



H.R. 3162 - Children's Health and Medicare Protection Act of 2007

Floor Situation

The Children's Health and Medicare Protection "CHAMP" Act of 2007 (HR 3162) was introduced by Rep. Dingell (D-MI) on July 24, 2007. This legislation was referred to the Committees on Energy and Commerce and Ways & Means.

Energy & Commerce

CHAMP was considered by the Energy & Commerce Committee on July 26-27, 2007. The legislation was not reported out of the committee.

Ways & Means

CHAMP was considered by the Ways & Means Committee on July 25, 2007 and was passed with one amendment by a vote of 24-17.

The Senate is currently debating a much smaller version of the SCHIP expansion bill. This legislation has been introduced in the Senate by Sen. Baucus (D-MT) the Children's Health Insurance Program Reauthorization Act of 2007 (S 1893). Currently this legislation is being debated on the Senate floor.

H.R. 3162 is being considered on the floor pursuant to a closed rule. The Rule:

- Provides 2 hours of debate with 1 hour equally divided and controlled by the Chairman and Ranking Member of the Committee on Ways and Means and 1 hour equally divided and controlled by the Chairman and Ranking Member of the Committee on Energy and Commerce.
- Waives all points of order against consideration of the bill except those arising under clauses 9 (earmarks) and 10 (PAYGO) of Rule XXI.
- Provides 1 motion to recommit with or without instructions.

**Note: The rule self-executes substitute text to the original bill. Bullets in bold in this Legislative Digest represent the changes made by the self-executing rule to the bill.*

H.R. 3162 is expected to be considered on the floor on August 1, 2007.

Executive Summary

HR 3162 significantly expands the State Children's Health Insurance Program (SCHIP) which was established under The Balanced Budget Act of 1997 to provide health coverage to uninsured children who would not otherwise qualify for Medicaid. Specifically this legislation would:

- Significantly expand the scope and coverage of SCHIP and Medicaid

Note: The bill provides significant increases in federal funds to states to enable them to dramatically expand SCHIP, costing \$210 billion in federal dollars over ten years. Further, this combined with federal and state spending will ultimately cost the American taxpayer \$300 billion over ten years.

Note: Using these new funds, a state could qualify a family of four making more than \$100,000 a year to receive taxpayer subsidized, government-run healthcare under a program that was originally intended for low-income children.

Note: The growth of SCHIP and Medicaid under HR 3162 will also cause almost 2 million children who currently have private health insurance coverage to lose this coverage.

- Defines children eligible for SCHIP to include person up to age 25.

Note: This is a change from the previous legislation which covered children up to that age of 19.

- **The amendment offered at Rules Committee would change the age from 25 to 21.**

- Allows immigrants to qualify for SCHIP and Medicaid

Note: Currently legal immigrants are barred from enrolling in Medicaid and SCHIP for their first five years in the U.S., because their sponsors have agreed as a condition of their admission into the country to provide for any assistance that these immigrants may require.

- Treats a pregnant woman as a child; if a child would qualify for SCHIP under the circumstances, then so does the pregnant woman.

Note: Many of these women would qualify for Medicaid and not require SCHIP. This creates a whole new SCHIP eligibility category.

- The legislation repeals the requirement from the Deficit Reduction Act that states verify an individual's citizenship before enrolling them in Medicaid.

Note: It would now be a state option to verify citizenship even though the federal taxpayer pays a majority cost of the program.

- Eliminates the five year waiting period for immigrants in order to be eligible for SCHIP and Medicaid

Note: This elimination allows immigrants to immediately enroll in programs that are funded by taxpayers and subsidized by the government. There is no incentive to be self sufficient.

- Provides “bonus payments” for States who cut corners, including the assets test.

Note: Disregarding the assets test enables states to fund families significantly above the FPL.

- Cuts payments to Medicare Advantage (MA) plans by \$157 billion over 10 years.

Note: These cuts will mean that over 3 million seniors will lose their current coverage under MA plans. Early estimates of these significant cuts find that all the MA beneficiaries in up to 22 states will lose their coverage. These plans provide benefits that traditional Medicare does not offer, including vision, dental coverage, protection against catastrophic health expenses, and assistance with co-payments and deductibles

- Cuts Medicare payments to a broad range of Medicare providers, including hospitals, nursing homes, and home health agencies.

Note: H.R. 3162 cuts \$7.7 billion from these providers over 5 years, and some providers have raised concerns about whether they will continue to be able to provide the same level of high quality care for Medicare beneficiaries if these cuts are enacted.

- Eliminates the 45% trigger that was implemented in the MMA to require Congress to act in an expeditious manner if general revenues made up more than 45% of total Medicare spending for two consecutive years in a seven year period.

Note: That trigger has been met and as such next year under current law Congress would be forced to address the long term solvency of the program

- Changes the period of time that a state has to spend its SCHIP allotment from three years to two years.

Note: A shorter time period deters a State’s focus from long term planning, encourages them to be less frugal and overspend their allotments. This has a particularly large impact on states with greater populations.

- Updates the Physician fee schedule for Medicare Reimbursements to 0.5% from 2008 to 2009.

Note: Physicians are currently scheduled to see their Medicare payments reduced by approximately 10% in 2008 and 5% in 2009.

The amendment offered at Rules Committee clarifies the formula for physician reimbursement, changing the allowable growth rate from 3% to 2.5% and freezes updates after 2012.

- Changes the substantial growth rate (SGR) of the physician fee schedule for Medicare reimbursements to system of six separate categories within the Medicare fee schedule.
- Changes the “Medicare Advantage Program (MA)” to Medicare Part C
- Amends the Internal Revenue Code to increase the rate of excise taxes on tobacco products and cigarette papers and tubes to approximately \$0.39 per package and increases the cigar tax from \$0.84 to a \$1
- Removes excise taxes on fuel for emergency and medical services
- Creates a new tax to begin in 2011, to help fund comparative effectiveness research at a cost of \$375 million annually. The tax would be imposed upon all health insurance policies in the nation at a per capita rate.
- This reauthorization does not include an expiration.

Background

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (SCHIP) Title XXI of the Social Security Act. The purpose of this program is to target children who are uninsured and otherwise would not qualify for Medicaid.

It should be noted that Title XXI currently does not establish a new *individual* entitlement or entitlement program. Instead, Title XXI enables *states* with approved state SCHIP block grants to establish a children's health program. SCHIP awarded \$40 billion in Federal block grants over a 10 year period to assist states in the coverage of children. States are provided a fixed federal contribution each year based on a formula that includes the number of low income children, uninsured children and the cost of health care in the state. Each state has access to the allotment for three years, and any remaining funds leftover are relocated to states that have exhausted their original allotments.

Eligibility

Children who are typically covered by SCHIP are under the age of 19, and are in families with incomes below 200% of the federal income poverty level (FPL). In 2004, this was \$31,340 for a family of three. Children who are eligible for Medicaid or other health insurance are generally not covered by SCHIP.

Administered

Similar to Medicaid, SCHIP is funded by a partnership between the federal government and the states. States provide SCHIP benefits in a variety of ways.

Some states targeting low-income children have elected to expand the Medicaid program to cover these children. There are 17 states that use Medicaid expansions.

Several states established an entirely new SCHIP program, and are subject to Title XXI law. Title XXI allows states to use the following factors in determining eligibility: geography (e.g., sub-state areas or statewide), age (e.g., subgroups under 19), income, resources, residency, disability status (so long as any standard relating to that status does not restrict eligibility), access to or coverage under other health insurance (to establish whether such access/coverage precludes SCHIP eligibility), and duration of SCHIP enrollment. These states with separate SCHIP programs are required to provide coverage for primary and preventive benefits. There are 18 states that have established separate state programs.

Finally, some states selected to do a combination of both. There are 21 states that elect to operate using this method.

Summary of SCHIP Today

At present there are approximately 6.1 million children covered by SCHIP/Medicaid and 794,000 children eligible for Medicaid/SCHIP but are not enrolled. While SCHIP enrollment has increased over time, the rate of growth has leveled off in recent years. However, the SCHIP population has expanded from its original definition of a child below 200% of the FPL. As of November 2006, 272 amendments to original state plans had been approved by HHS with 13 more were in review. Some states use amendments to extend coverage beyond income levels defined in their original state plans. Further States have submitted 1115 waivers to help expand those included under SCHIP and as a result 14 states are experiencing short falls. Since the establishment of SCHIP, several new populations have gained coverage:

Children Above 200% of FPL

Several states have begun to offer SCHIP coverage for children who are above 200% of the FPL. There are 18 states that currently have income eligibility threshold in SCHIP above 200% of the FPL. Some examples of these states range from 220% in West Virginia to 350% in New Jersey. Further, 16 states have income eligibility levels set at 200% of the FPL but apply in income disregards and/or deductions that allow them to effectively cover some children in families with incomes above 200% of FPL.

Pregnant Women

Another use for SCHIP funds has been directed toward unborn children. Five states have SCHIP waivers to cover pregnant women.

Parents

The Secretary of HHS granted waivers for parents whose children qualified for SCHIP, to enroll themselves along with their children. Eleven states provide family-based coverage that includes parents, covering 6.1 millions adults.

Other Adults

In The Deficit Reduction Act of 2005 (DRA) Congress prohibited HHS from granting new waivers that allowed states to use SCHIP funds to cover childless adults. However, five states had already received such waivers so they were permitted to continue operating them.

Legislation

Children's Health Insurance Program, Title I

- Establishes a new State-specific base for CHIP allotments:
 - Directs states to submit funding projections based on the previous year
 - Determines that State allotments would be the greater of a State's projections for FY08 as reported in May of 2007 or the State's FY 07 allotment increased by child population growth and per capita national health care expenditure growth.
 - Determines that for fiscal year 2010 and beyond, the allotment of a state is equal to the federal payments to the state that are made available in the previous fiscal year multiplied by the allotment increase factor
 - Provides payment equal to the State's average per capita federal expenditure for a child for State's who have enrolled children who are eligible but not currently enrolled in CHIP and are experiencing a shortfall.
 - Provides reporting requirements for states

- Provides states two years to spend the federal CHIP allotment for fiscal allotment (currently it is three years).

- Redistributes unused funds to address state shortfalls:
 - Establishes a system for redistributing any State allotments unspent after two years.
 - Employs the same method of even redistribution as used for previous shortfall adjustments enacted by Congress.

- Extends the option for *qualifying states* to use a portion of their CHIP allotment (30 percent) for children covered through Medicaid and increases the amount of the allotment that can be spent on such coverage.
 - A *qualifying state* is a state that on or after April 15, 1997 had an income eligibility standard of at least 185% of the FPL for at least one category of children, other than infants.

The amendment offered at the Rules committee would change this provision to from allowing states to use 30 percent of their allotment to 100 percent.

- Creates performance bonus payments for States that enroll children above their baseline. The Secretary can grant funds to States that meet at least 4 of the following conditions:
 - State elects to have continuous eligibility for children one year
 - Liberalization of asset requirements by eliminating the asset test, or takes steps to verify the parents/caregivers assets
 - Elimination of the in person interview
 - Use a joint application for Medicaid and CHIP
 - Automatic Renewal
 - Presumptive eligibility for children
 - Use of an Express Lane Eligibility (ELE) standard to determine eligibility, which is a less investigative method.

The performance bonus is available for enrollment of children who are currently eligible for CHIP or Medicaid but are not currently enrolled.

The amendment offered at the Rules committee would change this provision to place sunset provisions at the end of FY 2013 and requires a GAO study regarding the effectiveness of outreach bonuses.

- Makes additional funding available for Medicaid outreach programs to increase the number of pregnant woman and children beneficiaries.
- Makes additional funding available for culturally appropriate enrollment and retention practices
- **The amendment offered at the Rules committee adds an additional section (115) which requires that States have 12-months of continuous eligibility and coverage for children under 200% of the FPL.**
- Allots funding for Dental services, Federally-qualified health centers (FQHC) and rural health clinics (RHC). Also specifies that school health services are covered.
- Alters benchmark coverage

- Mandates that that Secretary-approved benchmark coverage is no less protective for children than the coverage offered in other benchmark options.
 - Requires States to use the most popular family coverage for state employee coverage benchmark
- Establishes a premium grace period of 30 days from the beginning of a new coverage period
- Permits states to grant coverage of older children in Medicaid and CHIP, up to the age of 25

The amendment offered at Rules Committee would change the age from 25 to 21

- Eliminate the five year ban on legal immigrant enrollment in SCHIP and Medicaid. Opening up coverage of legal immigrants under Medicaid and CHIP for women who are pregnant (as well as the 60 day period following giving birth) and children under the age of 25.
- **The amendment offered at Rules Committee added a section (135) to prohibit federal funding from going to illegal aliens.**
- **The amendment offered at Rules Committee added a section (136) to strengthen citizenship audits for eligibility under Medicaid and CHIP.**
- Permits State's to expand or add coverage of certain pregnant women and children under CHIP
 - As long as the pregnant woman is at least 185% of the FPL
 - Covers children with family incomes up to 200% of FPL
 - Automatic enrollment of children born to pregnant women who are already enrolled in CHIP
- Permits waivers for coverage of adults unless there is no other eligible target low income children in that state.
- Establishes the Children Access, Payment, and Equality (CAPE) Commission, to analysis access and quality of care for children under CHIP and Medicaid
- Instructs the Comptroller General to develop a model process for coordination between states no later than 18 months after enactment of CHAMP, and report to Congress on it.
- Eases documentation requirement of citizenship for Medicaid enrollment; providing grace periods, and stats to determine “satisfactory” evidence with regard citizenship.

- Provides Dental care access for children
 - Establishes an educational program for new parents regarding oral hygiene
 - Prohibits states from preventing federally-qualified health centers from entering into contractual relationships with private practice dental providers
 - Requires a GAO study and Report regarding dental services
- Prohibits the initiation of new health opportunity account demonstration programs.
- Establishes a program to develop quality measures for children's health, and evaluation of the overall program performances.
- Applies various managed care quality safeguards to CHIP determined by the State
- Require the Secretary to conduct a Federal Evaluation of CHIP.
- Requires Access to records fro IG and GAO audits and evaluations.
- Repeals section 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 regarding funding allotments.
- Provides States with an undetermined period of time to comply with the provisions of this title or title VIII, before CMS takes regulatory action.

Medicare Beneficiary- Title II

- Permits States to cover preventive service -including mental illness- that the Secretary determines to be reasonable and necessary.
- Eliminates co-insurance as a deductible for current preventive benefits and future preventive benefits added through this process.
- Decreases coinsurance by five percentage points annually from 50 percent to 20 percent for outpatient mental health services by 2012.
- Weakens the assets tests for Medicare Savings Program and Low-Income Subsidy program by increasing the amount of allowable resources to \$17,000 for an individual and \$34,000. Further in 2010, the limit is increased annually by \$1,000 per individual and \$2,000 per couple.
- Makes the Qualified Individual (QI) program permanent, which assists with premiums cost for certain low-income beneficiaries, and increases the QI income level to 150% of the FPL.

- Eases barriers to enrollment by allowing individuals under the Low-Income Subsidy (LIS) program as to be automatically reenrolled without reapplying.
- Eliminates the requirement to apply for estate recovery when receiving Medicare Part B benefits.

The amendment offered at Rules Committee alters the index assets test from \$1000 and \$2000 to an annual percentage increase in the consumer tax index.

- Mandates that dual eligible beneficiaries receiving home care are given the same cost-sharing treatment as those in nursing homes under Part D.
- Provides additional exemptions from income and resources to qualify for CHIP for Life insurance policies and pensions.

The amendment offered at Rules Committee clarifies the restrictions for individuals to self certify as well as provisions to simplify the application forms.

- Requires that Part D cap out-of-pocket spending under Part D to 2.5 percent of income annually for the lowest income Medicare beneficiaries.

Note: These provisions begin in 2009.

The amendment offered at Rules Committee changes the cost sharing limitation from 2.5 percent to 5 percent..

- Requires that low-income beneficiaries under Medicare are offered plans that:
 - Includes 95 percent of the 100 brand drugs most commonly used by Medicare;
 - Includes 95 percent of the 100 generic drugs most commonly used by Medicare beneficiaries;
 - Provides pharmacy access above minimum standards, and
 - Costs totaling in the lowest 25th percentile of plans where the beneficiary resides.

Note: These provisions begin in 2009.

- Permits beneficiaries to change their program enrollment mid-year changes if the formulary changes and has a negative impact an enrollee.
- Eliminates the Medicare part D late enrollment penalties paid for low income subsidy-eligible individuals below 135% of FPL, and creates a special premium rate for individual between 135% and 150% of FPL.
- Provides a special 90 day enrollment period for LIS subsidy-eligible individuals
- Requires the submission of Medicare data on race, ethnicity, and native language for analysis.

The amendment offered at Rules Committee clarifies the definition of patient record system and adds provisions regarding the collection of data.

- Instructs the Secretary to conduct a study on language services within the Medicare program
- Requires CMS to conduct a demonstration of the effect of Medicare reimbursement for culturally and linguistically appropriate services, as well as another demonstration project on the programs for Medicare beneficiaries who were previously uninsured.
- Requires the office of the Inspector General to report on nationwide compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare.
- Requires an IOM Report on impact of language access services

Physicians Service Payment Reform -Title III

- Establishes of separate target growth rates for service categories
- Mandates a 0.5% update in 2008 and 2009 for physician reimbursement.
- Replaces SGR with a system of six separate categories within the Medicare fee schedule.

The amendment offered at Rules Committee clarifies the formula for physician reimbursement, changing the allowable growth rate from 3% to 2.5% and freezes updates after 2012.

- Requires the Secretary to establish a panel to evaluate and identify physicians' services for which the relative value is potentially mis- valued.
- Requires the Secretary to implement a program to confidentially evaluate physicians.
- Creates funding incentives for physicians in certain areas in the low 5th percentile of utilization.
- Implements a Medical Home Demonstration Project, involving 500 hospitals, to study the effective of various initiatives, such as Health IT.
- Cuts payments for Imaging services:
 - Services may only be provided by accredited facilities

- Adjustment in practice expense –requires CMS to increase their assumption on the amount of time imaging equipment is in use from 50 to 75 percent of the time
- Requires 50 percent reduction in technical component for imaging
- Requires CMS to assume the interest rate for capital purchases reflects the prevailing rate in the market, but is capped at 11 percent
- Bans Global Billing

Medicare Advantage (MA) Reforms- Title IV

- Cuts payments to MA plans by \$54 Billion, reducing their payment levels to 100% of Fee-For-Service (FFS)
 - Phases-in cuts over four years to 100% FFS in 2011.
 - Restricts plans ability to offer flexible benefits packages.
 - Abolishes regional PPO stabilization fund in 2012 and 2013.
- Requests the National Association for Insurance Commissioners develop marketing, advertising and related protections.
- Restricts plans ability to vary cost sharing amounts.
- Provides the following MA plan enrollment modifications:
 - Allows for open enrollment for full-benefit dual eligible individual and Qualified Medicare Beneficiaries (QMB);
 - Provides special enrollment periods for beneficiaries with special health needs;
 - Eliminates continuous open enrollment of original fee-for service enrollees in MA non-prescription drug plans; and
 - Provides access to Medigap for individuals who leave MA plans
- Mandates that MA plans disclose the following information:
 - Requires each MA plan to submit a Medicare Loss Ratio (MLR) to be publicly reported
 - Requires that the MLR to be used as a part of MA bid process
 - Reduces plans that do not have a MLR benchmark of 0.85 percent beginning in 2010, limits new enrollment for the plan, and excludes such plans in 2012.
- Requires all MA plans to meet equal standards, and mandates that PFFS and PPO plans to report the same data reported by Coordinated Care Plans for HEDIS, CAHPS and HOS quality measures starting in 2010.
- Requires employer plans to have 90% of their members in counties where the MA plan is available, and prohibits permit MA provisions of the CHAMP Act to be waived for employer plans.

- Developing new quality reporting measures on racial disparities, using HEDIS measures.
- Strengthens the audit authority and provides HHS the ability to address deficiencies.
- Calls for an analysis of the appropriateness and accuracy of risk adjustment for MA plans.
- Prohibits hospitals, physicians and other providers would not be permitted to extra-bill PFFS plan members by 15%.
- Renames of MA program to Medicare Part C program.
- Extension and revision of authority for Special Needs Plans (SNP) –
 - Extends restriction on enrollment authority for SNPs to 2011
 - Continues the same payment of SNPs as other MA plans.
 - Revising the authority for dual Medicare-Medicaid SNPs to require that dual-SNP plans to have: 90% enrollees that are full-dual eligible or QMB Medicaid beneficiaries
 - Requires SNPs to report data for new HEDIS measures.
 - Allows the chronic disease SNPs to expire at the end of 2009.

The amendment offered at Rules Committee adds authority for Severe and Disabling Chronic Conditions Special Needs Plan (SDCC-SNPs). Further, requires to SDCC-SNPs to enroll 90% of beneficiaries with severe risk or chronic conditions.

Provisions relating to Medicare Part A- Title V

- Cuts Inpatient Hospital payment updates by a 0.25% in 2008.
- Cuts payments for inpatient rehabilitation facility (IRF):
 - Increase the fiscal rates by one percent for 2008
 - Reduces the market basket update in 2008
 - Freezes the compliance rate (the “75%” rule) at 60%.
- Provision for Long-term care (LTC) hospital:
 - Makes the prospective payment for LTC hospitals bases on 2007;
 - Defines LTC hospitals and patients;
 - Creates a moratorium on the building of new LTC hospitals for 4 years
 - Excludes freestanding and grandfather LTCHs from the 25% patient threshold for hospital referrals
 - Freezes Hospitals that are rural, co-located, or MSA dominant at 25% rule
 - Prevents Secretary from a one-time prospective adjustment

- Increases DSH adjustment cap for rural and small urban facilities to 16 percent in 2008 and 18 percent in 2009.
- Exempts cancer hospitals from LTC prospective-payment system (PPS)
- Freezes payment for skilled nursing facilities for 2008
- Repeals Joint Commission on Accreditation of Healthcare Organizations (JCAHO) unique statutory protection, effective 18 months after date of enactment.

Other Provisions Relations to Medicare Part B- Title VI

- Extends the exceptions process payment of therapy services for two years.
- Provides Medicare with a separate definition of outpatient speech language pathology services as physical therapy
- Increases reimbursement rate for certified nurse-midwives.
- Reduces in outpatient hospital fee schedule by 0.25% in 2008.
- Makes 60-day limit exceptions on Medicare substitute billing arrangements in case of physician ordered to active duty in the Armed Forces.
- Excludes clinical social worker services from coverage under the Medicare skilled nursing facility prospective payment system and consolidated payment.
- Provides coverage for marriage and family therapist services and mental health counselor services.
- Creates a one month waiting period for rental and purchase of power-driven wheelchairs, after prescription.
- Changes the rental and purchase of oxygen equipment from 36 months to 18 months.
- Increases the payment rate for Medicare mental health services by 5%.
- Extends floor on Medicare work geographic adjustment from 2008 to 2010.
- Extends of special treatment of certain physician pathology services under Medicare for two years.
- Extends of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas through 2010

- Extends of Medicare incentive payment program for physician to scarcity areas to 2010.
- Extends of temporary Medicare payment increase for ambulance services in rural areas to 2010 and increases payments by 2 percent.
- Creates a demonstration project regarding chronic kidney diseases
- Allots funding for kidney disease patient education services.
- Requires training for patient care dialysis technicians.
- Requires MedPAC to report on treatment modalities for patients with kidney disease.
- Develops an ESRD bundling system and quality incentive payments.
 - Starting in 2010, creates a bundled payment for dialysis and related drugs and services, with certain requirements to ensure appropriate anemia management.
 - Requires MedPAC to report on ESRD bundling system.

Provisions Relating to Medicare Parts A and B- Title VII

- Provides zero update for home health payments for 2008.
- Extends for two years (2010) the temporary Medicare payment increase for home health services furnished in rural areas, including a 5% add-on payment for rural home health services.
- Extends to 42 months the Medicare secondary payer for beneficiaries with end state renal disease for large group plans.
- Requires the Secretary to develop and inpatient a plan in the beginning in 2010, a policy to reduce or eliminate payments prohibit Medicare "never event"
 - **Note: "Never Event" means an event involving the delivery of (or failure to deliver) physicians services, inpatient or outpatient hospital services or facility services furnished in an ambulatory surgical facility in which there is an error in medial care that is clearly identifiable"*
- Extends for two years the provisions of the Medicare Modernization Act of 2003 relating to wage index reclassifications.
- **The amendment offered at Rules Committee created new criteria for reallocation of Medicare graduate residency slots.**

- **The amendment offered at Rules Committee added a section (706) providing for a study of the effect on home health remote monitoring on patient outcomes.**
- **The amendment offered at Rules Committee added a section (707) providing for a demonstration project to analysis the effectiveness of home health telemonitoring.**

Medicaid- Title VIII

- Creates a two year extension of the Transitional Medical Assistance program (TMA) through 2009.
- Provides a 12 month eligibility period for families to enroll.
- Allows states to wave the 2 month requirement
- Allows states to offer family planning services without a waiver from the government.
- Grants the authority to continue providing adult day health services approved under a State Medicaid plan until 2009.
- Provides States with the option to provide medical assistance for home and community-based services.
- Makes the following changes to payments for Puerto Rico and territories:
 - Increases the federal funding cap for Puerto Rico and the U.S. Territories.
 - Allows federal matching payments for improvements in data reporting systems for the Commonwealth of Puerto Rico and the U.S. Territories. These payments would not be counted against the funding limitation otherwise in effect for these areas.
- Increases the Medicaid drug applicable rebate to 20.1 percent
- Adjusts in computation of Medicaid FMAP to disregard any extraordinary employer pension contribution.
- **The amendment offered at Rules Committee creates a new section (817) which establishes a Social Security Income (SSI) web-based asset demonstration project to the Medicaid program.**
- Creates a one year moratorium on certain payment restrictions.
- Provides Tennessee DSH with a disproportionate allotment of \$30 million.

- Clarification permitting regional medical center to participate in other States' Medicaid financing mechanism
- Creates a demonstration project for employer buy-in for families' coverage in SCHIP.
- Extends diabetes grant funding to 2009

Miscellaneous- Title IX

- Makes clear that Medicare Payment Advisory Commission (MedPAC) was established by Congress and is a support agency.
- Repeal the comparative cost adjustment (CCA) program that was created under MMA
- Establishes a commission and trust fund called healthcare comparative effectiveness research trust fund (CERTF). CERTF conducts research on the effectiveness, and appropriateness of health care services and procedures in order to identify the areas in which disease can be prevented.
 - Creates a new per capita tax on all health insurance policies nationwide that is used to fund a healthcare comparative effectiveness research trust fund (CERTF), which is initially funded through the Medicare trust fund, to support the work of the Center and the Commission.

Miscellaneous- Title X

- Sec. 1001. Increase in rate of excise taxes on tobacco products and cigarette papers and tubes.
 - Amends the Internal Revenue Code to increase the rate of excise taxes on tobacco products and cigarette papers and tubes to approximately \$0.39 per package and increases the cigar tax from \$0.84 to a \$1
- Exempts from fuel excise taxes any liquid used by ambulances to provide emergency medical services.
- **The amendment offered at Rules Committee adds an additional section (909) which permits Congressional Support Agencies (MedPAC, GAO, and CBO) to obtain from CMS necessary data about the Medicare Part D program.**
- **The amendment offered at Rules Committee adds an additional section (910) which creates a separate program for abstinence education.**

“CBO estimates that enacting this legislation would increase federal direct spending by \$27.5 billion over the 2008-2012 period and by \$132.6 billion over the 2008-2017 period. CBO and JCT estimate that net revenues would increase under the bill by \$28.9 billion over the next five years and \$59.7 billion over the 10-year period. (A portion of that increase would be in off-budget revenues: \$0.8 billion for the 2008-2012 period and \$2.4 billion over the 2008-2017 period.)”

**Note: This CBO Cost Estimate was provided prior to the bill going to the Rules Committee.*

Staff Contact

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