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Comparison of the Bills to Extend State Children's Health Insurance Program (CHIP) Funding

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Summary

The State Children's Health Insurance Program (CHIP) is a means-tested program that provides health coverage to targeted low-income children and pregnant women in families that have annual income above Medicaid eligibility levels but have no health insurance. CHIP is jointly financed by the federal government and the states, and the states are responsible for administering CHIP.

In statute, FY2017 was the last year a federal CHIP appropriation was provided. Federal CHIP funding was not extended before the beginning of FY2018. As a result, states do not currently have full-year FY2018 CHIP allotments and states are funding their CHIP programs with unspent federal CHIP funds from prior years. The continuing resolutions enacted on December 8, 2017, and December 22, 2017, both include provisions that provide short-term funding for CHIP. The continuing resolution enacted on December 8, 2017, includes a special rule for redistribution funds, and the continuing resolution enacted on December 22, 2017, includes short-term appropriations and an extension of the special rule for redistribution funds. This short-term funding is not sufficient to fund CHIP through the end of FY2018.There are a couple of bills that would extend federal funding for CHIP for five years. On October 4, 2017, both the Senate Finance Committee and the House Energy and Commerce Committee had markups on different bills that would extend CHIP federal funding through FY2022, among other provisions.

The Senate Finance Committee reported the Keeping Kids' Insurance Dependable and Secure Act of 2017 (KIDS Act, S. 1827), which would extend federal CHIP funding through FY2022 and extend the increased enhanced federal medical assistance percentage (E-FMAP) rates for one year (i.e., through FY2020) but with an 11.5 percentage point increase instead of the 23 percentage point increase under current law. The bill also includes extensions of other CHIP provisions (e.g., the Express Lane eligibility option and the maintenance of effort for children with incomes below 300% of the federal poverty level) and other programs and demonstrations (e.g., the Child Obesity Demonstration Project and the Pediatric Quality Measures Program).

The House Energy and Commerce Committee reported the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017 (HEALTHY KIDS Act, H.R. 3921, H.Rept. 115-358), which includes almost identical language to the KIDS Act that would extend CHIP federal funding through FY2022 and extend the increased E-FMAP for one year at 11.5 percentage points. The HEALTHY KIDS Act also includes almost identical language that would extend the same CHIP provisions and other programs and demonstrations as the KIDS Act. The HEALTHY KIDS Act also includes some provisions that are not in the KIDS Act, such as adding a new CHIP state option for qualified CHIP look-alike plans, modifying the Medicaid disproportionate share hospital (DSH) allotment reductions, and providing additional Medicaid funding to Puerto Rico and the U.S. Virgin Islands. The HEALTHY KIDS Act includes the following provisions as offsets: modifications to Medicaid third party liability, treatment of lottery winnings for Medicaid eligibility, and Medicare Part B and D premium subsidies for higher-income individuals.

On October 30, 2017, the House Rules Committee posted an amendment in the nature of a substitute for the Community Health And Medical Professionals Improve Our Nation Act of 2017 (CHAMPION Act, H.R. 3922), meaning that it is intended to be considered by the House as an amendment to H.R. 3922 and the language of the CHAMPION Act would be stricken and the text of the amendment in the nature of the substitute would be inserted in its place. This amendment in the nature of a substitute is entitled the Continuing Community Health And Medical Professional Programs to Improve Our Nation, Increase National Gains, and Help Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017 (CHAMPIONING HEALTHY KIDS Act), and it includes revised language for the CHAMPION

Act (which would extend funding for community health centers and other programs among other things) under Division A and revised language for the HEALTHY KIDS Act under Division B. The House passed the CHAMPIONING HEALTHY KIDS Act on November 3, 2017, by a vote of 242 to 174.

This report compares and summarizes the provisions in the KIDS Act and in Division B of the CHAMPIONING HEALTHY KIDS Act.

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The State Children's Health Insurance Program (CHIP) is a federal-state program that provides health coverage to certain uninsured, low-income children and pregnant women in families that have annual income above Medicaid eligibility levels.[1] CHIP is jointly financed by the federal government and the states and is administered by the states.[2] Participation in CHIP is voluntary, and all states, the District of Columbia, and the territories participate.[3] The federal government sets basic requirements for CHIP, but states have the flexibility to design their own version of CHIP within the federal government's basic framework. As a result, there is significant variation across CHIP programs.

FY2017 was the last year federal CHIP funding was appropriated in statute, and FY2018 began on October 1, 2017, without CHIP funding being extended. As a result, states do not currently have full-year FY2018 CHIP allotments, and states are funding their CHIP programs with unspent federal CHIP funds from prior years.

Continuing Resolutions

On December 8, 2017, a law (P.L. 115-90) was enacted to extend continuing appropriations for federal agencies and programs, and this law includes language that amends the CHIP statute. Division B of P.L. 115-90 adds a special rule for redistribution funds available through CHIP for the first quarter of FY2018 to prioritize redistribution funds being allocated to emergency shortfall states, which are states estimated to exhaust federal CHIP funding before January 1, 2018.

On December 22, 2017, a law (P.L. 115-96) was enacted to extend continuing appropriations for most federal agencies and programs through January 19, 2018, under Division A of the bill. Division B of P.L. 115-96 provided full-year appropriations for the Department of Defense, and Division C of P.L. 115-96 provided short-term funding for some of the programs in the House-passed CHAMPIONING HEALTHY KIDS Act.

Section 3201 of P.L. 115-96 provides $2.85 billion in appropriations for CHIP for the period of October 1, 2017, through March 31, 2018. Section 3201 of P.L. 115-96 also extends the special rule for redistributions funds that was added by P.L. 115-90 for every month through March 2018.

According to the Centers for Medicare & Medicaid Services, the short-term funding should be enough to ensure no state exhausts its federal CHIP funding before January 19, 2018. However, CMS cannot say with any certainty whether the short-term funding is sufficient to fund the federal share of CHIP through March 31, 2018.[4]

On October 4, 2017, both the Senate Finance Committee and the House Energy and Commerce Committee had markups on different bills that would extend CHIP federal funding through FY2022, among other things.

The Senate Finance Committee reported the Keeping Kids' Insurance Dependable and Secure Act of 2017 (KIDS Act, S. 1827), which would extend federal CHIP funding through FY2022 and extend the increased enhanced federal medical assistance percentage (E-FMAP) rates for one year (i.e., through FY2020) but with an 11.5 percentage point increase instead of a 23 percentage point increase under current law. The bill also includes extensions of other CHIP provisions (e.g., the Express Lane eligibility option and the maintenance of effort [MOE] for children in families with

[1] For more information about the State Children's Health Insurance Program (CHIP), see CRS Report R43627, *State Children's Health Insurance Program: An Overview*, by Evelyne P. Baumrucker and Alison Mitchell.

[2] For more information about CHIP financing, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*, by Alison Mitchell.

[3] The five territories are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

[4] Phil Galewitz, "Running On Empty: CHIP Funding Could Run Out Jan. 19 For Some States," *Kaiser Health News*, January 5, 2018, at https://khn.org/news/running-on-empty-chip-funding-could-run-out-jan-19-for-some-states/; Rachel Roubein, "Week Ahead: Trump HHS Pick Faces Grilling on Drug Prices, ObamaCare," *The Hill*, January 8, 2018, at http://thehill.com/policy/healthcare/367681-week-ahead-trump-hhs-pick-faces-grilling-on-drug-prices-obamacare.

incomes below 300% of the federal poverty level [FPL]) and other programs and demonstrations (e.g., the Child Obesity Demonstration Project and the Pediatric Quality Measures Program).

According to the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) cost estimate, the KIDS Act is estimated to increase federal spending by $14.9 billion and revenues by $6.7 billion for a net cost of $8.2 billion over the period of FY2018 through FY2027.[5] On January 5, 2018, CBO and JCT updated the cost estimate for the KIDS Act to account for the repeal of penalties for the individual health insurance mandate that was included in P.L. 115-97, enacted on December 22, 2017. According to the cost estimate released on January 5, 2018, the KIDS Act is estimated to increase federal spending by $7.3 billion and revenues by $6.6 billion for a net cost of $0.8 billion over the period of FY2018 through FY2027.[6]

The House Energy and Commerce Committee reported the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017 (HEALTHY KIDS Act, H.R. 3921),[7] which includes almost identical language to the KIDS Act that would extend CHIP federal funding through FY2022 and extend the increased E-FMAP for one year at 11.5 percentage points. The HEALTHY KIDS Act also includes almost identical language that would extend the same CHIP provisions and other programs and demonstrations as the KIDS Act. The HEALTHY KIDS Act also includes some provisions that are not in the KIDS Act, such as adding a new CHIP state option for qualified CHIP look-alike plans; modifying the Medicaid disproportionate share hospital (DSH) allotment reductions; and providing additional Medicaid funding to Puerto Rico and the U.S. Virgin Islands. The HEALTHY KIDS Act includes the following provisions as offsets: modifications to Medicaid third party liability, treatment of lottery winnings for Medicaid eligibility, and Medicare Part B and D premium subsidies for higher-income individuals.

On October 30, 2017, the House Rules Committee posted an amendment in the nature of a substitute for the Community Health And Medical Professionals Improve Our Nation Act of 2017 (CHAMPION Act, H.R. 3922, H.Res. 601), meaning that it is intended to be considered by the House as an amendment to H.R. 3922 and the language of the CHAMPION Act would be stricken and the text of the amendment in the nature of the substitute would be inserted in its place. This amendment in the nature of a substitute is entitled the Continuing Community Health And Medical Professional Programs to Improve Our Nation, Increase National Gains, and Help Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017 (CHAMPIONING HEALTHY KIDS Act), and it includes revised language for the CHAMPION Act (which would extend funding for community health centers and other programs, among other things) under Division A and revised language for the HEALTHY KIDS

[5] Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT), *Cost Estimate:* S. 1827 *Keep Kids' Insurance Dependable and Secure Act of 2017*, October 20, 2017, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/s1827.pdf.

[6] CBO and JCT, *Updated Cost Estimate for S. 1827, the Keep Kids' Insurance Dependable and Secure Act of 2017*, January 5, 2018, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/s1827_0.pdf.

[7] The Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017 (HEALTHY KIDS Act; H.R. 3921) was introduced on October 3, 2017. At the House Energy and Commerce Committee markup October 4, 2017, the following amendments that were adopted with a voice vote are available at "PR-MEDCD-RSA_02" (at http://docs.house.gov/meetings/IF/IF14/20171004/106486/BILLS-115-3921-B001257-Amdt-123.pdf) and "LUJAN_068" (at http://docs.house.gov/meetings/IF/IF14/20171004/106486/BILLS-115-3921-L000570-Amdt-114.pdf). The committee report is H.Rept. 115-358.

Act under Division B.[8] (See the textbox for an overview of the provisions in Division A of the CHAMPIONING HEALTHY KIDS Act.)

The HEALTHY KIDS Act, under Division B of the CHAMPIONING HEALTHY KIDS Act, includes some changes to the provisions from the HEALTHY KIDS Act as reported by the House Energy and Commerce Committee. The CHAMPIONING HEALTHY KIDS Act amended the provision extending the outreach and enrollment program, the Medicaid DSH provision, and the Medicaid third party liability provision. In addition, the CHAMPIONING HEALTHY KIDS Act released on October 30, 2017, deleted the Medicare Parts B and D premium subsidies for higher-income individuals provision, but this provision was added back into the CHAMPIONING HEALTHY KIDS Act through an amendment adopted by the House Rules Committee on November 1, 2017.[9] According to the CBO and JCT cost estimate for the CHAMPIONING HEALTHY KIDS Act language posted on the House Rules Committee website on October 30, 2017,[10] the HEALTHY KIDS Act under Division B is estimated to increase federal spending by $11.4 billion and revenues by $6.7 billion for a net cost of $4.7 billion over the period of FY2018 through FY2027.[11] The House passed the CHAMPIONING HEALTHY KIDS Act on November 3, 2017, by a vote of 242 to 174.

Division A of the CHAMPIONING HEALTHY KIDS Act

Division A of the CHAMPIONING HEALTHY KIDS Act would extend federal funding and, in some cases, make programmatic changes to the following programs:

- the federal health centers program,
- the National Health Service Corps,
- graduate medical education payments for residents who train at teaching health centers,
- Special Diabetes Programs,
- Family-to-Family Health Information Centers,
- the Youth Empowerment Program, and
- the Personal Responsibility Education Program.

The offsets included in Division A are (1) a change to the qualified health plan grace period requirement for individuals who receive advanced premium tax credits for health insurance purchased on the exchanges and (2) reductions to the Prevention and Public Health Fund.

The provisions of Division A of the CHAMPIONING HEALTHY KIDS Act are summarized in the CRS Report R45012, *Division A of H.R. 3922: The CHAMPIONING HEALTHY KIDS Act*. This report provides summaries only of the provisions included in Division B of the CHAMPIONING HEALTHY KIDS Act.

This report contains a table that provides an overview of the provisions in the KIDS Act and Division B of the CHAMPIONING HEALTHY KIDS Act as baselined against current law. The

[8] The text for the Continuing Community Health And Medical Professional Programs to Improve Our Nation, Increase National Gains, and Help Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017 (CHAMPIONING HEALTHY KIDS Act) is at https://rules.house.gov/sites/republicans.rules.house.gov/files/1_Walden.pdf.

[9] The amendment adopted by the House Rules Committee on November 1, 2017 is at https://rules.house.gov/bill/115/hr-3922.

[10] The cost estimate for the CHAMPIONING HEALTHY KIDS Act does not include Medicare Part B and D premium subsidies for higher-income individuals. However, this provision was included in the cost estimate of the HEALTHY KIDS Act as reported by the House Energy and Commerce Committee (https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr3921rev.pdf).

[11] The full cost estimate for the CHAMPIONING HEALTHY KIDS Act shows the bill (including both Divisions A and B) is estimated to increase federal spending by $19.4 billion and increase revenue by $4.7 billion for a net cost of $14.7 billion. (CBO and JCT, *Estimate of the Direct Spending and Revenue Effects of* H.R. 3922 *The CHAMPIONING HEALTHY KIDS Act, an Amendment in the Nature of a Substitute [Version* H.R. 3922 *FLR-AINS_06.XML], as Posted on the Website of the House Committee on Rules October 30, 2017*, October 31, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr3922amendment.pdf).

section following the table provides more detailed summaries of the provisions in the KIDS Act and Division B of the CHAMPIONING HEALTHY KIDS Act.[12]

High-Level Comparison of Bills

Table 1 provides a high-level comparison of the provisions in the KIDS Act and Division B of the CHAMPIONING HEALTHY KIDS Act. For each provision, there is a summary of current law, an explanation of the provision in the KIDS Act, and an explanation of how the provision in Division B of the CHAMPIONING HEALTHY KIDS Act compares to the provision in the KIDS Act.

[12] The provisions of Division A of the CHAMPIONING HEALTHY KIDS Act are summarized in CRS Report R45012, *Division A of H.R. 3922: The CHAMPIONING HEALTHY KIDS Act*.

Table 1. Provisions in the KIDS Act (S. 1827) and the Division B of the CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Provision	Current Law	KIDS Act (S. 1827)	Division B of the CHAMPIONING HEALTHY KIDS Act (H.R. 3922)
CHIP Funding			
Five-Year Funding Extension of CHIP	CHIP was funded through FY2017 with appropriated amounts specified in statute. Since CHIP was first established in 1997, it has been funded through subsequent legislation. Most recently, MACRA provided funding for FY2016 and FY2017. The federal government reimburses states for a portion of every dollar they spend on CHIP, up to state-specific annual limits called allotments. Allotments are the federal funds allocated to each state for the federal share of its CHIP expenditures. State CHIP allotment funds are provided annually, and the funds are available to states for two years. Under current law, FY2017 was the last year CHIP allotments are authorized. There are two formulas for state allotments. In even years, the allotment is based on states' previous year allotment, and in odd years, it is based on states' previous year expenditures. State CHIP allotments can be increased to reflect CHIP eligibility or benefit expansions if a state submits the required information to the HHS Secretary no later than August 31st preceding the beginning of the fiscal year.	Section 2(a) would extend federal CHIP funding for five years by adding federal appropriations for FY2018 through FY2022 under SSA Section 2104(a). Section 2(b)(1)(A)-(D) would authorize CHIP allotments for FY2018 through FY2022 under SSA Section 2104(m). Section 2(b)(1)(E) would structure the federal CHIP funding for FY2022 under SSA Section 2104(m)(10) the same as it was structured for FY2015 and FY2017 with semiannual appropriations in addition to a one-time appropriation. Section 2(b)(3) would provide a one-time appropriation in the amount of $20.2 billion for FY2022. This funding would accompany the allotments for the first half of FY2022.	Sections 301(a) and (b) are identical to Sections 2(a) and (b) of provision in S. 1827 . Section 301(b) added a provision that, for FY2018, states would be able to submit the information regarding program expansions no later than 60 days after enactment.
Child Enrollment Contingency Fund			
Extension of Child Enrollment Contingency Fund	CHIPRA established the Child Enrollment Contingency Fund to provide shortfall funding to certain states. For FY2009 through FY2017, states with a funding shortfall and CHIP enrollment for children exceeding a state-specific	Section 2(c) would extend the funding mechanism for the Child Enrollment Contingency Fund under SSA Section 2104(n) and payments from the fund for the period of FY2018 through FY2022.	Section 301(c) is identical to the provision in S. 1827.

Provision	Current Law	KIDS Act (S. 1827)	Division B of the CHAMPIONING HEALTHY KIDS Act (H.R. 3922)
	target level received a payment from the Child Enrollment Contingency Fund.		
Qualifying States Option			
Extension of Qualifying States Option	Certain states are allowed to use their CHIP allotment funds to finance the difference between the Medicaid and CHIP matching rates (i.e., FMAP and E-FMAP rates, respectively) for the cost of children in Medicaid in families with income above 133% of FPL. Under current law, FY2017 was the last year in which the qualifying states option was authorized.	Section 2(d) would extend the qualifying states option under SSA Section 2105(g)(4) for the period of FY2018 through FY2022.	Section 301(d) is identical to the provision in S. 1827.
***Express Lane* Eligibility**			
Extension of *Express Lane* Eligibility Option	Under *Express Lane* eligibility, states are permitted to rely on a finding from specified *Express Lane* agencies (e.g., those that administer programs such as TANF, Medicaid, and CHIP) to determine whether a child has met Medicaid or CHIP eligibility requirements. Authority for *Express Lane* eligibility expired September 30, 2017.	Section 2(e) would amend SSA Section 1902(e)(13)(I) to extend authority for *Express Lane* eligibility determinations for the period of FY2018 through FY2022.	Section 301(e) is identical to the provision in S. 1827.
Child Maintenance of Effort (MOE)			
Assurance of Affordability Standard for Children and Families	As a condition for receiving Medicaid payments, the ACA MOE provisions require states to maintain the eligibility standards, methodologies, and procedures for Medicaid and CHIP that were in place on the date of enactment of the ACA through September 30, 2019, for children up to the age of 19.	Section 2(f) would extend the Medicaid (SSA Section 1902(gg)(2)) and CHIP (SSA Section 2105(d)(3)) MOE requirements for children for three years from October 1, 2019, through September 30, 2022. However, for this period, the Medicaid and CHIP MOE requirements would only apply to children in families with annual income less than 300% of FPL.	Section 301(f) is identical to the provision in S. 1827.
CHIP Look-Alike Plans			
CHIP Look-Alike Plans	Under federal law, states are permitted to establish CHIP buy-in programs that allow	No provision.	Section 301(g) would permit states (at SSA Section 2107) to consider all enrollees in

Provision	Current Law	KIDS Act (S. 1827)	Division B of the CHAMPIONING HEALTHY KIDS Act (H.R. 3922)
	children in families with annual income above the state's CHIP eligibility thresholds to purchase health coverage through the CHIP program at full cost. Historically, buy-in programs have not relied on federal CHIP funds and operate outside of CHIP program rules so states have flexibility in terms of program design. Under the ACA's individual mandate, most individuals have to maintain minimum essential coverage or pay a penalty for noncompliance. The types of coverage that are considered minimum essential coverage do not include CHIP buy-in programs.		CHIP and in *qualified CHIP look-alike programs* to be members of a single risk pool when developing rates and premiums. A *qualified CHIP look-alike program* would be defined as a state-only program (i.e., financed with nonfederal funds, including premiums) that is available for purchase for certain specified children and that provides benefits that are at least identical to CHIP. Section 301(g) would also amend IRC Section 5000A(f)(1) to add a *qualified CHIP look-alike program* to the types of coverage that qualify as minimum essential coverage. This provision would be effective with respect to taxable years after December 31, 2017.
Extensions of Certain Programs and Demonstration Projects			
Childhood Obesity Demonstration Project	CHIPRA Section 401(a) established a demonstration project to develop a model for reducing childhood obesity by awarding grants to eligible entities to carry out the project. FY2017 was the last year funds were appropriated for the demonstration project.	Section 3(a) would amend SSA Section 1139A(e)(8) to appropriate $25 million for the period of FY2018 through FY2022 to carry out the childhood obesity demonstration project.	Section 302(a) is identical to the provision in S. 1827.
Pediatric Quality Measures Program	CHIPRA established a variety of activities related to pediatric quality measurement and care, for example, publishing an initial core set of pediatric quality measures and establishing a Pediatric Quality Measure Program. FY2017 was the last year funds were appropriated for some of the activities under this section.	Section 3(b) would amend SSA Section 1139A(i) to appropriate funding in the amount of $75 million for the period of FY2018 through FY2022 to be used to carry out the activities of Section 1139A (except for subsections (e), (f), and (g)), and the funding would remain available until expended.	Section 302(b) is identical to the provision in S. 1827.
Outreach and Enrollment Programs			
Outreach and Enrollment Program	CHIPRA established grants that are provided to eligible entities (e.g., states, local governments,	Section 4 would amend SSA Section 2113(a)(1) and (g) to appropriate $100	Section 303(a) includes language identical to the provision in S. 1827.

Provision	Current Law	KIDS Act (S. 1827)	Division B of the CHAMPIONING HEALTHY KIDS Act (H.R. 3922)
	community-based organizations, elementary or secondary schools) to conduct outreach and enrollment efforts that increase the participation of Medicaid and CHIP-eligible children. FY2017 was the last year funds were appropriated for the outreach and enrollment grants.	million for CHIP outreach and enrollment grants for the period of FY2018 through FY2022.	In addition, Section 303(b) would add organizations that use *parent mentors* to the list of entities that are eligible to receive outreach and enrollment grants under SSA Section 2113(f) and provide examples of the assistance such individuals could deliver using these grant funds. Section 303(c) would amend Section 1902(e)(14) to specify that compensation received by *parent mentors* for allowable activities would be disregarded when determining Medicaid eligibility for individuals for whom the MAGI income counting rules apply.
CHIP Increase to E-FMAP Rate			
Extension and Reduction of Additional Federal Financial Participation for CHIP	The federal government's share of CHIP expenditures (including both services and administration) is the E-FMAP rate, which can range from 65% to 85%. The ACA includes a provision to increase the E-FMAP rate by 23 percentage points (not to exceed 100%) for most CHIP expenditures from FY2016 through FY2019.	Section 5 would increase the E-FMAP rate under SSA Section 2105(b) for FY2020 by 11.5 percentage points.	Section 304 is identical to the provision in S. 1827.
Medicaid DSH Allotment Reductions			
Modifying Reduction in Medicaid DSH Allotments	The ACA required aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020. Subsequent laws amended these reductions. Under current law, the aggregate reductions to the Medicaid DSH allotments are to impact FY2018 through FY2025.	No provision.	Section 305 would further amend the Medicaid DSH reductions under SSA Section 1923(f)(7) by eliminating the reductions for FY2018 and FY2019 and increasing the annual reduction amounts for FY2021 through FY2023.
Medicaid Funding for Puerto Rico and the U.S. Virgin Islands			
Puerto Rico and U.S. Virgin Islands Medicaid Payments	Medicaid financing for the territories is different than the financing for the states. The FMAP for the states varies by state according to each state's per capita income and can range from	No provision.	Section 306 would (1) increase the annual growth in Puerto Rico's and the U.S. Virgin Islands' annual Medicaid allotments under SSA Section 1108(g)(2) from CPI-U to CPI-U

Provision	Current Law	KIDS Act (S. 1827)	Division B of the CHAMPIONING HEALTHY KIDS Act (H.R. 3922)
	50% to 83%, whereas the territories all have the same FMAP rate of 55%. Federal Medicaid funding to the states is open-ended, but the Medicaid programs in the territories are subject to annual federal spending caps. The ACA provided the territories with $7.3 billion in additional Medicaid funding available through FY2019. In May 2017, Puerto Rico received an additional $296 million in Medicaid funding through the Consolidated Appropriations Act, 2017 (P.L. 115-31).		plus one percentage point for FY2018 and FY2019; (2) provide additional Medicaid funding under SSA Section 1108(g)(5) to Puerto Rico and the U.S. Virgin Islands available through FY2019; and (3) increase the FMAP rate for compensation or training of skilled medical personnel and the establishment and operation of a State Medicaid fraud control unit for CY2018 and CY2019 by adding a new SSA Section 1903(a)(8).
Medicaid Third Party Liability			
Medicaid Third Party Liability Provisions	Medicaid generally serves as the payer of last resort. This means that Medicaid will pay for services only to the extent that third parties are not liable. This rule is referred to as TPL. States must in general engage in *cost avoidance* by requiring providers to bill liable third parties before billing Medicaid. However, there are exceptions for preventive pediatric services, prenatal services, and certain services rendered to individuals on whose behalf child support enforcement is being carried out. When a state pays for a Medicaid service and is later reimbursed by a third party for that service, the reimbursement for the state's expenditure is treated as an overpayment, and the state must return the federal share to CMS. BBA 13 Section 202 made two amendments to Medicaid TPL rules. First, it allowed states to choose to limit the TPL cost avoidance exceptions. BBA 13 also contained a provision enabling states to recover all portions of judgments received by Medicaid enrollees and clarifying that states may impose liens against Medicaid enrollees' assets obtained as part of a	No provision.	Section 401 would modify and add to the TPL requirements. Major provisions include: Section 401(a)(1) would postpone the effective date of the TPL amendments made by BBA 13 by two years, to October 1, 2019. Section 401(a)(3) would eliminate the cost avoidance exceptions that apply under current law. Under Section 401(a)(6), for TPL recoveries associated with ACA Medicaid expansion enrollees, the standard FMAP rate, rather than the enhanced newly eligible FMAP rate, would apply in determining the federal share of the overpayment. Section 401(b) would allow the HHS Secretary to impose a penalty for noncompliance with statutory TPL requirements. Section 401(c) would apply the Medicaid TPL requirements to CHIP.

Provision	Current Law	KIDS Act (S. 1827)	Division B of the CHAMPIONING HEALTHY KIDS Act (H.R. 3922)
	liability settlement. BBA 13 provisions took effect on October 1, 2017.		
Treatment of Lump-Sum Income for Medicaid Eligibility			
Treatment of Lottery Winnings and Other Lump-Sum Income for Purposes of Income Eligibility Under Medicaid	MAGI income counting rules—set in law and regulation—are used in determining eligibility for most of Medicaid's nonelderly populations. Under Medicaid regulations, irregular income received as a lump sum (e.g., state income tax refunds, lottery or gambling winnings, one-time gifts or inheritances) is counted as income only in the month received.	No provision.	Section 402 would amend SSA Section 1902(e)(14) to require states to consider *qualified lottery winnings* and/or *qualified lump sum income* received by an individual on or after January 1, 2018, when determining eligibility for Medicaid based on MAGI for each such individual. The provision would specify the period over which such income would be considered for a period ranging from one month to ten years depending on the amount, and would establish enrollee protections (e.g., hardship exemptions) for impacted individuals.
Medicare Part B and Part D Premium Subsidies			
Adjustments to Medicare Part B and Part D Premium Subsidies for Higher-Income Individuals	Most Medicare beneficiaries' monthly premiums cover 25% of the average annual per capita cost of coverage for Part B and 25.5% for Part D. The rest of the amount is subsidized by the federal government. Higher-income beneficiaries pay a higher percentage of the costs of their Parts B and D benefits. In 2018, individuals with annual incomes over $85,000 and couples with incomes over $170,000 will pay premiums that cover 35% to 80% of the cost on a sliding scale. At the highest income category, individuals earning more than $160,000 and couples earning more than $320,000 will pay 80% of the benefit cost. The income thresholds will be adjusted for inflation beginning in 2020.	No provision.	Section 403 would amend SSA Section 1839 to require individuals with incomes of $500,000 or more and couples with incomes of $875,000 or more to pay premiums for Parts B and D that cover 100% of the average annual per capita costs of these benefits. The income thresholds at this top level would be frozen through 2026, and adjusted annually for inflation beginning in 2027.

Source: Congressional Research Service (CRS) analysis of the Keeping Kids' Insurance Dependable and Secure (KIDS) Act of 2017 (S. 1827), as reported by the Senate Finance Committee on October 4, 2017, and Division B of the Continuing Community Health And Medical Professional Programs to Improve Our Nation, Increase

National Gains, and Help Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017 (CHAMPIONING HEALTHY KIDS Act), which is the amendment in the nature of a substitute for the Community Health And Medical Professionals Improve Our Nation Act of 2017 (CHAMPION Act, H.R. 3922, H.Res. 601), posted on the House Rules Committee website on October 30, 2017, and amended on November 1, 2017 (https://rules.house.gov/bill/115/hr-3922).

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); BBA 13 = Bipartisan Budget Act of 2013 (P.L. 113-67, Division A); CHIP = State Children's Health Insurance Program; CHIPRA = Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3); CMS = Centers for Medicare & Medicaid Services; CPI-U = Consumer price index for all urban consumers; DSH = Disproportionate share hospital; E-FMAP = Enhanced federal medical assistance percentage; FMAP = Federal medical assistance percentage; FPL = Federal poverty level; FY = Fiscal year; HHS = Department of Health and Human Services; IRC = Internal Revenue Code; MACRA = Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10); MAGI = Modified adjusted gross income; MOE = Maintenance of effort; SSA = Social Security Act; TANF = Temporary Assistance for Needy Families; TPL = Third-party liability.

Detailed Summaries of the Provisions

This section provides more detailed summaries of each provision in the KIDS Act and Division B of the CHAMPIONING HEALTHY KIDS Act. For each provision, there is a current law summary followed by an explanation of the provision in the KIDS Act. Then, there is an explanation of how the provision in Division B of the CHAMPIONING HEALTHY KIDS Act compares to the provision in the KIDS Act.

Five-Year Funding Extension of the Children's Health Insurance Program[13]

Funding

Current Law

CHIP is funded through FY2017 with appropriated amounts specified in statute. Since CHIP was first established in 1997, it has been funded through subsequent legislation. For instance, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA; P.L. 111-3) provided federal CHIP funding for FY2009 through FY2013, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) provided federal CHIP funding for FY2014 and FY2015, and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) provided funding for FY2016 and FY2017.[14]

For FY2016 and FY2017, the annual appropriation amounts were $19.3 billion and $20.4 billion, respectively. The FY2017 appropriation was the combination of semiannual appropriations of $2.85 billion from Section 2104(a) of the Social Security Act (SSA) plus a one-time appropriation of $14.7 billion from MACRA Section 301(b)(3), which was provided for the first six months of the fiscal year and remains available until expended.

Explanation of KIDS Act (S. 1827) Provision

Section 2(a) of the KIDS Act would extend federal CHIP funding for five years by adding federal appropriations for FY2018 through FY2022 under SSA Section 2104(a). The funding amounts are as follows:

- $21.5 billion for FY2018,
- $22.6 billion for FY2019,
- $23.7 billion for FY2020,
- $24.8 billion for FY2021, and
- $25.9 billion for FY2022.

The funding for FY2022 would be structured as it was for FY2017, with semiannual appropriations of $2.85 billion plus a one-time appropriation (see "One-Time Appropriation for

[13] Section 2(b)(2) of the KIDS Act and Section 301(b)(2) of the CHAMPIONING HEALTHY KIDS Act are not summarized because they are the same identical technical amendment fixing an issue with the language from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10).

[14] For more information about CHIP financing, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*, by Alison Mitchell.

FY2022") in the amount of $20.2 billion to be provided for the first six months of the fiscal year and remain available until expended.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922) Provision

Section 301(a) of the CHAMPIONING HEALTHY KIDS Act is identical to the provision in S. 1827.

Allotments

Current Law

The federal government reimburses states for a portion of every dollar they spend on CHIP, up to state-specific annual limits called allotments. Allotments are the federal funds allocated to each state for the federal share of its CHIP expenditures. State CHIP allotment funds are provided annually, and the funds are available to states for two years. Under current law, FY2017 is the last year CHIP allotments are authorized. There are two formulas for determining state allotments: an even-year formula and an odd-year formula.

In even years, such as FY2016, state CHIP allotments are based on each state's federal *allotment* for the prior year plus any Child Enrollment Contingency Fund payments (see "Extension of the Child Enrollment Contingency Fund") from the previous year, adjusted for growth in per capita National Health Expenditures and child population in the state (i.e., the allotment growth factor).

In odd years, state CHIP allotments are based on each state's *spending* for the prior year (including federal CHIP payments from the state CHIP allotment, Child Enrollment Contingency Fund payments, and redistribution funds). This figure is adjusted using the same growth factor as the even-year formula (i.e., growth in per capita National Health Expenditures and child population in the state). Because the odd-year formula is based on states' actual use of CHIP funds, it is called the *rebasing year*, and a state's CHIP allotment can either increase or decrease depending on that state's CHIP expenditures in the previous year.

State CHIP allotments can be increased to reflect CHIP eligibility or benefit expansions in either even or odd years. For a state's allotments to increase due to an expansion, the state needs to submit the required information to the Secretary of the Department of Health and Human Services (HHS) no later than August 31st preceding the beginning of the fiscal year.

Explanation of KIDS Act (S. 1827) Provision

Sections 2(b)(1)(A)-(D) of the KIDS Act would authorize CHIP allotments for FY2018 through FY2022 under SSA Section 2104(m), maintaining the allotment formulas for odd- and even-year allotments.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Sections 301(b)(1)(A)-(D) of the CHAMPIONING HEALTHY KIDS Act would authorize CHIP allotments for FY2018 through FY2022 in the same way as the provision in S. 1827. However, for FY2018, the HEALTHY KIDS Act would allow states to submit the required information regarding program expansions no later than 60 days after the enactment.

Funding for FY2022

Current Law

Prior to MACRA, FY2015 was the last year federal CHIP funding was available, and under current law, FY2017 is the last year federal CHIP funding is available. For both FY2015 and FY2017, semiannual appropriations were provided under SSA Section 2104(a) in addition to a one-time appropriation. CHIP allotments for the first half of the year were available from the semiannual appropriation amount provided in SSA Section 2104(a) provided for the first half of the year in addition to a one-time appropriation. For the second half of the year, allotments were made available from the funding provided in the first half of the year in addition to the semiannual appropriation amount provided in SSA Section 2104(a) for the second half of the year.

In FY2015 and FY2017, the full-year amount for state allotments was determined according to the odd-year formula for CHIP allotments, which means the allotments were equal to federal spending from the prior year multiplied by the allotment growth factor.

Explanation of KIDS Act (S. 1827) Provision

Section 2(b)(1)(E) of the KIDS Act would structure the federal CHIP funding for FY2022 under SSA Section 2104(m)(10) the same as it was structured for FY2015 and FY2017. For FY2022, funding for the first half of the year would be available from SSA Section 2104(a)(25)(A) and from the FY2022 one-time appropriation provided for in Section 2(b)(3) of this draft bill. Funding for the second half of the year would be provided in SSA Section 2104(a)(25)(B).

The full-year amount for state allotments would be determined according to the even-year formula for CHIP allotments, which means each state's allotment would equal the allotment for the prior year plus any Child Enrollment Contingency Fund payments from the previous year, multiplied by the allotment increase factor.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 301(b)(1)(E) of the CHAMPIONING HEALTHY KIDS Act is identical to the provision in S. 1827.

One-Time Appropriation for FY2022

Current Law

When FY2015 and FY2017 were the last years federal CHIP funding was available, one-time appropriations in the amount of $15.4 billion and $14.7 billion (respectively) were provided for allotments for the first six months of each year in addition to the semiannual appropriations provided in SSA Section 2104(a). The funds from the one-time appropriation were to remain available until expended.

The one-time appropriation for FY2015 was provided in CHIPRA Section 108, and the one-time appropriation for FY2017 was provided in MACRA Section 301(b)(3).

Explanation of KIDS Act (S. 1827) Provision

Section 2(b)(3) of the KIDS Act would provide a one-time appropriation in the amount of $20.2 billion for FY2022. This funding would accompany the allotments for the first half of FY2022, and the funding would remain available until expended.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 301(b)(3) of the CHAMPIONING HEALTHY KIDS Act is identical to the provision in S. 1827.

Extension of the Child Enrollment Contingency Fund

Current Law

CHIPRA established the Child Enrollment Contingency Fund to provide shortfall funding to certain states. It was funded with an initial deposit equal to 20% of the appropriated amount for FY2009 (i.e., $2.1 billion). In addition, for FY2010 through FY2017, such sums as were necessary for making Child Enrollment Contingency Fund payments to eligible states were to be deposited into this fund, but these transfers could not exceed 20% of the appropriated amount for the fiscal year or period.

For FY2009 through FY2017, states with a funding shortfall and CHIP enrollment for children exceeding a state-specific target level received a payment from the Child Enrollment Contingency Fund. This payment was equal to the amount by which the enrollment exceeds the target, multiplied by the product of projected per capita expenditures and the E-FMAP.

Explanation of KIDS Act (S. 1827) Provision

Section 2(c) of the KIDS Act would extend the funding mechanism for the Child Enrollment Contingency Fund under SSA Section 2104(n) and payments from the fund for FY2018 through FY2022.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 301(c) of the CHAMPIONING HEALTHY KIDS Act is identical to the provision in S. 1827.

Extension of Qualifying States Option

Current Law

In a few situations, federal CHIP funding is used to finance Medicaid expenditures. For instance, certain states had significantly expanded Medicaid eligibility for children prior to the enactment of CHIP in 1997, and these states are allowed to use their CHIP allotment funds to finance the difference between the Medicaid and CHIP matching rates (i.e., federal medical assistance percentage [FMAP] and E-FMAP rates, respectively) for the cost of children in Medicaid in families with income above 133% of FPL. The following 11 states meet the definition: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. This provision is referred to as the *qualifying states option*. Under current law, FY2017 was the last year in which the qualifying states option was authorized.

Explanation of KIDS Act (S. 1827) Provision

Section 2(d) of the KIDS Act would extend the qualifying states option under SSA Section 2105(g)(4) for FY2018 through FY2022.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 301(d) of the CHAMPIONING HEALTHY KIDS Act is identical to the provision in S. 1827.

Extension of *Express Lane* Eligibility Option

Current Law

CHIPRA created a state plan option for *Express Lane* eligibility through September 30, 2013. Under this option, states are permitted to rely on a finding from specified *Express Lane* agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and the Supplemental Nutrition Assistance Program) for

- determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility for Medicaid or CHIP,
- eligibility redeterminations for Medicaid or CHIP, or
- renewal of eligibility coverage under Medicaid or CHIP.

This provision was extended through subsequent legislation. Authority for *Express Lane* eligibility determinations expired September 30, 2017.[15]

Explanation of KIDS Act (S. 1827) Provision

Section 2(e) of the KIDS Act would amend SSA Section 1902(e)(13)(I) to extend authority for *Express Lane* eligibility determinations from FY2018 through FY2022.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 301(e) of the CHAMPIONING HEALTHY KIDS Act is identical to the provision in S. 1827.

Assurance of Affordability Standard for Children and Families

Current Law

Eligibility for Medicaid and CHIP is determined by both federal and state law, whereby states set individual eligibility criteria within federal standards. Statewide upper income eligibility thresholds for CHIP-funded child coverage vary substantially across states, ranging from a low of 170% of FPL to a high of 400% of FPL, as of July 1, 2016.[16] The Centers for Medicare &

[15] For more information see CRS Report R44662, *Health Care-Related Expiring Provisions of the 115th Congress, First Session*, coordinated by Joy M. Grossman.

[16] Medicaid and CHIP Payment and Access Commission (MACPAC), *Exhibit 34. Medicaid and CHIP Income Eligibility Levels as a Percentage of FPL for Children and Pregnant Women by State*, MACStats, July 2016.

Medicaid Services (CMS) administrative data show that CHIP enrollment is concentrated among families with annual income at lower levels. FY2013 state-reported administrative data show that approximately 99.4% of CHIP child enrollees were in families with annual income at or below 300% of FPL.[17]

Under the ACA MOE provisions, states are required to maintain their Medicaid programs with the same eligibility standards, methodologies, and procedures in place on the date of enactment of the ACA until January 1, 2014, for adults and through September 30, 2019, for children up to the age of 19 (SSA Section 1902(gg)(2)). The ACA also requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving payments under Medicaid (SSA Section 2105(d)(3)).[18] The penalty to states for not complying with either the Medicaid or the CHIP MOE requirements would be the loss of all federal Medicaid funds.

Under the CHIP statute, FY2017 was the last year federal CHIP funding is provided, even though the ACA child MOE requirement is in place through FY2019. The MOE requirement impacts CHIP Medicaid expansion programs and separate CHIP programs differently.

- *For CHIP Medicaid expansion programs*, when federal CHIP funding is exhausted, the CHIP-eligible children in these programs will continue to be enrolled in Medicaid but financing will switch from CHIP to Medicaid.
- *For separate CHIP programs*, states are provided a couple of exceptions to the MOE requirement: (1) states may impose waiting lists or enrollment caps to limit CHIP expenditures, and (2) after September 1, 2015, states may enroll CHIP-eligible children in qualified health plans in the health insurance exchanges. In addition, in the event that a state's CHIP allotment is insufficient to fund CHIP coverage for all eligible children, a state must establish procedures to screen children for Medicaid eligibility and enroll those who are Medicaid eligible. For children not eligible for Medicaid, the state must establish procedures to enroll CHIP children in qualified health plans in the health insurance exchanges that have been certified by the HHS Secretary to be "at least comparable" to CHIP in terms of benefits and cost sharing.

Explanation of KIDS Act (S. 1827) Provision

Section 2(f) of the KIDS Act would extend the Medicaid (SSA Section 1902(gg)(2)) and CHIP (SSA Section 2105(d)(3)) MOE requirements for children for three years from FY2020 through FY2022. However, for this period, the Medicaid and CHIP MOE requirements would only apply to children in families with annual income less than 300% of FPL. During this specified period, states would be permitted to roll back Medicaid and/or CHIP eligibility for children in families with annual income that exceeds 300% of FPL without the loss of all federal Medicaid matching funds.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 301(f) of the CHAMPIONING HEALTHY KIDS Act is identical to the provision in S. 1827.

[17] Centers for Medicare & Medicaid Services, Child Health Insurance Program Budget Report, based on Form 21E and 64.21E Combined, as of April 2014.

[18] For more information about the CHIP maintenance of effort requirement, see CRS Report R43909, *CHIP and the ACA Maintenance of Effort (MOE) Requirement: In Brief*, by Alison Mitchell and Evelyne P. Baumrucker.

CHIP Look-Alike Plans

Current Law

Under federal law, states are permitted to establish CHIP buy-in programs that allow children in families with annual income above the state's CHIP income eligibility thresholds to purchase health coverage through the CHIP program at full cost (including administrative fees). Historically, buy-in programs have not relied on federal CHIP funds and operate outside of CHIP program rules. As a result, states have flexibility in how they design a buy-in program, including requirements related to eligibility and enrollment processes, benefit coverage, cost-sharing, state-financed subsidies, etc.

Under the ACA's individual mandate, most individuals have to maintain minimum essential coverage or pay a penalty for noncompliance. The types of coverage that are considered minimum essential coverage are listed in Section 5000A of the Internal Revenue Code (IRC) and its implementing regulations.[19] Most types of comprehensive coverage are considered minimum essential coverage, including public coverage, such as coverage under programs sponsored by the federal government (e.g., Medicaid and CHIP), as well as private insurance (e.g., employer-sponsored insurance and non-group, or individual, insurance). CHIP buy-in programs are not listed among the types of coverage that qualify as minimum essential coverage.

Explanation of KIDS Act (S. 1827) Provision

No provision.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 301(g) of the CHAMPIONING HEALTHY KIDS Act would add a new state option at SSA Section 2107 to allow states to consider all enrollees in CHIP and in *qualified CHIP look-alike programs* to be members of a single risk pool when developing rates and premiums for program participation. A *qualified CHIP look-alike program* would be defined as a state-only program (i.e., financed with nonfederal funds, including premiums) that is available for purchase for children through the age of 18 who are not eligible for Medicaid or CHIP and that provides benefits that are at least identical to CHIP state plan benefits (or a waiver of such plan). Section 301(g) would also amend IRC Section 5000A(f)(1) to add a *qualified CHIP look-alike program* to the types of coverage that qualify as minimum essential coverage. This provision would be effective with respect to taxable years after December 31, 2017.

Extension of Certain Programs and Demonstration Projects

Childhood Obesity Demonstration Project

Current Law

SSA Section 1139A(e), as added by CHIPRA Section 401(a), requires the HHS Secretary, in consultation with the CMS Administrator, to conduct a demonstration project to develop a model for reducing childhood obesity by awarding grants to eligible entities (e.g., community-based organizations, federally-qualified health centers, and universities and colleges) to carry out the

[19] 26 U.S.C. §5000A(f) and 26 C.F.R. §1.5000A-2.

project. The law specifies how awarded funds shall be used (e.g., to carry out community-based activities related to reducing childhood obesity), and requires the Secretary to prioritize grants to certain eligible entities (e.g., those that can demonstrate having previously received funds to carry out activities that promote individual and community health, and those located in medically underserved communities or areas in which the average poverty rate is at least 150% of the average poverty rate in the state involved). CHIPRA required the Secretary to design the demonstration project within one year of enactment and to submit to Congress a report describing the demonstration project and evaluating its effectiveness not later than three years after project implementation.

CHIPRA authorized the appropriation of $25 million for the period of FY2009 through FY2013 to fund the demonstration project. ACA Section 4306 replaced the authorization of appropriations with a total appropriation of $25 million for the period of FY2010 through FY2014. In 2011, the Centers for Disease Control and Prevention (CDC) awarded funding to four grantees to conduct a four-year Childhood Obesity Research Demonstration (CORD) Project.[20] Funding was not appropriated for FY2015. MACRA Section 304(a) appropriated $10 million to fund the demonstration project for FY2016 and FY2017. The CDC launched an expansion to the first demonstration project titled CORD 2.0, which provided funding to two grantees for 2016 through 2018, focusing on clinical and weight management program interventions.[21]

Explanation of KIDS Act (S. 1827) Provision

Section 3(a) of the KIDS Act would amend SSA Section 1139A(e)(8) to appropriate $25 million for the period of FY2018 through FY2022 to carry out the childhood obesity demonstration project.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 302(a) of the CHAMPIONING HEALTHY KIDS Act is identical to the provision in S. 1827.

Pediatric Quality Measures Program

Current Law

SSA Section 1139A authorizes a variety of activities related to pediatric quality measurement and care. Under SSA Section 1139A(a), the HHS Secretary was required to identify and publish an initial core set of pediatric quality measures by no later than January 1, 2010. SSA Section 1139A(b) required the Secretary to establish a Pediatric Quality Measures Program (PQMP) by January 1, 2011. This program is required to identify pediatric quality measure gaps and development priorities, award grants and contracts to develop measures, and revise and strengthen the core measure set, among other things. Section 1139A(c) requires states to submit reports to the Secretary annually to include information about state-specific child health quality measures applied by the state, among other things. Under Section 1139A(d), the Secretary also was required, between FY2009 and FY2013, to award no more than 10 grants to states and child health providers for demonstration projects to evaluate ideas to improve the quality of children's

[20] CDC, Childhood Obesity Research Demonstration Project (CORD) 1.0, page updated July 11, 2017, https://www.cdc.gov/obesity/strategies/healthcare/cord1.html.

[21] CDC, CDC's Childhood Obesity Research Demonstration (CORD) Project 2.0, page updated August 16, 2017, https://www.cdc.gov/obesity/strategies/healthcare/cord2.html.

health care. In addition, the Secretary, not later than January 1, 2010, was required by Section 1139A(f) to establish a program to encourage the development and dissemination of a model electronic health record for children. The Institute of Medicine (IOM) was required under Section 1139A(g) to develop a report on the measurement of child health status and quality by no later than July 1, 2010.

Funding for these activities was appropriated in the amount of $45 million for each of FY2009 through FY2013. Section 210 of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) extended funding for only the PQMP for FY2014 by requiring that not less than $15 million of the $60 million appropriated for adult health quality measures under SSA Section 1139B(e) for FY2014 be used to carry out Section 1139A(b). The appropriation in Section 1139A(i) for funding to carry out Section 1139A (except for 1139A(e), the childhood obesity demonstration project) expired in FY2013; the funding designated to carry out Section 1139A(b) expired in FY2014.

MACRA Section 304(b) appropriated $20 million for the period FY2016 through FY2017 for the purposes of carrying out SSA Section 1139A. This funding was specifically excluded from being used to carry out the activities under Section 1139A(e), the childhood obesity demonstration project; Section 1139A(f), the development of a model electronic health record for children; and Section 1139A(g), the IOM study of pediatric health quality.

Explanation of KIDS Act (S. 1827) Provision

Section 3(b) of the KIDS Act would amend SSA Section 1139A(i) to appropriate funding in the amount of $75 million for the period of FY2018 through FY2022 to be used to carry out the activities of Section 1139A (except for subsections (e), (f), and (g)), and the funding would remain available until expended.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 302(b) of the CHAMPIONING HEALTHY KIDS Act is identical to the provision in S. 1827.

Extension of Outreach and Enrollment Program

Current Law

CHIPRA Section 201 appropriated (out of funds in the Treasury that were not otherwise appropriated) $100 million in outreach and enrollment grants for FY2009 through FY2013 to be used by eligible entities (e.g., states, local governments, community-based organizations, elementary or secondary schools) to conduct outreach and enrollment efforts that increase the participation of Medicaid and CHIP-eligible children.[22] Of the total appropriation, 10% is directed to a national campaign to improve the enrollment of underserved child populations, and 10% is targeted to outreach for Native American children. The remaining 80% is distributed among eligible entities for the purpose of conducting outreach campaigns, focusing on rural areas and underserved populations. Grant funds also are targeted at proposals that address cultural and linguistic barriers to enrollment. The ACA appropriated $140 million for FY2009 through

[22] For more information on CHIP Outreach and Enrollment grants see CRS Report R40821, *Medicaid and Children's Health Insurance Program (CHIP) Provisions in America's Affordable Health Choices Act of 2009 (H.R. 3200)*, by Evelyne P. Baumrucker, Cliff Binder, and Elicia J. Herz.

FY2015 for outreach and enrollment grants. MACRA Section 303 appropriated $40 million for FY2016 and FY2017 for outreach and enrollment grants. Under current law, appropriated funds for CHIP outreach and enrollment grants have not been enacted for FY2018 or subsequent fiscal years.[23]

Explanation of KIDS Act (S. 1827) Provision

Section 4 of the KIDS Act would amend SSA Section 2113(a)(1) and (g) to appropriate $100 million for CHIP outreach and enrollment grants for the period of FY2018 through FY2022.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Like the provision in S. 1827, Section 303(a) of the CHAMPIONING HEALTHY KIDS Act would amend SSA Section 2113(a)(1) and (g) to appropriate $100 million for CHIP outreach and enrollment grants for the period of FY2018 through FY2022.

In addition, Section 303(b) of the CHAMPIONING HEALTHY KIDS Act would add organizations that use *parent mentors* to the list of entities that are eligible to receive outreach and enrollment grants under SSA Section 2113(f). A *parent mentor* would be defined as a parent or guardian of a child who is eligible for Medicaid or CHIP and who is trained to assist families with uninsured children to improve social determinants of health. Such assistance may include educating families about how to obtain health insurance coverage, assisting families with completing (and submitting) health insurance coverage applications, serving as a liaison between families and representatives of Medicaid and CHIP, providing guidance to families on identifying medical and dental homes and community pharmacies for children, and providing assistance and referrals to families to address social determinants of children's health (e.g., poverty, food insufficiency, and housing). Section 303(c) would amend SSA Section 1902(e)(14) to specify that compensation received by parent mentors for allowable activities would be disregarded when determining Medicaid eligibility for individuals for whom the modified adjusted gross income (MAGI) income counting rules apply.

Extension and Reduction of Additional Federal Financial Participation for CHIP

Current Law

The federal government's share of CHIP expenditures (including both services and administration) is determined by the E-FMAP rate.[24] The E-FMAP rate is derived each year by the HHS Secretary using a set formula, and it varies by state.[25] By statute, the E-FMAP (or federal matching rate) can range from 65% to 85%.

The ACA included a provision to increase the E-FMAP rate by 23 percentage points (not to exceed 100%) for most CHIP expenditures from FY2016 through FY2019. This increases the

[23] For more information on the legislative history of the CHIP Outreach and Enrollment Grants, see CRS Report R44662, *Health Care-Related Expiring Provisions of the 115th Congress, First Session*, coordinated by Joy M. Grossman.

[24] For more information about the enhanced federal medical assistance percentage (E-FMAP) rate, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*, by Alison Mitchell.

[25] The E-FMAP rate is calculated by reducing the state share under the federal medical assistance percentage (FMAP) rate (which is the federal matching rate for most Medicaid expenditures) by 30%.

statutory range of the E-FMAP rate to 88% through 100%. With this 23 percentage point increase, the federal share of CHIP expenditures is higher, which means states are spending through their limited federal CHIP funding (i.e., state CHIP allotments) faster. In FY2017, the E-FMAP rates ranged from 88% (13 states) to 100% (12 states).

Explanation of KIDS Act (S. 1827) Provision

Section 5 of the KIDS Act would extend the increase to the E-FMAP rate under SSA Section 2105(b) for one year through FY2020. However, for FY2020 the increase to the E-FMAP would be 11.5 percentage points instead of 23 percentage points.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 304 of the CHAMPIONING HEALTHY KIDS Act is identical to the provision in S. 1827.

Modifying Reduction in Medicaid Disproportionate Share Hospital (DSH) Allotments

Current Law

SSA Section 1923 requires states to make Medicaid DSH payments to hospitals treating large numbers of low-income patients.[26] This provision was intended to recognize the disadvantaged financial situation of those hospitals because low-income patients are more likely to be uninsured or Medicaid enrollees. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates generally are lower than the rates paid by Medicare and private insurance.

Whereas most federal Medicaid funding is provided on an open-ended basis, federal Medicaid DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments. Each state's Medicaid DSH allotment increases annually by the percentage change in the Consumer Price Index for All Urban Consumers (CPI-U) for the prior fiscal year.

The ACA reduced the number of uninsured individuals in the United States through its health insurance coverage provisions. Built on the premise that with fewer uninsured individuals there should be less need for Medicaid DSH payments, the ACA included a provision directing the HHS Secretary to make aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020. However, multiple subsequent laws have amended these reductions. Under current law, the aggregate reductions to the Medicaid DSH allotments total $43 billion and are to impact FY2018 through FY2025. After FY2025, allotments will be calculated as though the reductions never occurred, which means the allotments will include the inflation adjustments for the years during the reductions.

Explanation of KIDS Act (S. 1827) Provision

No provision.

[26] For more information about Medicaid disproportionate share hospital (DSH) payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by Alison Mitchell.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 305 of the CHAMPIONING HEALTHY KIDS Act would further amend the Medicaid DSH reductions under SSA Section 1923(f)(7) by eliminating the reductions for FY2018 and FY2019 and increasing the annual reduction amounts for FY2021 through FY2023. The aggregate reduction amounts would increase from $43.0 billion to $44.0 billion. Specifically, under this provision, the annual aggregate reductions to the Medicaid DSH allotments would be $4.0 billion in FY2020 and $8.0 billion for each year from FY2021 through FY2025. In FY2026, states' DSH allotments would be calculated as though the reductions never occurred, with the annual inflation adjustments for FY2020 through FY2025.

Puerto Rico and U.S. Virgin Islands Medicaid Payments

Current Law

Medicaid financing for the territories (i.e., America Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands) is different than the financing for the 50 states and the District of Columbia.

The five territories all have the same FMAP rate (i.e., federal matching rate) of 55%, whereas the FMAP for the 50 states and the District of Columbia varies by state according to each state's per capita income and can range from 50% to 83%. The territories are eligible for some (but not all) of the FMAP exceptions available to states and the District of Columbia for certain states, situations, populations, providers, and services. For instance, expenditures for compensation or training of skilled medical personnel of the state agency or public agency are matched at 75%, and expenditures for the establishment and operation of a State Medicaid fraud control unit are matched at 90% for the first twelve-quarter period after the unit is established and 75% after that period.

Federal Medicaid funding to the states and the District of Columbia is open-ended, but the Medicaid programs in the territories are subject to annual federal spending caps (i.e., allotments). These Medicaid caps increase annually according to the change in CPI-U. Once the cap is reached, the territories assume the full cost of Medicaid services or, in some instances, may suspend services or cease payments to providers until the next fiscal year.

Prior to the ACA, all five territories typically exhausted their federal Medicaid funding prior to the end of the fiscal year. For this reason, the territories received an additional $7.3 billion in funding through the ACA from two provisions of the law. One provision provided $6.3 billion in additional Medicaid federal funding to the territories to be distributed proportionally, and this funding is available between July 1, 2011, and September 30, 2019. In addition, another ACA provision provided $1.0 billion in increased Medicaid funding to the territories because none of the territories established exchanges. In May 2017, Puerto Rico received an additional $296 million in Medicaid funding through the Consolidated Appropriations Act, 2017 (P.L. 115-31).[27]

The Puerto Rico Oversight, Management, and Economic Stability Act (P.L. 114-187) set up a Financial Management and Oversight Board with broad fiscal powers to approve, for territory governments or instrumentalities of those governments (such as public corporations or municipal governments): fiscal plans; budgets; voluntary agreements with bondholders; debt restructuring plans; and critical projects eligible for expedited permitting processes.

[27] For more information about the Medicaid program in Puerto Rico, see CRS Report R44275, *Puerto Rico and Health Care Finance: Frequently Asked Questions*, coordinated by Annie L. Mach.

Explanation of KIDS Act (S. 1827) Provision

No provision.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 306(a) of the CHAMPIONING HEALTHY KIDS Act would increase the annual growth in Puerto Rico's and the U.S. Virgin Islands' annual Medicaid allotments under SSA Section 1108(g)(2) from CPI-U to CPI-U plus one percentage point for FY2018 and FY2019.

Section 306(a) of the CHAMPIONING HEALTHY KIDS Act would also increase Medicaid funding for Puerto Rico provided under SSA Section 1108(g)(5) by $880 million that is available through September 30, 2019. An additional $120 million would be available to Puerto Rico through September 30, 2019, if the Financial Management and Oversight Board certifies that Puerto Rico has taken reasonable and appropriate steps during the period of October 1, 2017, through December 31, 2019, to (1) reduce Medicaid fraud, waste, and abuse; (2) implement strategies to reduce unnecessary, inefficient, or excessive Medicaid spending; (3) improve the use and availability of Medicaid data for program oversight and operation; and (4) improve quality of care and patient experience for Medicaid enrollees.

Section 306(a) of the CHAMPIONING HEALTHY KIDS Act would increase the Medicaid funding for the U.S. Virgin Islands provided under SSA Section 1108(g)(5) by an amount equal to the per capita equivalent of the increased Medicaid funding provided to Puerto Rico under Section 306. The per capita equivalent is defined as the ratio of the population of the U.S. Virgin Islands to the population of Puerto Rico using the most recent estimates from the Bureau of the Census released before September 4, 2017.

Section 306(b) of the CHAMPIONING HEALTHY KIDS Act would add a new SSA Section 1903(a)(8), which would increase Puerto Rico and U.S. Virgin Islands' Medicaid matching rates during the period of January 1, 2018, through December 31, 2019, for expenditures for (1) compensation or training of skilled medical personnel of the state agency or public agency from 75% to 90% and (2) the establishment and operation of a State Medicaid fraud control unit from 75% to 90% after the first twelve-quarter period after the unit is established. The payments for these increases to the matching rate would not be taken into account for Puerto Rico's and U.S. Virgin Islands' annual Medicaid allotment funding.

Medicaid Third Party Liability Provisions[28]

Medicaid Third Party Liability

Current Law

Under SSA Section 1902(a)(25), Medicaid generally serves as the payer of last resort. This means that Medicaid will pay for services only to the extent that third parties are not liable.[29] This principle is referred to as *third-party liability* ("TPL").

[28] Section 201(f) provides the effective date for Section 201(a)-(e). Except as otherwise specified, Section 201 would take effect on October 1, 2019, and apply to Medicaid and CHIP services provided after that date. If, under a Medicaid state plan or CHIP state plan, state legislation would be needed in order for the state to meet a specific statutory requirement under Section 201, then the requirement would be deemed to take effect on the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature beginning after enactment.

[29] Social Security Act (SSA) §1902(a)(25)(A); 42 C.F.R. §433.139.

Under the statute, states must meet numerous TPL requirements with respect to both *third parties* in general, and *health insurers* that may be liable for care furnished to Medicaid enrollees. For example, states must collect TPL-related information at the time of Medicaid eligibility determinations and redeterminations and must submit to the HHS Secretary a plan for pursuing third parties, to be monitored as part of the HHS Secretary's review of the state's mechanized claims processing system. States must require health insurers to disclose to the state Medicaid agency information concerning the insurer's coverage of Medicaid-eligible individuals, must respond to the state's TPL inquiries, and must process third-party claims filed by the state.

Under the federal Medicaid regulations, states must require providers to bill liable third parties before billing Medicaid. (This requirement is referred to as *cost avoidance.*) SSA Section 1902(a)(25)(E) and (F) provides for exceptions to the cost avoidance rule. Specifically, for preventive pediatric services, prenatal services, and certain services rendered to individuals on whose behalf child support enforcement is being carried out, states are required to pay providers' claims under standard claims payment rules and then seek reimbursement from liable third parties, rather than withholding payment until the third party's liability has been determined.

In general, where an enrollee is entitled to payment by a third party for an item or service but Medicaid has already paid, the enrollee is considered to have assigned his or her claim to payment to the state. In addition, when a state makes a payment to a provider for a service and the state is later reimbursed by a third party for that service, the state's service expenditure is treated as an overpayment to the extent of the third party's payment to the state. The state is required to return to CMS the federal share of the overpayment.

Section 202 of the Bipartisan Budget Act of 2013 (BBA 13; P.L. 113-67, Division A), made two amendments to Medicaid TPL rules under SSA Section 1902(a)(25). First, it limited the exceptions to the Medicaid TPL requirement of cost avoidance described above. Specifically, states may choose to defer payment to providers of preventive pediatric, prenatal services and services to children on whose behalf child support enforcement is being carried out, such that the state pays the provider only if a liable third party has not made payment within 90 days after the date the provider submitted a claim to the third party relating to the services. BBA 13 also amended the SSA to enable states to recover all portions of judgments received by Medicaid enrollees and clarified that states may impose liens against Medicaid enrollees' assets obtained as part of a liability settlement. The BBA 13 provisions, as amended by PAMA and MACRA, took effect on October 1, 2017.

Explanation of KIDS Act (S. 1827) Provision

No provision.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 401(a)(1) of the CHAMPIONING HEALTHY KIDS Act would postpone the effective date of the TPL amendments made by BBA 13 by two years, to October 1, 2019. The provision postponing the effective date would take effect on September 30, 2017, and apply with respect to any open claims, including claims generated or filed, after that date.

Section 401(a)(2) of the CHAMPIONING HEALTHY KIDS Act would substitute the current terms *third party* and *health insurer* in current SSA Section 1902(a)(25) with one term, *responsible third party*. It would add a new SSA Section 1902(nn) defining *responsible third party.* This represents a change from current law because at present, the terms *third party* and *health insurer* are not explicitly defined in the statute.

Section 401(a)(3) of the CHAMPIONING HEALTHY KIDS Act would amend SSA Section 1902(a)(25)(E) and repeal Section 1902(a)(25)(F) in order to eliminate the cost avoidance exceptions that currently apply to pediatric preventive services, prenatal services, and services furnished to children on whose behalf child support enforcement is being carried out. A cost avoidance exception would apply only to pediatric vaccines furnished under the Vaccines for Children program.

Section 401(a)(4) of the CHAMPIONING HEALTHY KIDS Act would add a new SSA Section 1902(a)(25)(F) clarifying both the role of Medicaid managed care entities (and other health insurers) in furnishing Medicaid benefits under contract with the state, as well as the role of health insurers as *responsible third parties*. For example, the provision would require that where states provide Medicaid services through a contract with a health insurer, the contract must specify any responsibility of the health insurer with respect to recovery of payment from *responsible third parties* pursuant to the delegation or transfer by the state to the insurer of enrollees' right to payment by third parties. It would require that where a state elects to delegate or transfer its TPL rights to a health insurer, the state must ensure the state law confers on the insurer the same authority that the state would otherwise have with respect to the state's dealings with other health insurers on TPL matters. The provision would require that reimbursements made by *responsible third parties* to a health insurer under contract with the state be treated as overpayments, just as such TPL reimbursements would be treated if paid directly to the state.

Section 401(a)(5) of the CHAMPIONING HEALTHY KIDS Act would clarify the scope of the obligations that states must impose on health insurers as *responsible third parties* under SSA Section 1902(a)(25)(I). For example, currently, states must require health insurers to respond to the state's inquiries regarding TPL claims; the new provision would specify that the insurer must respond within 60 days. Similarly, under current law, states must require health insurers to agree not to deny TPL claims submitted by the state solely on the basis of the date of submission of the claim, or the type or format of the claim. The new provision would add that such claims may not be denied solely on the basis of a lack of prior authorization.

Section 401(a)(6) of the CHAMPIONING HEALTHY KIDS Act would amend SSA Section 1903(d)(2)(B) to provide that, with respect to expenditures for Medicaid services provided to individuals who are eligible for Medicaid by virtue of the ACA eligibility expansion (*ACA Medicaid expansion enrollees*), the HHS Secretary, in determining the amount of the federal overpayment to the state relating to a TPL recovery (i.e., the federal share of the state's overpayment to the provider), would apply the state's standard FMAP rate, rather than the *newly eligible* matching rate.[30] This would mean that the states would retain a larger percentage of the third-party overpayment recoveries for services furnished to *ACA Medicaid expansion enrollees*.

Compliance with Third Party Insurance Reporting

Current Law

The federal government's share for most Medicaid expenditures is called the FMAP rate. States' FMAP rates are subject to various exceptions for specific types of situations, enrollee

[30] Under the *newly eligible* federal matching rate, from 2014 through 2016, states received a 100% federal matching rate for the cost of individuals who gained eligibility for Medicaid as a result of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) Medicaid expansion. This *newly eligible* federal matching rate phases down to 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter. For more information on the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*, by Alison Mitchell.

populations, services, or providers. The FMAP exceptions currently in effect are increases to, rather than reductions to, a state's standard FMAP.

Current law does not impose any specific penalties on states for failure to comply with the TPL requirements in SSA Section 1902(a)(25). In general, CMS has the authority to disallow federal participation in states' Medicaid expenditures in specific instances where CMS determines that the expenditure does not comply with the state plan or federal Medicaid requirements.

Explanation of KIDS Act (S. 1827) Provision

No provision.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 401(b) of the CHAMPIONING HEALTHY KIDS Act would add a new Section 1905(ee) to the SSA providing that, beginning in 2020, if a state fails to comply with the TPL requirements in SSA Section 1902(a)(25) with respect to each calendar quarter of a year, the HHS Secretary may reduce the FMAP by 0.1 percentage point (one-tenth of one percentage point) for calendar quarters of each subsequent year in which the state also fails to comply.

Application to CHIP

Current Law

SSA Section 2107(e), which lists specific provisions of Title XIX (Medicaid) of the SSA that apply to CHIP, does not list the TPL requirements in SSA Section 1902(a)(25).

Under SSA Section 1902(a)(25)(I)(i), states must, through state law, require health insurers to provide to the state, upon state request, information concerning Medicaid enrollees or Medicaid-eligible individuals to determine during what period the individual was covered by the health insurer. At state option, the same requirements can be imposed on health insurers with respect to enrollees or eligible individuals under CHIP.

Explanation of KIDS Act (S. 1827) Provision

No provision.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 401(c)(1) of the CHAMPIONING HEALTHY KIDS Act would amend SSA Section 2107(e)(1) to include the TPL requirements at SSA Section 1902(a)(25) as a Medicaid provision binding on the CHIP program.

Section 401(c)(2) of the CHAMPIONING HEALTHY KIDS Act would amend SSA Section 1902(a)(25)(I)(i) to make its application to CHIP mandatory rather than optional for the state.

Training on Third Party Liability

Current Law

SSA Section 1936 requires the HHS Secretary to establish a Medicaid Integrity Program, under which the HHS Secretary contracts with eligible entities to conduct various review, audit, education, and training activities. SSA Section 1936(b)(4) requires the HHS Secretary to provide

for education and training of state or local personnel responsible for the administration of the Medicaid program, as well as providers, managed care entities, and enrollees, concerning "payment integrity and quality of care."

Explanation of KIDS Act (S. 1827) Provision

No provision.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 401(d) of the CHAMPIONING HEALTHY KIDS Act would add a new SSA Section 1936(f) requiring that the education and training included in the Medicaid Integrity Program include training on the liability of *responsible third parties*. It would require that, as part of this education and training, the HHS Secretary (1) publish information on its website concerning TPL best practices, (2) monitor states' efforts to assess TPL and analyze the challenges posed by such assessment, (3) distribute to state Medicaid agencies information relating to these efforts and challenges, and (4) provide guidance to state Medicaid agencies concerning state oversight of TPL efforts by Medicaid managed care plans under SSA Section 1903(m) or 1932.

Development of Model Uniform Fields for States to Report Third Party Information

Current Law

CMS makes quarterly Medicaid grant awards to states to cover the federal share of Medicaid expenditures. The amount of the grant is determined on the basis of information submitted by the state to CMS in quarterly estimate and quarterly expenditure reports. States are required to submit Form CMS-64, the Quarterly Medicaid Statement of Expenditures, within 30 days after the end of each quarter. The Form CMS-64 contains a schedule relating to aggregate TPL collections.

Explanation of KIDS Act (S. 1827) Provision

No provision.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 401(e) of the CHAMPIONING HEALTHY KIDS Act would require the HHS Secretary, in consultation with the states, to develop and make available to states not later than January 1, 2019, a model uniform set of reporting fields and accompanying guidance that states may use for purposes of (1) reporting to CMS through the Transformed Medicaid Statistical Information System (T-MSIS) and (2) collecting information identifying *responsible third parties* and other relevant information for ascertaining their responsibility to pay for Medicaid and CHIP services.[31]

[31] The Medicaid Statistical Information System (MSIS) is used by the Centers for Medicare & Medicaid Services (CMS) to gather eligibility, enrollment, program, utilization, and expenditure data for Medicaid and CHIP. T-MSIS represents CMS' modernization of the MSIS, which is currently in process.

Treatment of Lottery Winnings and Other Lump-Sum Income for Purposes of Income Eligibility Under Medicaid

Current Law

The ACA created IRC Section 36B to provide premium assistance tax credits for individuals to purchase coverage through the health insurance exchanges, among other purposes. Section 36B includes a definition of household income, based on MAGI. Section 36B's definition of MAGI is used to determine eligibility for various federal health programs, including Medicaid. As of January 1, 2014, MAGI rules are used in determining eligibility for most of Medicaid's nonelderly populations, including the ACA Medicaid expansion.

Medicaid's MAGI income-counting rule is set forth in law and regulation.[32] Under the Medicaid MAGI counting rules, the state looks at each individual's MAGI, deducts 5%, which the law provides as a standard disregard for individuals at the highest income limit for coverage, and compares that income to the income standards set by the state in coordination with CMS.

For Medicaid, MAGI is defined as the IRC's adjusted gross income (AGI, which reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments) increased by certain types of income (e.g., tax-exempt interest income received or accrued during the taxable year and the nontaxable portion of Social Security benefits). In addition, under Medicaid regulations, certain types of income are subtracted (e.g., certain scholarships and fellowships) to arrive at MAGI. Also under Medicaid regulations, irregular income received as a lump sum (e.g., state income tax refunds, lottery or gambling winnings, one-time gifts or inheritances) is counted as income only in the month received. In addition to specifying the types of household income that must be considered during eligibility determinations, the regulations also define "household." The income of any person defined as a part of an individual's "household" must be counted when determining that individual's income level for purposes of a Medicaid eligibility determination.

Medicaid program regulations make a distinction with regard to the budget period when determining income eligibility for applicants and new enrollees as compared to eligibility redeterminations for current enrollees. Specifically, income eligibility for applicants and new enrollees is based on current monthly household income. When redetermining eligibility for current Medicaid enrollees, states are permitted to use current monthly income and family size, or projected annual income and family size for the remaining months of the calendar year. For states that choose the latter measure when redetermining eligibility, Medicaid requires the applicant to predict income and household size for the remaining months of the calendar year.

Explanation of KIDS Act (S. 1827) Provision

No provision.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 402 of the CHAMPIONING HEALTHY KIDS Act would amend SSA Section 1902(e)(14) to require states to consider *qualified lottery winnings* and/or *qualified lump sum income* received by an individual on or after January 1, 2018, when determining eligibility for Medicaid based on MAGI for each such individual. Such income would not be counted as

[32] For more information on Medicaid's MAGI income-counting rule, see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*, coordinated by Evelyne P. Baumrucker.

household income when determining Medicaid eligibility for other members (other than the individual's spouse) of the individual's household.

Winnings and/or income in an amount less than $80,000 would be considered in the month that such winnings and/or income are received. Amounts greater than or equal to $80,000 but less than $90,000 would be prorated over a period of 2 months. Amounts greater than or equal to $90,000 but less than $100,000 would be prorated over a period of 3 months. For purpose of prorating winnings and/or income in amounts greater than or equal to $100,000, one additional month would be added for each increment of $10,000 received, not to exceed 120 months (or 10 years) for winnings and/or income of $1,260,000 or more. Winnings and/or income greater than or equal to $80,000 would be required to be counted in equal monthly installments over the applicable time period.

The provision would establish a state option for a hardship exemption for individuals for whom the denial of Medicaid eligibility based on such income would cause an undue medical or financial hardship as determined by criteria established by the HHS Secretary. States would be required to inform individuals in advance of their loss of Medicaid eligibility and of their option to enroll in a qualified health plan offered through the health insurance exchange during a special enrollment period (due to the loss of Medicaid or CHIP coverage) and to provide technical assistance to assist such individuals in enrolling in such coverage. The state would also be required to inform each individual of the date that such individual would be permitted to reapply for Medicaid.

The provision would define "qualified lottery winnings" as winnings (including amounts awarded as a lump sum payment) from a state-conducted sweepstakes or lottery, or a lottery operated by a multistate or multijurisdictional lottery association. The bill would define "qualified lump sum" income as income received as a lump sum: (1) from monetary winnings from gambling (as defined by the HHS Secretary and including monetary winnings from gambling activities described in section 1955(b)(4) of title 18 of the United States Code), (2) damages received by suit or agreement in lump sums or as periodic payments (other than monthly payments) on account of causes of action (other than causes of action arising from personal physical injuries or physical sickness), or (3) as liquid assets from the estate of a deceased individual (as defined in SSA Section 1917(b)(4)). The bill would specify that states may recover lottery winnings awarded to the individual to pay for Medicaid medical assistance furnished to the individual.

Adjustments to Medicare Part B and Part D Premium Subsidies for Higher-Income Individuals

Current Law

For the first 41 years of the Medicare program, all Part B enrollees paid the same Part B premium amounts, regardless of their income. However, the Medicare Modernization Act of 2003 (P.L. 108-173) required that, beginning in 2007, higher-income Part B enrollees pay higher premiums. Similarly, when the Part D program began in 2006, all enrollees in the same Part D plan paid the same premiums. The ACA subsequently imposed high-income premiums on Part D prescription drug benefit enrollees, beginning in 2011. The Social Security Administration notes that fewer than 5% of Medicare beneficiaries pay these higher premiums.[33]

[33] Social Security Administration, "Medicare Premiums: Rules for Higher-Income Beneficiaries," January 2017,

For Part B, standard premiums (i.e., premiums paid by enrollees who are not considered high income) are set at 25% of average annual per capita Part B program expenditures, and the remaining 75% of costs are subsidized by the federal government.[34] Similarly, under Part D, base premiums are set at 25.5% of average annual per capita costs for standard Part D coverage, and the remaining 74.5% is subsidized by the federal government.[35] Adjustments are made to the Parts B and D premiums for higher-income beneficiaries, with the percentage of per capita expenditures paid by these beneficiaries increasing with income. (In other words, the federal subsidy declines as income levels increase.) This percentage currently ranges from 35% to 80% of average per capita expenditures for both Parts B and D. The income thresholds for couples who file joint tax returns are 200% of the individual income threshold at each level. In 2017, individuals whose annual income exceeds $85,000 ($170,000 for a couple) are subject to higher premium amounts. (See **Table 2**.)

Table 2. 2017 Monthly Medicare Part B Premiums and Part D Premium Adjustments

Beneficiaries Who File Individual Tax Returns with Income:	Beneficiaries Who File Joint Tax Returns with Income:	Applicable Percentage[a]	2017 Monthly Part B Premiums	2017 Monthly Part D Premium Adjustment
Less Than or Equal to $85,000	Less Than or Equal to $170,000	25%[b]	$134.00	$0.0
Greater Than $85,000 and Less Than or Equal to $107,000	Greater Than $170,000 and Less Than or Equal to $214,000	35%	$187.50	$13.30
Greater Than $107,000 and Less Than or Equal to $160,000	Greater Than $214,000 and Less Than or Equal to $320,000	50%	$267.90	$34.20
Greater Than $160,000 and Less Than or Equal to $214,000	Greater Than $320,000 and Less Than or Equal to $428,000	65%	$348.30	$55.20
Greater Than $214,000	Greater Than $428,000	80%	$428.60	$76.20

Sources: Centers for Medicare & Medicaid Services (CMS), "Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2017," 81 *Federal Register* 80063, November 15, 2016, and CMS, "Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information," July 29, 2016.

Notes: The Part B column shows the full premium. The Part D column represents the high-income adjustment that is added onto the Part D drug plan premium, which can vary among plans.

a. Applicable percentage refers to the percentage of average per capita benefit costs covered by beneficiary premiums in each income category.

b. For Part D, the applicable percentage in the lowest income category is 25.5%.

As required by the ACA, and modified by MACRA, income thresholds used in determining high-income premiums for 2011 through 2017 are frozen at the 2010 levels. Prior to 2010, annual

https://www.ssa.gov/pubs/EN-05-10536.pdf.

[34] In 2017, the standard monthly Part B premium is $134.00. However some individuals pay lower amounts due to the application of a hold-harmless provision in the Social Security Act that protects Social Security benefits from being reduced from one year to the next as a result of an increase in Part B premiums. For additional information on Part B premiums, see CRS Report R40082, *Medicare: Part B Premiums*, by Patricia A. Davis.

[35] In 2017, the base monthly Part D premium is $35.63; however, actual premiums paid by beneficiaries vary depending on the prescription drug plan that they select. Part D plans must offer either a statutorily defined standard benefit or a plan that is actuarially equivalent; plans can also provide additional, "enhanced," benefits. The Part D base premium is equal to the product of 25.5% and the national average monthly bid amount (which is an enrollment-weighted average of bids submitted by both stand-alone and Medicare Advantage Part D plans). See CMS, "Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information," July 29, 2016, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2017.pdf.

adjustments to these thresholds were based on annual changes in the CPI-U, rounded to the nearest $1,000. This has meant that over time, as income—including Social Security benefits—has increased with inflation, a greater proportion of Medicare enrollees have paid the high-income premiums.

Beginning in 2018, MACRA Section 402 lowers the income thresholds for the top two income groups as shown in **Table 3** (current law heading). Individuals with incomes between $133,500 and $160,000 per year will be in the 65% applicable percentage group (instead of those with incomes between $160,000 and $214,000), and the income threshold for the highest group (80%) will be $160,000 (instead of $214,000). For years 2020 and thereafter, the thresholds will be adjusted annually for inflation based on the CPI-U. The adjustments will be based on the new (2018 and 2019) threshold levels.

Explanation of KIDS Act (S. 1827) Provision

No provision.

Explanation of CHAMPIONING HEALTHY KIDS Act (H.R. 3922)

Section 403 of the CHAMPIONING HEALTHY KIDS Act would amend SSA Section 1839 to add an additional income tier for individuals with annual earnings of $500,000 or more or couples filing jointly with earnings of $875,000 or more. (See **Table 3** (proposed modification heading).) Enrollees exceeding these thresholds would pay premiums that cover 100% of the average per capita cost of the Parts B and D benefits. The threshold for couples filing jointly in this new income tier would be calculated as 175% of the individual income level rather than 200% as in the other income tiers. This top threshold would be frozen through 2026, and would be adjusted annually for inflation starting in 2027 based on the CPI-U.

Table 3. Current Law and Proposed Income Thresholds for High-Income Medicare Premiums Starting in 2018

Current Law			Proposed Modification	
Beneficiaries Who File Individual Tax Returns with Income:	**Beneficiaries Who File Joint Tax Returns with Income:**	**Applicable Percentage[a]**	**Beneficiaries Who File Individual Tax Returns with Income:**	**Beneficiaries Who File Joint Tax Returns with Income:**
Less Than or Equal to $85,000	Less Than or Equal to $170,000	25%[b]	Less Than or Equal to $85,000	Less Than or Equal to $170,000
More Than $85,000 but Not More Than $107,000	More Than $170,000 but Not More Than $214,000	35%	More Than $85,000 but Not More Than $107,000	More Than $170,000 but Not More Than $214,000
More Than $107,000 but Not More Than $133,500	More Than $214,000 but Not More Than $267,000	50%	More Than $107,000 but Not More Than $133,500	More Than $214,000 but Not More Than $267,000
More Than $133,500 but Not More Than $160,000	More Than $267,000 but Not More Than $320,000	65%	More Than $133,500 but Not More Than $160,000	More Than $267,000 but Not More Than $320,000
More Than $160,000	More Than $320,000	80%	More Than $160,000 but Less Than $500,000	More Than $320,000 but Not More Than $875,000

Current Law			Proposed Modification	
Beneficiaries Who File Individual Tax Returns with Income:	**Beneficiaries Who File Joint Tax Returns with Income:**	**Applicable Percentage[a]**	**Beneficiaries Who File Individual Tax Returns with Income:**	**Beneficiaries Who File Joint Tax Returns with Income:**
n/a	n/a	100%	At Least $500,000	More Than $875,000

Source: SSA Section 1839(i)(3)(C)(i)(II) and Section 403 of the Continuing Community Health And Medical Professional Programs to Improve Our Nation, Increase National Gains, and Help Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017 (CHAMPIONING HEALTHY KIDS Act, H.R. 3922), as approved by the House Rules Committee on November 1, 2017.

Note: n/a = not applicable.

a. Applicable percentage refers to the percentage of average per capita benefit costs covered by beneficiary premiums in each income category.

b. For Part D, the applicable percentage in the lowest income category is 25.5%.

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