

Subtitle J_State Children's Health Insurance Program

CHAPTER 1_STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 4901. ESTABLISHMENT OF PROGRAM.

(a) Establishment._The Social Security Act is amended by adding at the end the following new title:

``TITLE XXI_STATE CHILDREN'S HEALTH INSURANCE PROGRAM

``SEC. 2101. PURPOSE; STATE CHILD HEALTH PLANS.

``(a) Purpose._The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage through_

``(1) obtaining coverage that meets the requirements of section 2103, or

``(2) providing benefits under the State's medicaid plan under title XIX,

or a combination of both.

“(b) State Child Health Plan Required. _A State is not eligible for payment under section 2105 unless the State has submitted to the Secretary under section 2106 a plan that_

“(1) sets forth how the State intends to use the funds provided under this title to provide child health assistance to needy children consistent with the provisions of this title, and

“(2) has been approved under section 2106.

“(c) State Entitlement. _This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under section 2104.

“(d) Effective Date. _No State is eligible for payments under section 2105 for child health assistance for coverage provided for periods beginning before October 1, 1997.

“SEC. 2102. GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH.

“(a) General Background and Description. _A State child health plan shall include a description, consistent with the requirements of this title, of_

“(1) the extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children

classified by income and other relevant factors, currently have creditable health coverage (as defined in section 2110(c)(2));

“(2) current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships;

“(3) how the plan is designed to be coordinated with such efforts to increase coverage of children under creditable health coverage;

“(4) the child health assistance provided under the plan for targeted low-income children, including the proposed methods of delivery, and utilization control systems;

“(5) eligibility standards consistent with subsection (b);

“(6) outreach activities consistent with subsection (c); and

“(7) methods (including monitoring) used__

“(A) to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan, and

“(B) to assure access to covered services, including emergency services.

“(b) General Description of Eligibility Standards and Methodology._

“(1) Eligibility standards._

“(A) In general._The plan shall include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Such standards may include (to the extent consistent with this title) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

“(B) Limitations on eligibility standards._Such eligibility standards_

“(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income, and

“(ii) may not deny eligibility based on a child having a preexisting medical condition.

“(2) Methodology. The plan shall include a description of methods of establishing and continuing eligibility and enrollment.

“(3) Eligibility screening; coordination with other health coverage programs. The plan shall include a description of procedures to be used to ensure

“(A) through both intake and followup screening, that only targeted low-income children are furnished child health assistance under the State child health plan;

“(B) that children found through the screening to be eligible for medical assistance under the State medicaid plan under title XIX are enrolled for such assistance under such plan;

“(C) that the insurance provided under the State child health plan does not substitute for coverage under group health plans;

“(D) the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)); and

“(E) coordination with other public and private programs providing creditable coverage for low-income children.

“(4) Nonentitlement. Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

“(c) Outreach and Coordination._A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

“(1) Outreach._Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

“(2) Coordination with other health insurance programs._Coordination of the administration of the State program under this title with other public and private health insurance programs.

“SEC. 2103. COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE.

“(a) Required Scope of Health Insurance Coverage._The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 2101(a) shall consist, consistent with subsection (c)(5), of any of the following:

“(1) Benchmark coverage._Health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

“(2) Benchmark-equivalent coverage._Health benefits coverage that meets the following requirements:

“(A) Inclusion of basic services._The coverage includes benefits for items and services within each of the categories of basic services described in subsection (c)(1).

“(B) Aggregate actuarial value equivalent to benchmark package._The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

“(C) Substantial actuarial value for additional services included in benchmark package._With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

“(3) Existing comprehensive state-based coverage._Health benefits coverage under an existing comprehensive State-based program, described in subsection (d)(1).

“(4) Secretary-approved coverage._Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage.

“(b) Benchmark Benefit Packages._The benchmark benefit packages are as

follows:

“(1) FEHBP-equivalent children's health insurance coverage. The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

“(2) State employee coverage. A health benefits coverage plan that is offered and generally available to State employees in the State involved.

“(3) Coverage offered through hmo. The health insurance coverage plan that

“(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

“(B) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

“(c) Categories of Services; Determination of Actuarial Value of Coverage.

“(1) Categories of basic services._For purposes of this section, the categories of basic services described in this paragraph are as follows:

“(A) Inpatient and outpatient hospital services.

“(B) Physicians' surgical and medical services.

“(C) Laboratory and x-ray services.

“(D) Well-baby and well-child care, including age-appropriate immunizations.

“(2) Categories of additional services._For purposes of this section, the categories of additional services described in this paragraph are as follows:

“(A) Coverage of prescription drugs.

“(B) Mental health services.

“(C) Vision services.

“(D) Hearing services.

“(3) Treatment of other categories._Nothing in this subsection shall be construed as preventing a State child health plan from providing

coverage of benefits that are not within a category of services described in paragraph (1) or (2).

“(4) Determination of actuarial value. The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared__

“(A) by an individual who is a member of the American Academy of Actuaries;

“(B) using generally accepted actuarial principles and methodologies;

“(C) using a standardized set of utilization and price factors;

“(D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;

“(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

“(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

“(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

“(5) Construction on prohibited coverage. Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this title, notwithstanding that any benchmark benefit package includes coverage for such an item or service.

“(d) Description of Existing Comprehensive State-Based Coverage.

“(1) In general. A program described in this paragraph is a child health coverage program that

“(A) includes coverage of a range of benefits;

“(B) is administered or overseen by the State and receives funds from the State;

“(C) is offered in New York, Florida, or Pennsylvania; and

“(D) was offered as of the date of the enactment of this title.

“(2) Modifications. A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of

“(A) the actuarial value of the coverage under the program as of the date of the enactment of this title, or

“(B) the actuarial value described in subsection (a)(2)(B),

evaluated as of the time of the modification.

“(e) Cost-Sharing.

“(1) Description; general conditions.

“(A) Description. A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

“(B) Protection for lower income children._The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income.

“(2) No cost sharing on benefits for preventive services._The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in subsection (c)(1)(D).

“(3) Limitations on premiums and cost-sharing._

“(A) Children in families with income below 150 percent of poverty line._In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose_

“(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) (with respect to individuals described in such section); and

“(ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1916(a)(3), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

“(B) Other children._For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all targeted low-income children in a family under this title may not exceed 5 percent of such family's income for the year involved.

“(4) Relation to medicaid requirements._Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low-income children who are provided child health assistance in the form of coverage under a medicaid program under section 2101(a)(2).

“(f) Application of Certain Requirements._

“(1) Restriction on application of preexisting condition exclusions._

“(A) In general._Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

“(B) Group health plans and group health insurance coverage._If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage,

the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

“(2) Compliance with other requirements. Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

“SEC. 2104. ALLOTMENTS.

“(a) Appropriation; Total Allotment. For the purpose of providing allotments to States under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated_

“(1) for fiscal year 1998, \$4,275,000,000;

“(2) for fiscal year 1999, \$4,275,000,000;

“(3) for fiscal year 2000, \$4,275,000,000;

“(4) for fiscal year 2001, \$4,275,000,000;

((5) for fiscal year 2002, \$3,150,000,000;

((6) for fiscal year 2003, \$3,150,000,000;

((7) for fiscal year 2004, \$3,150,000,000;

((8) for fiscal year 2005, \$4,050,000,000;

((9) for fiscal year 2006, \$4,050,000,000; and

((10) for fiscal year 2007, \$5,000,000,000.

((b) Allotments to 50 States and District of Columbia. _

((1) In general. _Subject to paragraph (4) and subsection (d), of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of _

((A) the product of (i) the number of children described in paragraph (2) for the State for the fiscal year and (ii) the State cost factor for that State (established under paragraph (3)); to

“(B) the sum of the products computed under subparagraph (A).

“(2) Number of children._

“(A) In general._The number of children described in this paragraph for a State for_

“(i) each of fiscal years 1998 through 2000 is equal to the number of low-income children in the State with no health insurance coverage for the fiscal year;

“(ii) fiscal year 2001 is equal to_

“(I) 75 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

“(II) 25 percent of the number of low-income children in the State for the fiscal year; and

“(iii) each succeeding fiscal year is equal to_

“(I) 50 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

“(II) 50 percent of the number of low-income children in the State for the fiscal year.

“(B) Determination of number of children. For purposes of subparagraph (A), a determination of the number of low-income children (and of such children who have no health insurance coverage) for a State for a fiscal year shall be made on the basis of the arithmetic average of the number of such children, as reported and defined in the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the fiscal year.

“(3) Adjustment for geographic variations in health costs. _

“(A) In general. For purposes of paragraph (1)(A)(ii), the ‘State cost factor’ for a State for a fiscal year equal to the sum of _

“(i) 0.15, and

“(ii) 0.85 multiplied by the ratio of _

“(I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to

“(II) the annual average wages per employee for the 50 States and the District of Columbia.

“(B) Annual average wages per employee._For purposes of subparagraph (A), the ‘annual average wages per employee’ for a State, or for all the States. for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

“(4) Floor for states._Subject to paragraph (5), in no case shall the amount of the allotment under this subsection for one of the 50 States or the District of Columbia for a year be less than \$2,000,000. To the extent that the application of the previous sentence results in an increase in the allotment to a State above the amount otherwise provided, the allotments for the other States and the District of Columbia under this subsection shall be reduced in a pro rata manner (but not below \$2,000,000) so that the total of such allotments in a fiscal year does not exceed the amount otherwise provided for allotment under paragraph (1) for that fiscal year.

“(c) Allotments to Territories._

“(1) In general._Of the amount available for allotment under subsection (a) for a fiscal year, subject to subsection (d), the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

“(2) Percentage._The percentage specified in this paragraph for_

((A) Puerto Rico is 91.6 percent,

((B) Guam is 3.5 percent,

((C) Virgin Islands is 2.6 percent,

((D) American Samoa is 1.2 percent, and

((E) the Northern Mariana Islands is 1.1 percent.

((3) Commonwealths and territories. A commonwealth or territory described in this paragraph is any of the following if it has a State child health plan approved under this title:

((A) Puerto Rico.

((B) Guam.

((C) the Virgin Islands.

((D) American Samoa.

((E) the Northern Mariana Islands.

“(d) Certain Medicaid Expenditures Counted Against Individual State Allotments._The amount of the allotment otherwise provided to a State under subsection (b) or (c) for a fiscal year shall be reduced by the sum of_

“(1) the amount (if any) of the payments made to that State under section 1903(a) for calendar quarters during such fiscal year that is attributable to the provision of medical assistance to a child during a presumptive eligibility period under section 1920A, and

“(2) the amount of payments under such section during such period that is attributable to the provision of medical assistance to a child for which payment is made under section 1903(a)(1) on the basis of an enhanced FMAP under section 1905(b).

“(e) 3-Year Availability of Amounts Allotted._Amounts allotted to a State pursuant to this section for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year; except that amounts reallocated to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are reallocated.

“(f) Procedure for Redistribution of Unused Allotments._The Secretary shall determine an appropriate procedure for redistribution of allotments from States that were provided allotments under this section for a fiscal year but that do not expend all of the amount of such allotments during the period in which such allotments are available for expenditure under subsection (e), to States that have fully expended the

amount of their allotments under this section.

``SEC. 2105. PAYMENTS TO STATES.

``(a) In General._Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104 (taking into account any adjustment under section 2104(d)), an amount for each quarter equal to the enhanced FMAP of expenditures in the quarter_

``(1) for child health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 2103; and

``(2) only to the extent permitted consistent with subsection (c)_

``(A) for payment for other child health assistance for targeted low-income children;

``(B) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);

``(C) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and

“(D) for other reasonable costs incurred by the State to administer the plan.

“(b) Enhanced FMAP. For purposes of subsection (a), the ‘enhanced FMAP’, for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent.

“(c) Limitation on Certain Payments for Certain Expenditures. _

“(1) General limitations. Funds provided to a State under this title shall only be used to carry out the purposes of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

“(2) Limitation on expenditures not used for medicaid or health insurance assistance. _

“(A) In general. Except as provided in this paragraph, payment shall not be made under subsection (a) for expenditures for items described in subsection (a) (other than paragraph (1)) for a quarter in a fiscal year to the extent the total of such expenditures exceeds 10 percent of the sum of _

“(i) the total Federal payments made under subsection (a) for such quarter in the fiscal year, and

“(ii) the total Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 1905(u)(2) for such quarter.

“(B) Waiver authorized for cost-effective alternative. The limitation under subparagraph (A) on expenditures for items described in subsection (a)(2) shall not apply to the extent that a State establishes to the satisfaction of the Secretary that

“(i) coverage provided to targeted low-income children through such expenditures meets the requirements of section 2103;

“(ii) the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under section 2103; and

“(iii) such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923.

“(3) Waiver for purchase of family coverage. Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that

“(A) purchase of such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved, and

“(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

“(4) Use of non-federal funds for state matching requirement. _Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of non-Federal contributions required under subsection (a).

“(5) Offset of receipts attributable to premiums and other cost-sharing. _For purposes of subsection (a), the amount of the expenditures under the plan shall be reduced by the amount of any premiums and other cost-sharing received by the State.

“(6) Prevention of duplicative payments. _

“(A) Other health plans. _No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

“(B) Other federal governmental programs. Except as otherwise provided by law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

“(7) Limitation on payment for abortions.

“(A) In general. Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

“(B) Exception. Subparagraph (A) shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

“(C) Rule of construction. Nothing in this section shall be construed as affecting the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than funds expended under the State plan) for any abortion or for health benefits coverage that includes coverage of abortion.

“(d) Maintenance of Effort. _

“(1) In medicaid eligibility standards. _No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of June 1, 1997.

“(2) In amounts of payment expended for certain state-funded health insurance programs for children. _

“(A) In general. _The amount of the allotment for a State in a fiscal year (beginning with fiscal year 1999) shall be reduced by the amount by which _

“(i) the total of the State children's health insurance expenditures in the preceding fiscal year, is less than

“(ii) the total of such expenditures in fiscal year 1996.

“(B) State children's health insurance expenditures. _The term ‘State children's health insurance expenditures’ means the following:

“(i) The State share of expenditures under this title.

“(ii) The State share of expenditures under title XIX that are attributable to an enhanced FMAP under section 1905(u).

“(iii) State expenditures under health benefits coverage under an existing comprehensive State-based program, described section 2103(d).

“(e) Advance Payment; Retrospective Adjustment._The Secretary may make payments under this section for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

“SEC. 2106. PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF STATE CHILD HEALTH PLANS.

“(a) Initial Plan._

“(1) In general._As a condition of receiving payment under section 2105, a State shall submit to the Secretary a State child health plan that meets the applicable requirements of this title.

“(2) Approval._Except as the Secretary may provide under subsection (e), a State plan submitted under paragraph (1)_

“(A) shall be approved for purposes of this title, and

“(B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than October 1, 1997.

“(b) Plan Amendments._

“(1) In general._A State may amend, in whole or in part, its State child health plan at any time through transmittal of a plan amendment.

“(2) Approval._Except as the Secretary may provide under subsection (e), an amendment to a State plan submitted under paragraph (1)_

“(A) shall be approved for purposes of this title, and

“(B) shall be effective as provided in paragraph (3).

“(3) Effective dates for amendments._

“(A) In general._Subject to the succeeding provisions of this paragraph, an amendment to a State plan shall take effect on one or more effective dates specified in the amendment.

“(B) Amendments relating to eligibility or benefits._

“(i) Notice requirement._Any plan amendment that eliminates or

restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior public notice of the change, in a form and manner provided under applicable State law.

“(ii) Timely transmittal._Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60-day period unless the amendment has been transmitted to the Secretary before the end of such period.

“(C) Other amendments._Any plan amendment that is not described in subparagraph (B) and that becomes effective in a State fiscal year may not remain in effect after the end of such fiscal year (or, if later, the end of the 90-day period on which it becomes effective) unless the amendment has been transmitted to the Secretary.

“(c) Disapproval of Plans and Plan Amendments._

“(1) Prompt review of plan submittals._The Secretary shall promptly review State plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this title.

“(2) 90-day approval deadlines._A State plan or plan amendment is considered approved unless the Secretary notifies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval) or that specified additional information is needed.

“(3) Correction._In the case of a disapproval of a plan or plan amendment, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such disapproval.

“(d) Program Operation._

“(1) In general._The State shall conduct the program in accordance with the plan (and any amendments) approved under subsection (c) and with the requirements of this title.

“(2) Violations._The Secretary shall establish a process for enforcing requirements under this title. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State under this paragraph, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such an action.

“(e) Continued Approval._An approved State child health plan shall continue in effect unless and until the State amends the plan under subsection (b) or the Secretary finds, under subsection (d), substantial noncompliance of the plan with the requirements of this title.

“SEC. 2107. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.

“(a) Strategic Objectives and Performance Goals._

“(1) Description._A State child health plan shall include a description of_

“(A) the strategic objectives,

“(B) the performance goals, and

“(C) the performance measures,

the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

“(2) Strategic objectives._Such plan shall identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

“(3) Performance goals._Such plan shall specify one or more performance goals for each such strategic objective so identified.

“(4) Performance measures._Such plan shall describe how performance under the plan will be_

“(A) measured through objective, independently verifiable means, and

“(B) compared against performance goals, in order to determine the State's performance under this title.

“(b) Records, Reports, Audits, and Evaluation. _

“(1) Data collection, records, and reports. _A State child health plan shall include an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title.

“(2) State assessment and study. _A State child health plan shall include a description of the State's plan for the annual assessments and reports under section 2108(a) and the evaluation required by section 2108(b).

“(3) Audits. _A State child health plan shall include an assurance that the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.

“(c) Program Development Process. _A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.

“(d) Program Budget. _A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non-Federal share of plan expenditures,

including any requirements for cost-sharing by beneficiaries.

“(e) Application of Certain General Provisions._The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:

“(1) Title xix provisions._

“(A) Section 1902(a)(4)(C) (relating to conflict of interest standards).

“(B) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

“(C) Section 1903(w) (relating to limitations on provider taxes and donations).

“(2) Title xi provisions._

“(A) Section 1115 (relating to waiver authority).

“(B) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

“(C) Section 1124 (relating to disclosure of ownership and related information).

“(D) Section 1126 (relating to disclosure of information about certain convicted individuals).

“(E) Section 1128A (relating to civil monetary penalties).

“(F) Section 1128B(d) (relating to criminal penalties for certain additional charges).

“(G) Section 1132 (relating to periods within which claims must be filed).

“SEC. 2108. ANNUAL REPORTS; EVALUATIONS.

“(a) Annual Report._The State shall_

“(1) assess the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered low-income children; and

“(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

“(b) State Evaluations._

“(1) In general._By March 31, 2000, each State that has a State child health plan shall submit to the Secretary an evaluation that includes each of the following:

“(A) An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage.

“(B) A description and analysis of the effectiveness of elements of the State plan, including_

“(i) the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State plan ends,

“(ii) the quality of health coverage provided including the types of benefits provided,

“(iii) the amount and level (including payment of part or all of any premium) of assistance provided by the State,

“(iv) the service area of the State plan,

“(v) the time limits for coverage of a child under the State plan,

“(vi) the State's choice of health benefits coverage and other methods used for providing child health assistance, and

“(vii) the sources of non-Federal funding used in the State plan.

“(C) An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.

“(D) A review and assessment of State activities to coordinate the plan under this title with other public and private programs providing health care and health care financing, including medicaid and maternal and child health services.

“(E) An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

“(F) A description of any plans the State has for improving the availability of health insurance and health care for children.

“(G) Recommendations for improving the program under this title.

“(H) Any other matters the State and the Secretary consider appropriate.

“(2) Report of the secretary._The Secretary shall submit to Congress and make available to the public by December 31, 2001, a report based on the evaluations submitted by States under paragraph (1), containing any conclusions and recommendations the Secretary considers appropriate.

“SEC. 2109. MISCELLANEOUS PROVISIONS.

“(a) Relation to Other Laws._

“(1) HIPAA._Health benefits coverage provided under section 2101(a)(1) (and coverage provided under a waiver under section 2105(c)(2)(B)) shall be treated as creditable coverage for purposes of part 7 of subtitle B of title II of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

“(2) ERISA._Nothing in this title shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg-0991(a)(1))).

“SEC. 2110. DEFINITIONS.

“(a) Child Health Assistance._For purposes of this title, the term ‘child health assistance’ means payment for part or all of the cost of

health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

“(1) Inpatient hospital services.

“(2) Outpatient hospital services.

“(3) Physician services.

“(4) Surgical services.

“(5) Clinic services (including health center services) and other ambulatory health care services.

“(6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

“(7) Over-the-counter medications.

“(8) Laboratory and radiological services.

“(9) Prenatal care and prepregnancy family planning services and supplies.

“(10) Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

“(11) Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.

“(12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

“(13) Disposable medical supplies.

“(14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

“(15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.

“(16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

``(17) Dental services.

``(18) Inpatient substance abuse treatment services and residential substance abuse treatment services.

``(19) Outpatient substance abuse treatment services.

``(20) Case management services.

``(21) Care coordination services.

``(22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

``(23) Hospice care.

``(24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is_

``(A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

``(B) performed under the general supervision or at the direction of a

physician, or

“(C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

“(25) Premiums for private health care insurance coverage.

“(26) Medical transportation.

“(27) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

“(28) Any other health care services or items specified by the Secretary and not excluded under this section.

“(b) Targeted Low-Income Child Defined. _For purposes of this title_

“(1) In general. _Subject to paragraph (2), the term ‘targeted low-income child’ means a child_

“(A) who has been determined eligible by the State for child health assistance under the State plan;

“(B)(i) who is a low-income child, or

“(ii) is a child whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the medicaid applicable income level; and

“(C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

“(2) Children excluded. _Such term does not include_

“(A) a child who is an inmate of a public institution or a patient in an institution for mental diseases; or

“(B) a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

“(3) Special rule. _A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

“(4) Medicaid applicable income level. _The term ‘medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under section 1902(l)(2) for the age of such child.

“(c) Additional Definitions._For purposes of this title:

“(1) Child._The term ‘child’ means an individual under 19 years of age.

“(2) Creditable health coverage._The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).

“(3) Group health plan; health insurance coverage; etc._The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings given such terms in section 2191 of the Public Health Service Act.

“(4) Low-income._The term ‘low-income child’ means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.

“(5) Poverty line defined._The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

“(6) Preexisting condition exclusion._The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of

the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

“(7) State child health plan; plan. Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under section 2106.

“(8) Uncovered child. The term ‘uncovered child’ means a child that does not have creditable health coverage.”.

(b) Conforming Amendments. _

(1) Definition of state. _Section 1101(a)(1) is amended _

(A) by striking “and XIX” and inserting “XIX, and XXI”, and

(B) by striking “title XIX” and inserting “titles XIX and XXI”.

(2) Treatment as state health care program. _Section 1128(h) (42 U.S.C. 1320aŷ097(h)) is amended by _

(A) in paragraph (2), by striking “or” at the end;

(B) in paragraph (3), by striking the period and inserting “, or”; and

(C) by adding at the end the following:

“(4) a State child health plan approved under title XXI.”.

CHAPTER 2_EXPANDED COVERAGE OF CHILDREN UNDER MEDICAID

SEC. 4911. OPTIONAL USE OF STATE CHILD HEALTH ASSISTANCE FUNDS FOR ENHANCED MEDICAID MATCH FOR EXPANDED MEDICAID ELIGIBILITY.

(a) Increased FMAP for Medical Assistance for Expanded Coverage of Targeted Low-Income Children._Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 4702(a)(2), is amended_

(1) in subsection (b), by adding at the end the following new sentence:
“(u)(1) Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures described in subsection (u)(2)(A) or subsection (u)(3) the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b).”; and

(2) by adding at the end the following new subsection:

“(u)(1) The conditions described in this paragraph for a State plan are as follows:

“(A) The State is complying with the requirement of section 2105(d)(1).

“(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out paragraph (2) and section 2104(d).

“(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (C), but not in excess, for a State for a fiscal year, of the amount described in subparagraph (B) for the State and fiscal year.

“(B) The amount described in this subparagraph, for a State for a fiscal year, is the amount of the State's allotment under section 2104 (not taking into account reductions under section 2104(d)(2)) for the fiscal year reduced by the amount of any payments made under section 2105 to the State from such allotment for such fiscal year.

“(C) For purposes of this paragraph, the term ‘optional targeted low-income child’ means a targeted low-income child as defined in section 2110(b)(1) who would not qualify for medical assistance under the State plan under this title based on such plan as in effect on April 15, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(2)(D)).

“(3) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1902(l)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this title based on such State plan as in effect as of April 15, 1997.”.

(b) Establishment of Optional Eligibility Category._Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 4733, is amended_

(1) in subclause (XII), by striking ``or" at the end;

(2) in subclause (XIII), by adding ``or" at the end; and

(3) by adding at the end the following:

``(XIV) who are optional targeted low-income children described in section 1905(u)(2)(C);".

(c) Effective Date._The amendments made by this section shall apply to medical assistance for items and services furnished on or after October 1, 1997.

SEC. 4912. MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.

(a) In General._Title XIX of the Social Security Act is amended by inserting after section 1920 the following new section:

``presumptive eligibility for children

``Sec. 1920A. (a) A State plan approved under section 1902 may provide for making medical assistance with respect to health care items and

services covered under the State plan available to a child during a presumptive eligibility period.

“(b) For purposes of this section:

“(1) The term ‘child’ means an individual under 19 years of age.

“(2) The term ‘presumptive eligibility period’ means, with respect to a child, the period that_

“(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the State plan, and

“(B) ends with (and includes) the earlier of_

“(i) the day on which a determination is made with respect to the eligibility of the child for medical assistance under the State plan, or

“(ii) in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

“(3)(A) Subject to subparagraph (B), the term ‘qualified entity’ means any entity that_

((i)(I) is eligible for payments under a State plan approved under this title and provides items and services described in subsection (a) or (II) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act (42 U.S.C. 9821 et seq.), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.), eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786); and

((ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

((B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

((C) Nothing in this section shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

((c)(1) The State agency shall provide qualified entities with_

((A) such forms as are necessary for an application to be made on behalf of a child for medical assistance under the State plan, and

((B) information on how to assist parents, guardians, and other persons in completing and filing such forms.

“(2) A qualified entity that determines under subsection (b)(1)(A) that a child is presumptively eligible for medical assistance under a State plan shall_

“(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

“(B) inform the parent or custodian of the child at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

“(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1).

“(d) Notwithstanding any other provision of this title, medical assistance for items and services described in subsection (a) that_

“(1) are furnished to a child_

“(A) during a presumptive eligibility period,

“(B) by a entity that is eligible for payments under the State plan; and

((2) are included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903."

(b) Conforming Amendments._

(1) Section 1902(a)(47) (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: ((and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section"

(2) Section 1903(u)(1)(D)(v) (42 U.S.C. 1396b(u)(1)(D)(v)) is amended by inserting before the period at the end the following: ((or for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section"

(c) Effective Date._The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 4913. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI BENEFITS.

(a) In General._Section 1902(a)(10)(A)(i)(II) (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting ((or were being paid as

of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-09193)) and would continue to be paid but for the enactment of that section" after ``title XVI".

(b) Effective Date._The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

CHAPTER 3_DIABETES GRANT PROGRAMS

SEC. 4921. SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following section:

``SEC. 330B. SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES.

``(a) Type I Diabetes in Children._The Secretary shall make grants for services for the prevention and treatment of type I diabetes in children, and for research in innovative approaches to such services. Such grants may be made to children's hospitals; grantees under section 330 and other federally qualified health centers; State and local health departments; and other appropriate public or nonprofit private entities.

``(b) Funding._Notwithstanding section 2104(a) of the Social Security Act, from the amounts appropriated in such section for each of fiscal

years 1998 through 2002, \$30,000,000 is hereby transferred and made available in such fiscal year for grants under this section."

SEC. 4922. SPECIAL DIABETES PROGRAMS FOR INDIANS.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.), as amended by section 4921, is further amended by adding at the end the following section:

``SEC. 330C. SPECIAL DIABETES PROGRAMS FOR INDIANS.

``(a) In General._The Secretary shall make grants for providing services for the prevention and treatment of diabetes in accordance with subsection (b).

``(b) Services Through Indian Health Facilities._For purposes of subsection (a), services under such subsection are provided in accordance with this subsection if the services are provided through any of the following entities:

``(1) The Indian Health Service.

“(2) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act.

“(3) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

“(c) Funding._Notwithstanding section 2104(a) of the Social Security Act, from the amounts appropriated in such section for each of fiscal years 1998 through 2002, \$30,000,000 is hereby transferred and made available in such fiscal year for grants under this section.”.

SEC. 4923. REPORT ON DIABETES GRANT PROGRAMS.

(a) Evaluation._The Secretary of Health and Human Services shall conduct an evaluation of the diabetes grant programs established under the amendments made by this chapter.

(b) Reports._The Secretary shall submit to the appropriate committees of Congress_

(1) an interim report on the evaluation conducted under subsection (a)

not later than January 1, 2000, and

(2) a final report on such evaluation not later than January 1, 2002.