

**This issue is part of a series of periodic reports from the National Health Law Program's Washington office, reporting briefly on recent and forthcoming developments in federal policy of interest to NHeLP advocates and friends. We always appreciate your feedback and comments. Please send them to Deborah Reid at [reid@healthlaw.org](mailto:reid@healthlaw.org). For updates and information on NHeLP publications, go to <http://www.healthlaw.org>**

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## **SCHIP**

### **Children's Health Reauthorization Act of 2007 (CHIPRA):**

Prior to passage of a joint resolution (see below), the State Children's Health Insurance Program was scheduled to expire on September 30. On October 3, President Bush vetoed the House and Senate compromise bill, the Children's Health Insurance Reauthorization Act of 2007, H.R. 976. On October 18, the House failed to override the President's veto, falling short of the necessary two-thirds majority with a vote of 273-156 (290 votes were needed).

CHIPRA would have reauthorized SCHIP for five years, providing annual allotments for FYs 2008 – 2012. The bill authorized \$35 billion in new spending, which would have insured an estimated 3.8 million additional children, was based on a \$0.61 per pack increase in the federal tobacco tax. The bill allowed states a two-year period to spend their SCHIP allotments, and contained a mental health parity provision that would have ensured that health coverage is equally considered for mental and physical illnesses. In addition, CHIPRA designated dental coverage as a guaranteed benefit.

The vetoed legislation provided grant funds for targeted outreach and to increase access to eligible, but uninsured children in certain populations, including Native Americans, rural residents, limited English proficient communities, racial and ethnic minorities, and other disparity populations. CHIPRA also addressed some barriers to Medicaid enrollment caused by existing citizenship documentation requirements, such as providing Medicaid coverage for newborns of all mothers insured by Medicaid, and including tribal documents as acceptable proof.

On the other hand, the compromise bill would have for the first time extended citizenship documentation to the SCHIP program, thereby giving states the option to perpetuate and expand the known disparate impact that those requirements have had on African Americans (see Federal Factoid below). Furthermore, the bill did not include any of the provisions that would have addressed SCHIP coverage for documented immigrant children, as described in the Legal Immigrant Children's Health Improvement Act of 2007, (ICHIA), H.R. 1308 and S. 764.

#### *Continuing Resolution for SCHIP*

On September 29, President Bush signed into law a continuing appropriation for FY 2008 to allow the federal government to stay in operation at current funding levels until November 16. This continuing resolution, which includes temporary funding for a variety of federal programs including SCHIP, that were scheduled to expire on September 30, was necessary because Congress has not completed its regular spending bills for FY 2008, which started on October 1.

#### *Next Steps*

On October 25, the House passed a modified version of the SCHIP bill, H.R. 3963, by a vote of 265-142, which revised requirements for outreach and enrollment, and SCHIP allotments, as well as other provisions. The Senate then voted to approve the legislation on November 1, by a vote of 64-30. Thus, negotiations on potential amendments continue between Senate and House Democrats and Republicans, if a presidential veto occurs and an override is unsuccessful.

*Administrative Restrictions on SCHIP Expansion Proposals:*

*On August 17, CMS issued a "Dear State Health Official" letter "clarifying" how the agency reviews state requests to expand SCHIP eligibility to children in families with incomes above 250 percent of the federal poverty level (FPL). Under SCHIP, states have had broad authority to determine how to calculate family income for purposes of eligibility. As a result, many states cover children in families with gross incomes above 200 percent FPL.*

The August 17 letter announced that CMS would no longer allow states to cover children with gross incomes above 250 percent of FPL, unless a state could demonstrate that it was already covering at least 95 percent of all children eligible for Medicaid and SCHIP with incomes below 200 percent of FPL. No state has yet been able to achieve this level of coverage. Ostensibly to prevent individuals from substituting SCHIP coverage for private health insurance (so-called "crowd-out"), CMS mandated a one-year period of uninsurance before a child could be covered by SCHIP, and a showing that private employer sponsored insurance in the state has not declined by more than 2 percent over a five year period. To view the August 17 letter, go to: <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf>

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Some states viewed the CMS letter as an illegal attack on their SCHIP programs instead of a "clarification" of existing policy, since states could not submit comments about the requirements due to the lack of formal regulations, with an opportunity for public notice and comment. As a result, New York and New Jersey announced their intent to sue the agency and Maryland, New Hampshire, California, Arizona, Washington, and Illinois indicated their willingness to participate in those or similar suits. New Jersey subsequently filed their lawsuit on October 1.

## **OTHER PENDING LEGISLATIVE AND ADMINISTRATIVE ACTIVITY**

*Children's Mental Health Parity Act, S. 1337*

*Similar to mental health parity provisions in the CHIPRA legislation, this bill eliminates state-imposed restrictions on mental health services that are not customarily applied to medical and surgical care. S. 1337 was referred to the Senate Committee on Finance on May 8.*

*Mental Health Parity Act, S. 558*

On September 18, the Senate passed the Mental Health Parity Act of 2007, S. 558, by unanimous consent.□ Senators Pete Domenici (R-NM) and Edward Kennedy (D-MA) sponsored the bill.□ Among other provisions, the legislation provides that the financial requirements and treatment limitations found in group health plans or health insurance plans, such as benefits covered in the plan, deductibles, co-payments, and coinsurance, be the same for mental health benefits as they are for medical and surgical benefits. Although S. 558 provides an exemption for health plans offered by employers who employ 50 or fewer employees, the bill does not preempt applicable state insurance laws.□ The legislation was referred for further action to the House Subcommittee on Health Employment Labor and Pensions on October 17.

*Paul Wellstone Mental Health and Addiction Equity Act of 2007, H.R. 1424*

Another mental health parity bill is currently awaiting a full vote before the House. On October 15, the House Ways and Means Committee and the Committee on Education and Labor voted to approve the Paul Wellstone Mental Health and Addiction Equity Act of 2007, H.R. 1424. The Wellstone legislation would also require health plans that offer mental health coverage to provide similar treatment limits and financial requirements as for medical and surgical coverage, and would not preempt more stringent state mental health parity laws. Under this bill, current and potential beneficiaries and contracting providers would be able to obtain information from health plans about factors used for medical necessity determinations for mental health and substance abuse treatment. Additionally, health plans would have to disclose reasons for denials of benefits.

The Wellstone bill differs from the Senate's Mental Health Parity Act by defining the "minimum scope of coverage." Under the Wellstone legislation, if a group health plan offers any type of mental health benefit, then it must cover the same scope of mental illnesses and substance related disorders covered by the health plan with the largest enrollment of federal employees. The minimum scope of coverage is not detailed in S. 558.

*Freedom of Choice Act, H.R. 1964*

*This bill prohibits the government from denying or interfering with a woman's right to choose to begin, prevent, continue, or terminate a pregnancy, and provides aggrieved parties with an opportunity to obtain appropriate legal relief against governmental interference.□ H.R. 1964 was referred to the House Subcommittee on the Constitution and Civil Liberties on May 4.*

*Minority Health Improvement and Health Disparity Act, S. 1576*

*This proposed legislation would increase workforce diversity and cultural competency through education and training; expand funding for reducing or eliminating racial and ethnic health disparities; and require health professional schools to collect demographic data on its applicants, students, and graduates. S. 1576 was referred to Senate Committee on Health, Education, Labor and Pensions (HELP) on June 7.*

*Thomas J. Manton Prostate Cancer Early Detection and Treatment Act, S. 1275*  
*This bill provides grants to states to conduct free prostate cancer screenings for low income and uninsured men who are not ordinarily eligible for Medicaid. S. 1275 was referred to the Senate Committee on Finance on May 2.*

*National Health Information and Privacy Advancement Act, S. 1455*  
*The bill requires the establishment of a national health information technology and privacy system to respond to health care needs and improve health care quality. It also provides for federal supervision of a newly created private nonprofit corporation that would be responsible for accomplishing the bill's objectives, as well as paying attention to the confidentiality and security of patients' medical records. S. 1455 was referred to the Senate HELP Committee on May 23.*

*Wired for Health Care Quality Act, S. 1693*  
*The bill establishes a public-private Partnership for Health Care Improvement to recommend actions to achieve a nationwide interoperable health information technology structure. It also provides for federal government adoption of national standards for the electronic exchange of health information. S. 1693 was placed on Senate legislative calendar on Aug. 1. Senator Edward Kennedy, Chairperson of the Senate HELP Committee, filed a written report on the bill on Oct. 1.*

## **NEW LAWS**

*TMA, Abstinence Education, and QI Programs Extension Act of 2007*  
*President Bush signed the TMA, Abstinence Education, and QI Programs Extension Act of 2007, H.R. 3668, into law on Sept. 29. Among other provisions, H.R. 3668 authorizes through*

*December 31, 2007 the Temporary Medical Assistance (TMA) program, which provides extended coverage to people who would otherwise lose Medicaid due to earned income. TMA had been set to expire on September 30. Funding for the Title V Abstinence Education Program was also extended through December 31. This program authorizes \$50 million annually in five-year block grants to states to finance programs directed towards school-aged children to teach abstinence from non-marital sexual activity.*

H.R. 3668 also extends the Qualifying Individual (QI) Program through December 2007. The QI Program authorizes Medicaid to pay the Medicare Part B premium for Medicare beneficiaries with incomes between 120 – 135 percent of FPL and few assets.

#### *Medicaid Tamper Proof Prescription Pads Law*

*The U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, signed into law on May 25, 2007, required all Medicaid prescriptions be written on tamper-resistant prescription pads. This provision (amending Section 7002(b) of the Social Security Act) was intended as an anti-fraud measure, and was scheduled to take effect on October 1, 2007. Advocates and pharmacists alike feared that Medicaid beneficiaries would be unable to fill prescriptions in the many states that had not taken the necessary steps to meet this new requirement.*

On September 20, over 90 members of Congress requested a delay in implementation of the tamper proof prescription pad requirement, in response to a joint education effort by pharmacists and advocates, including NHeLP. On September 26, Rep. John Dingell (D-MI) introduced the TMA Act, H.R. 3668 (discussed above) that included a provision delaying implementation of the tamper resistant prescription pad mandate until March 31, 2008. After passing both Houses of Congress, the bill was signed into law on September 29.

#### **FEDERAL FACTOIDS**

**On July 10, The Center on Budget and Policy Priorities released a study entitled, "Medicaid Documentation Requirement Disproportionately Harms Non-Hispanics, New State Data Show." The analysis examined the citizenship documentation provisions that require presenting original documentation of identity and citizenship to local Medicaid officials for enrollment and re-certification purposes. The study found the greatest declines in enrollment of African American children, followed by reduced enrollments of white children in three states. Enrollment levels rose among undocumented immigrants children in one state, with the smallest declines in enrollment in the other two states.**

More information on the study can be found at: <http://www.cbpp.org/7-10-07health.pdf> .

A George Washington University School of Public Health and Health Services' Policy Brief, "An Initial Assessment of the Effects of Medicaid Documentation Requirements on Health Centers and Their Patients," determined that between 105,000 to 319,500 eligible Medicaid beneficiaries could lose their coverage provided at federally qualified health centers because of the federal citizenship and identity documentation requirements. It will cost health centers \$28 to \$85 million to continue treatment for patients who have lost their Medicaid coverage because of the DRA's documentation requirements. For further details on the Policy Brief go to: [http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/Medicaid\\_Doc\\_Requirements.pdf](http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/Medicaid_Doc_Requirements.pdf)

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## **PUBLICATIONS**

The National Health Law Program recently released the publication, "Over the Counter or Out of Reach? A Report on Evolving State Medicaid Policies for Covering Emergency Contraception," in recognition of the importance of ensuring that low income women on Medicaid are not prevented from obtaining over-the-counter access to Plan B® emergency contraception (EC). The report identifies the nature and extent of each state's current written policies affecting Medicaid coverage of EC. Women's health advocates can use the report's chart and 50 state resources list to determine how their state and others are responding to the FDA's approval for distributing EC over-the-counter to Medicaid beneficiaries. The Over the Counter report can be found at: <http://www.healthlaw.org/link.cfm?8412> .

NHeLP's "Over the Counter" report should be used in conjunction NARAL/NY's National Institute for Reproductive Health Access's publication, Expanding Medicaid Coverage for EC on the State Level, which provides additional information on state Medicaid coverage of emergency contraception, as well as advocacy strategies. This publication is located at: <http://www.prochoiceny.org/assets/files/ecreport.pdf>

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