has estimated the cost of BBRA 99 at \$16 billion over the FY2000-FY2004 period and \$27 billion over the FY2000-FY2009 period.<sup>4</sup> Taken together, the Medicaid and SCHIP provisions account for a small fraction of the total cost of this package. The Medicaid subtotal is \$700 million over 5 years and \$1.2 billion over 10 years. Nearly one-half of these Medicaid expenditures (43% over 5 years and 50% over 10 years) represent interactions with Part B premiums under Medicare and cost sharing.<sup>5</sup> The remaining costs are primarily associated with increased DSH payments to certain states, extension of the availability of the \$500 million fund for Medicaid eligibility determinations due to welfare reform, and delays in the phase-out of cost-based reimbursement for Federally Qualified Health Centers and Rural Health Clinics. The SCHIP subtotal is \$200 million over 5 years and \$400 million over 10 years. Nearly all of these SCHIP expenditures are due to the increased allotments for territories and new data collection and evaluation provisions.

The following side-by-side comparison provides a brief description of prior law and the changes to Medicaid and SCHIP under the BBRA 99.<sup>6</sup> Unless otherwise specified, the Medicaid and SCHIP provisions became effective upon enactment.

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<sup>4</sup> U.S. Congressional Budget Office. *CBO Pay-As-You-Go Estimate: H.R. 3194, An Act Making Consolidated Appropriations for the Fiscal Year Ending September 30, 2000, and for Other Purposes*. December 8, 1999. Washington, GPO, 1999.

<sup>5</sup> BBRA 99 includes higher payments to Medicare providers, resulting in higher Part B premiums and cost-sharing for beneficiaries. Because Medicaid covers Medicare premiums and cost-sharing for certain low-income persons eligible for both programs, Medicaid expenditures will also increase.

<sup>6</sup> Additional changes to the Medicaid program enacted during the first session of the 106<sup>th</sup> Congress are described in the CRS Report RS20406, *Work Incentives for the Disabled: A Summary of H.R. 1180*, by Celinda Franco, Carol O'Shaughnessy and Carmen Solomon-Fears.

**Changes Made to Medicaid and SCHIP by BBRA 99**  
**(as incorporated in the Consolidated Appropriations Act for FY2000)**

**Title VI — Medicaid**

Provision	Prior law	BBRA 99
Increase in DSH Allotment for Certain States and the District of Columbia (Sec. 601)	The federal share of Medicaid disproportionate share (DSH) payments, payments for hospitals that treat a disproportionate share of uninsured and Medicaid enrollees, is capped at specified amounts for each state.	For each of fiscal years 2000 through 2002, increases the ceiling on the federal share of DSH payments for the District of Columbia, from \$23 million to \$32 million; for Minnesota, from \$16 million to \$33 million; for New Mexico, from \$5 million to \$9 million; and for Wyoming, from 0 to \$.1 million.
Removal of Fiscal Year Limitation on Certain Transitional Administrative Costs Assistance (Sec. 602)	A fund of \$500 million was created by Congress in 1996 to assist states with the transitional costs of the new Medicaid eligibility activities resulting from welfare reform. The funds are available at an increased federal matching rate for states that can demonstrate that such administrative costs are attributable to welfare reform. The increased matching funds were available for the period beginning with FY1997 and ending with FY2000 and had to be related to costs incurred during the first 12 quarters following the welfare reform effective date.	Extends the availability of the transitional increased federal matching funds beyond fiscal year 2000 and allows costs for which the increased matching funds are claimed to relate to costs incurred for the calendar quarters beyond the first 12 following the effective date of welfare reform.
Modification of the Phase-out of Payment for Federally Qualified Health Center (FQHC) Services and Rural Health Clinic (RHC) Services Based on Reasonable Costs (Sec. 603)	States pay FQHCs and RHCs a percentage of the facilities' reasonable costs for providing services. This percentage decreased for specified fiscal years — 100% of costs for services furnished during FY1998 and FY1999; 95% for FY2000; 90% for FY2001; 85% for FY2002; and 70% for FY2003. For services furnished on or after October 1, 2003, no required payment percentage would apply.	Imposes a 2-year moratorium on the phase-down of the cost-based reimbursement system, freezing the phase-down at 95% for fiscal years 2001 and 2002. The phase-down will resume at 90% in 2003, 85% in 2004 and cost-based reimbursement will be repealed in 2005. The General Accounting Office (GAO) will conduct an analysis of the impact of reducing or modifying payments based on the reasonable cost standard for FQHCs and RHCs and the populations they serve. The GAO shall report back to Congress within 12 months with their findings and recommendations.

Provision	Prior law	BBRA 99
<p>Parity in Reimbursement for Certain Utilization and Quality Control Services; Elimination of Duplicative Requirements for External Quality Review of Medicaid Managed Care Organizations (Sec. 604)</p>	<p>a. Parity in Reimbursement for Certain Utilization and Quality Control Services</p> <p>Under current law, states receive federal funds at a 75% matching rate when contracting with a Peer Review Organization (PRO) for medical and utilization reviews and for quality reviews. Under prior law, states could also receive a 75% federal matching rate when they contracted with a PRO-like entity but only for external quality reviews of Medicaid managed care. For all other reviews and entities, the standard 50% federal matching rate applied.</p> <p>A PRO is an entity that has a Medicare contract to perform medical and utilization reviews. A PRO-like entity is one that is certified by the Secretary as meeting the requirements of Section 1152 which defines standards for PROs under Medicare.</p>	<p>a. Parity in Reimbursement for Certain Utilization and Quality Control Services</p> <p>States will receive 75% in federal matching when PRO-like entities conduct medical and utilization reviews for fee-for-service Medicaid, and quality reviews for Medicaid managed care.</p>
<p>Inapplicability of Enhanced Match Under the State Children's Health Insurance Program to Medicaid DSH Payments (Sec. 605)</p>	<p>b. Elimination of Duplicative Requirements for External Quality Review of Medicaid Managed Care Organizations:</p> <p>The requirement that Medicaid managed care organizations obtain annual independent, external reviews using either a utilization and quality control peer review organization, a PRO defined under Section 1152, or a private accreditation body was contained in three different sections of Medicaid law.</p>	<p>b. Elimination of Duplicative Requirements for External Quality Review of Medicaid Managed Care Organizations</p> <p>Deletes the external review requirements in two of three sections of Medicaid law.</p> <p>The parity provisions and the provisions regarding the elimination of duplicative requirements become fully effective after the Secretary of HHS certifies to Congress that the external review requirement for Medicaid managed care is implemented.</p>
<p>Inapplicability of Enhanced Match Under the State Children's Health Insurance Program to Medicaid DSH Payments (Sec. 605)</p>	<p>Medicaid DSH payments are matched by the federal government at the federal medical assistance percentage (FMAP), the same percentage that applies to most other Medicaid payments for benefits. Medicaid payments for children who are eligible as targeted low-income children under Title XXI are matched at a considerably higher enhanced FMAP.</p>	<p>Clarifies that Medicaid DSH payments are matched at the FMAP and not at the enhanced federal matching percentage authorized under Title XXI.</p> <p>This amendment applies to expenditures made on or after October 1, 1999.</p>

Provision	Prior law	BBRA 99
Optional Deferment of the Effective Date for Outpatient Drug Agreements (Sec. 606 )	Medicaid law required that rebate agreements between the Secretary (or, if authorized by the Secretary, with the states) and drug manufacturers that were not in effect before March 1, 1991 become effective the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into.	Allows rebate agreements entered into after the date of enactment of this Act to become effective on the date on which the agreement is entered into, or at state option, any date before or after the date on which the agreement is entered into.
Making Medicaid DSH Transition Rule Permanent (Sec. 607)	For the period July 1, 1997 through July 1, 1999, hospital-specific disproportionate share payments for the state of California were capped at 175% of the cost of care provided to Medicaid recipients and individuals who have no health insurance or other third-party coverage for services during the year (net of non-disproportionate share Medicaid payments and other payments by uninsured individuals).	Removes the July 1, 1999, end date for increased hospital-specific disproportionate share payments for the state of California, extending the transition period indefinitely.
Medicaid Technical Corrections (Sec. 608)	No provision.	Makes technical corrections to selected sections of Title XIX.

## Title VII — State Children's Health Insurance Program

Provision	Prior law	BBRA 99
Stabilizing the State Children's Health Insurance Program Allocation Formula (Sec. 701)	States and the District of Columbia are allotted funds for SCHIP using a distribution formula based on the product of the "number of children" and a "state cost factor." Under prior law for FY1998 through FY2000, the number of children was equal to the 3-year average of uninsured children in families with income below 200% FPL (federal poverty level), using the three most recent March supplements of the Current Population Survey (CPS). For subsequent fiscal years, the number of children was a combination of low-income uninsured children and low-income children (75/25 percent split for FY2001 and a 50/50 percent split for FY2002 and thereafter). The state cost factor for a fiscal year equals the sum of .85 multiplied by the ratio of the annual average wages per	Accelerates by one fiscal year the phase-in of the use of low-income children in calculating the "number of children" in the allotment distribution formula (e.g., references to FY2000 are changed to FY1999, etc.). Changes the data set to be used to estimate the number of children for a fiscal year from the three most recent March supplements of the CPS to the three most recent supplements available before the calendar year in which the fiscal year begins. Similarly, changes the data set used to estimate annual average wages for a given fiscal year to the three most recent years before the beginning of the calendar year in which such fiscal year begins. Specifies new methods for determining floors and ceilings on allotments for the states and the District of

Provision	Prior law	BBRA 99
	<p>employee to the national average wages per employee and .15. The measure for the annual average wages per employee was based on the three most recent years for employees in the health services industry as reported by the Bureau of Labor Statistics. SCHIP allotments are subject to a floor of \$2 million.</p> <p>file:///C:/Users/rl30400/...</p>	<p>Columbia for FY2000 and beyond. The floor remains \$2 million. For each fiscal year, the floor will not be less than 90% of a state's allotment proportion for the preceding year. The cumulative floor is set at 70% of the proportion for FY1999. The cumulative ceiling is capped at 145% of a state's allotment proportion for FY1999. If these methods create a deficit in a given year, there will be a ceiling on the maximum increase permitted in that year to ensure budget neutrality; if these methods create a surplus in a given year, there will be a pro-rata increase for all states below the ceiling. These new methods do not apply to unspent allotments that are redistributed to states as specified in Section 2104(f) of Title XXI.</p>
<p>Increased Allotments for Territories Under the State Children's Health Insurance Program (Sec. 702)</p>	<p>Of the total amount available for allotment for SCHIP, commonwealths and territories are allotted .25%, to be divided among them based on specified percentages. In addition, for FY1999, commonwealths and territories were allotted \$32 million, also divided among them based on the same specified percentages as the basic allotment.</p> <p>file:///C:/Users/rl30400/...</p>	<p>Requires additional allotments for the commonwealths and territories of \$34.2 million for each of fiscal years 2000 and 2001, \$25.2 million for each of fiscal years 2002 through 2004, \$32.4 million for each of fiscal years 2005 and 2006, and \$40 million for FY2007.</p>
<p>Improved Data Collection and Evaluations of the State Children's Health Insurance Program (Sec. 703)</p>	<p>a. Funding for Reliable Annual State-by-State Estimates on the Number of Children Who Do Not Have Health Insurance Coverage: No provision.</p> <p>file:///C:/Users/rl30400/...</p>	<p>a. Funding for Reliable Annual State-by-State Estimates on the Number of Children Who Do Not Have Health Insurance Coverage: Requires that the Secretary of Commerce make appropriate adjustments to the annual CPS to produce statistically reliable annual state-level data on the number of uninsured low-income children. Requires that \$10 million be appropriated for FY2000 for this purpose, and for each year thereafter. These changes to the CPS will improve critical data for evaluation purposes. They will also affect state-specific counts of number of low-income children and the number of such children who are uninsured that feed into the formula that determines annual state-specific allotments from federal SCHIP appropriations.</p>

Provision	Prior law	BBRA 99
Improved Data Collection and Evaluations of the State Children's Health Insurance Program (Sec. 703) (continued)	<p>b. Federal Evaluation of State Children's Health Insurance Programs: The Secretary is required to submit to Congress by December 31, 2001, a report based on the annual evaluations submitted by states, with conclusions and recommendations, as appropriate.</p> <p><a href="http://wikileaks.org/wiki/CRS-RL30400">http://wikileaks.org/wiki/CRS-RL30400</a></p>	<p>b. Federal Evaluation of State Children's Health Insurance Programs: Adds a new federal evaluation to prior law. The Secretary of HHS is required to conduct an independent evaluation of 10 states with approved SCHIP plans. The selected states must represent diverse approaches to providing child health assistance, a mix of geographic areas, and a significant portion of uninsured children. The federal evaluation will include, but not be limited to: (1) a survey of the target population, (2) an assessment of effective and ineffective outreach and enrollment practices for both SCHIP and Medicaid, (3) an analysis of Medicaid eligibility rules and procedures that are a barrier to enrollment in Medicaid, and how coordination between Medicaid and SCHIP has affected enrollment under both programs, (4) an assessment of the effects of cost-sharing policies on enrollment, utilization and retention, and (5) an analysis of disenrollment patterns and factors influencing this process. The Secretary must submit the results of the federal evaluation to Congress no later than December 31, 2001. Requires that \$10 million be appropriated for this purpose for FY2000. This appropriation shall remain available through FY2002.</p>
	<p>c. Inspector General Audit and GAO Report on Enrollees Eligible for Medicaid: No provision.</p>	<p>c. Inspector General Audit and GAO Report on Enrollees Eligible for Medicaid: Requires that the Inspector General of HHS conduct an audit to determine how many Medicaid-eligible children are incorrectly enrolled in SCHIP among a sample of states that provide child health assistance through separate programs only (not via a Medicaid expansion). This audit will also assess progress in reducing the number of uninsured children relative to the goals stated in approved SCHIP plans. The first such audit will be conducted in FY2000, and will be repeated every third fiscal year thereafter. Requires the GAO to monitor these audits and report their results to Congress within 6 months of audit completion (i.e., by March 1 of the fiscal year following each audit).</p>

