

**NATIONAL ACADEMY**  
*for STATE HEALTH POLICY*

The following chart is a comparison of the major priorities of SCHIP directors, as discussed in *Reauthorizing SCHIP: Principles, Issues and Ideas from State Directors*, with the key provisions of the Senate and House reauthorization bills currently under consideration in Congress. Only the provisions that address the principles of SCHIP directors from the *Reauthorizing SCHIP* document have been included.

<b>SCHIP Directors' Principles: Comparisons with SCHIP reauthorization legislation in the United States Senate and House of Representatives</b>		
<b>Principle #1: SCHIP funding should be renewed and increased substantially to provide sufficient and predictable funds for states to effectively manage programs and reduce the number of uninsured.</b>		
<i>Reauthorizing SCHIP: Principles, Issues and Ideas from State Directors</i>	<i>"Children's Health Insurance Program (CHIP) Reauthorization Act of 2007" S. 1893</i>	<i>"The Children's Health and Medicare Protection Act of 2007" (CHAMP) H.R. 3162</i>
<b>Future funding needs to increase substantially</b>	❖ \$35.4 billion allocated over the next five years according to CBO estimates; substantial increase in funding for all states	❖ \$47.8 billion allocated over the next five years according to CBO estimates
<b>Funding should be stable and predictable (and adjusted for population growth, cost increases, and health care inflation)</b>	❖ Initial funding for FY 2008 based on the highest of these four factors (all multiplied by an annual adjustment of a state's population percentage growth and percentage increase in National Health Expenditures): <ul style="list-style-type: none"> <li>➢ A state's FY 2007 allotment</li> <li>➢ A state's FY 2007 SCHIP spending</li> <li>➢ For FY 2007 shortfall states, projected FY 2007 spending as of November 2006 (or as</li> </ul>	❖ Initial FY 2008 funding based on higher of FY 2007 allocation or state FY 2008 estimated spending as reported in May 2007, multiplied by percentage increases in National Health Expenditures and a state's population growth  ❖ States have two years, instead of the current three years, to spend initial allotments, beginning with FY 2008 allotments.

	<p>of May 2006 for a state that had a May 2006 projection \$95-\$96 million higher than November 2006 projection)</p> <ul style="list-style-type: none"> <li>➤ Projected FY 2008 spending as of August 2007.</li> </ul> <ul style="list-style-type: none"> <li>❖ States will have two years, instead of the current three years, to spend initial allotment beginning with a state's FY 2007 allotment (States will still have three years to spend FY 2005 and 2006 allotments).</li> <li>❖ For FY 2009-FY 2012, allotments will be 110 percent of projected spending, as of August 31 of the previous year. If total state allotments exceed the money allocated for that fiscal year, allotments would be based on a four part formula: <ul style="list-style-type: none"> <li>➤ projected SCHIP expenditures as of August 31 of previous year multiplied by <b>75 percent</b>.</li> <li>➤ <b>12.5 percent</b> multiplied by number of low-income children in the state.</li> <li>➤ The states projected SCHIP spending for the preceding fiscal year, as of November of that fiscal year, multiplied by <b>7.5 percent</b>.</li> <li>➤ Actual SCHIP spending from two years before multiplied by <b>5 percent</b>.</li> </ul> </li> <li>❖ SCHIP Contingency Fund established, beginning in FY 2009, to finance state shortfalls. <ul style="list-style-type: none"> <li>➤ Amount equal to 12.5% of total appropriation would be allocated; additional</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>❖ In FY 2009 and every second year thereafter, a state's allotment will be equal to the state's allotment for the previous fiscal year multiplied by percentage increases in National Health Expenditures and a state's population growth.</li> <li>❖ Rebasing in 2010 and ever second year thereafter. Allotments in rebasing year based on total payments to state in previous fiscal year, including shortfall payments, multiplied by percentage increases in National Health Expenditures and a state's population growth.</li> <li>❖ States that are successful in enrolling children and, as a result face shortfalls (in any fiscal year), will be eligible for additional performance-based federal payment to offset these increased costs. Payments will be based on state's average cost per child. <ul style="list-style-type: none"> <li>➤ Consistent with current law, redistributed funding will also be available as a result of unspent state allotments. Redistributed funds will only be available in the fiscal year they are redistributed.</li> </ul> </li> <li>❖ Outreach/performance bonuses available for states that implement five out of seven outreach and enrollment provisions. Provisions include: <ul style="list-style-type: none"> <li>➤ 12-month continuous eligibility</li> <li>➤ Asset test elimination</li> <li>➤ Elimination of face-to-face interview</li> <li>➤ Joint Medicaid/SCHIP application</li> </ul> </li> </ul>
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	<p>appropriations in future years made as needed (maximum amount 12.5% of total fiscal year allotment)</p> <ul style="list-style-type: none"> <li>➤ Payments are only to eliminate state shortfall, and states are deemed eligible based on a few criteria: less than 5 percent shortfall or a major disaster or extreme economic downturn hits a state.</li> </ul> <p>❖ “Incentive Pool”, with \$3 billion in initial funding (and six sources of future funding), for states that increase enrollment of low-income children in SCHIP and Medicaid above a set baseline level.</p> <ul style="list-style-type: none"> <li>➤ States that are eligible for bonus would receive payments for each additional child enrolled in Medicaid above the baseline.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Automatic renewal</li> <li>➤ Presumptive eligibility</li> <li>➤ Implementing Express-lane eligibility option</li> </ul> <p>❖ Bonuses to be used for enrolling current eligible but unenrolled children.</p>
<b>Funding should increase over time</b>	<p>❖ SCHIP allocations will increase each year under the bill (each appropriation is in addition to the \$5 billion annual baseline).</p> <ul style="list-style-type: none"> <li>➤ \$9.125 billion in FY 2008</li> <li>➤ \$10.675 billion in FY 2009</li> <li>➤ \$11.85 billion in FY 2010</li> <li>➤ \$13.75 billion in FY 2011</li> <li>➤ \$3.5 billion + \$12.5 billion in FY 2012 (The \$12.5 billion is a one-time appropriation to comply with Congressional budget rules)</li> </ul>	<p>❖ No funding amounts specified in the legislation, but funding expected to increase over time.</p>
<b>Fix formula penalty for enrolling more children</b>	<p>❖ Unlike the current formula, the formula in S. 1893 does not consider the percentage of uninsured children. States will not be penalized for enrolling more children.</p>	<p>❖ Unlike the current formula, the formula in H.R. 3162 does not consider the percentage of uninsured children. States will not be penalized for enrolling more children.</p>

<p><b>CPS data is often inconsistent with state level data; SCHIP directors believe new data source should be considered</b></p>	<ul style="list-style-type: none"> <li>❖ CPS data will continue to be used in determining the number of low-income uninsured children in each state.</li> <li>❖ \$20 million is allocated for the Secretary of Commerce to make adjustments to CPS and determine whether the American Community Survey (ACS) is a more reliable data source. Commerce Secretary will make a recommendation to Secretary of HHS. <ul style="list-style-type: none"> <li>➤ If ACS is recommended, either to replace or be used in concert with the CPS, HHS Secretary may provide a transition period that does not adversely affect states.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>❖ No provision</li> </ul>
	<p><b>Additional Relevant Provision:</b></p> <ul style="list-style-type: none"> <li>❖ State may offer coverage in SCHIP up to 300 percent of the federal poverty line and receive enhanced match</li> <li>❖ States already above 300 percent at the time of enactment can continue to offer SCHIP coverage with an enhanced match</li> <li>❖ States that increase eligibility above 300 percent of the federal poverty line in SCHIP can do so with a Medicaid match.</li> </ul>	<p><b>Additional Relevant Provision:</b></p> <ul style="list-style-type: none"> <li>❖ Includes option for states to offer coverage to children in SCHIP and Medicaid through age 24.</li> </ul>

Principle #2: SCHIP and Medicaid play vital, complementary roles in covering children and adolescents, and *each* program needs to be maintained and strengthened.

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<b>Dependents of state employees should be eligible in separate SCHIP programs</b>	❖ No provision	❖ No provision
<b>Allow coverage for legal immigrant children</b>	❖ No provision	❖ States have the option to cover legal immigrant children through SCHIP and Medicaid. Legal-immigrant pregnant women, even if they do not meet the 5-year residency requirement, will also be eligible.
<b>Continuity of coverage if family income changes</b>	❖ No provision	❖ No provision
<b>Family choice of enrolling all children in one program</b>	❖ No provision	❖ No provision

<b>Principle #3: The progress that states have achieved in simplifying enrollment for children and families should be supported and not hampered by federal program requirements.</b>		
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<b>Rescind or substantially modify citizenship documentation requirement</b>	<ul style="list-style-type: none"> <li>❖ Citizenship documentation and identity requirements will apply to SCHIP, in addition to Medicaid.</li> <li>❖ States would now have an alternative method to document citizenship and identity.</li> <li>❖ States could use Social Security numbers, sent to the SSA for verification, to check whether an applicant is a citizen (enrollment would be allowed while the SSN was being checked by SSA). <ul style="list-style-type: none"> <li>➤ If the SSN does not match the name, the applicant would have 90 days to present evidence of citizenship or face disenrollment. Penalties could be assessed to states for a greater than 7 percent invalid SSN rate.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>❖ States regain option whether to require documentation proving citizenship for children in Medicaid. <ul style="list-style-type: none"> <li>➤ All states must agree to an audit of sample cases. Error rate must be lower than 3 percent or a state will face financial penalty.</li> </ul> </li> <li>❖ States that choose to no longer require citizenship documentation can offer retroactive eligibility dating back to July 1, 2006.</li> <li>❖ Provides option for certain tribal membership documents to be used for adults and children to prove citizenship.</li> </ul>
<b>Exempt outreach activities from 10 percent administrative cap</b>	<ul style="list-style-type: none"> <li>❖ \$100 million grant program <b>exempt from 10 percent administrative cap</b> for outreach and enrollment efforts in SCHIP and Medicaid <ul style="list-style-type: none"> <li>➤ Grants would be awarded for outreach campaigns, especially for those that target specialized and underserved populations.</li> <li>➤ 10 percent allocated for outreach grants to American Indian children</li> <li>➤ 10 percent for a national enrollment</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>❖ No provision</li> </ul>

	<ul style="list-style-type: none"> <li>➤ campaign run by Secretary of HHS</li> <li>➤ Translation services for these outreach activities could now get SCHIP match</li> </ul>	
<b>Auto-enrollment/ 'express-lane' flexibility</b>	<ul style="list-style-type: none"> <li>❖ Creates a three year, state demonstration program for 10 states to implement 'express-lane' programs to determine a child's eligibility for SCHIP and Medicaid</li> <li>❖ Program would provide \$44 million for states to implement 'express-lane' and upgrade systems</li> <li>❖ \$5 million allocated to evaluate demonstration program</li> </ul>	<ul style="list-style-type: none"> <li>❖ States are granted an "express-lane" option to use information from other programs for low-income Americans to determine eligibility.</li> </ul>

<b>Principle #4: State flexibility in specific areas of program design has been an important component of SCHIP's success and should be supported and enhanced.</b>		
<i>Reauthorizing SCHIP: Principles, Issues and Ideas from State Directors</i>	<i>"Children's Health Insurance Program (CHIP) Reauthorization Act of 2007" S. 1893</i>	<i>"The Children's Health and Medicare Protection Act of 2007" (CHAMP) H.R. 3162</i>
<b>Improved options for premium assistance programs</b>	<ul style="list-style-type: none"> <li>❖ The legislation revises rules for premium assistance. <ul style="list-style-type: none"> <li>➤ Modifies cost-effectiveness test to deem that premium assistance is cost effective if the cost of such coverage is less than the amount the state would have made to enroll the child or family (as applicable) in SCHIP (and total amount spent on all kids is less than would be spent in SCHIP).</li> <li>➤ Requires private plans to provide benefit plan information to help states determine cost-effectiveness.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>❖ No provisions</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Group plans would have to contribute at least 40 percent to employee coverage premiums.</li> <li>▪ Employer must also provide notice to employees of all premium assistance options.</li> <li>➤ Make eligibility for SCHIP/Medicaid a ‘qualifying event’ for ESI coverage, even outside of open-enrollment period.</li> </ul>	
<b>Add options for supplemental benefits to address needs not covered under private insurance, e.g. dental, mental health, vision, hearing, and/or prescription drugs</b>	<ul style="list-style-type: none"> <li>❖ The legislation requires access to mental health benefits must be offered consistent with benefits for other medical services.</li> <li>❖ \$200 million in dental health grants offered to states.</li> </ul>	<ul style="list-style-type: none"> <li>❖ Legislation mandates dental coverage under SCHIP.</li> <li>❖ Legislation requires mental health parity in SCHIP benchmark plans.</li> </ul>
<b>Principle #5: States should be supported in their efforts to improve program performance and promote access to quality care.</b>		
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<b>Payment Error Rate Measurement (PERM) should be revisited, revised or rescinded</b>	<ul style="list-style-type: none"> <li>❖ Payment Error Rate Measurement (PERM) would be exempt from 10 percent administrative cap.</li> <li>❖ Federal matching rate of 90 percent would apply on PERM related administrative expenditures.</li> <li>❖ Once final PERM rule is in effect, would allow states for which PERM was in effect in</li> </ul>	<ul style="list-style-type: none"> <li>❖ No provision</li> </ul>

	<p>either FY 2007 or FY 2008, to either except the payment error rate for that year, or instead have FY 2010 and FY 2011 (respectively) be the first year that PERM applies to their state.</p> <ul style="list-style-type: none"> <li>❖ Provisions are included that would help reduce the admin burden on states.</li> </ul>	
<p><b>Prior federal technical assistance was valuable and should be reinstated</b></p>	<ul style="list-style-type: none"> <li>❖ Legislation requires HHS Secretary to provide technical assistance to states to help and encourage them to utilize new child health quality measures.</li> </ul>	<ul style="list-style-type: none"> <li>❖ Legislation requires HHS Secretary to provide technical assistance to states to help them in the reporting of quality measures under Title XIX and Title XXI.</li> </ul>
<p><b>Optional child health quality measures should be developed for multiple federal programs to use</b></p>	<ul style="list-style-type: none"> <li>❖ HHS Secretary directed to develop new child health measures and attempt to standardize state reporting (in consultation with states). Also requires Secretary to develop pediatric quality measures.</li> <li>❖ Provides \$20 million (out of the \$45 million appropriated for quality measures over 5 years) for up to 10 state demonstration grants on quality, in order to improve the quality of children's health care.</li> <li>❖ States are required to report quality of care measures in their Annual Report. Also in the Annual Report, states must include information on various access measures.</li> </ul>	<ul style="list-style-type: none"> <li>❖ HHS Secretary will be directed to develop new pediatric health quality and performance measurement program. <ul style="list-style-type: none"> <li>➤ Designed to improve the quality of pediatric care.</li> <li>➤ Will work with states, providers, advocates and others to develop child health quality measures.</li> </ul> </li> </ul>