



## **SCHIP Reauthorization in 2009: An Update on the Debate and Side-by-Side of Key Bills Under Consideration**

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### **Introduction**

Congressional leaders have made quick action on SCHIP reauthorization a top priority for the new Congress. The House and the Senate already have moved forward with a long overdue overhaul of this program. Originally slated to be renewed in 2007, earlier bipartisan efforts to take action on SCHIP ran into President Bush's veto pen. By making it a goal to send a bill to President Obama as early in his term as possible, Congress is showing a commitment to finding a way to cover millions more of the nation's children during this difficult economic time and beyond, creating a bridge to economic recovery and health reform.

### **The 2007 SCHIP Debate**

As it moves forward on reauthorization, Congress is using as its vehicle bipartisan SCHIP legislation developed in 2007 when the ten-year old SCHIP program initially was to have been reauthorized.

The first 2007 SCHIP bill, known as "[CHIPRA 1](#)" was negotiated by congressional leaders in the House and the Senate, including Senate Finance Committee Chairman Max Baucus (MT-D), Ranking Member Charles Grassley (IA-R), and Finance Committee members Senator Jay Rockefeller (WV-D) and Senator Orrin Hatch (UT-R). In September of 2007, it was [passed](#) by a strong majority in the House (265 yeas to 159 nays) and two-thirds of Senators, but was vetoed by President Bush. The Senate had a two-thirds majority, but the House fell short of a veto override by a little more than a dozen votes.

After the veto, the same bi-partisan team developed a second bill, known as [CHIPRA 2](#). It was designed to garner enough additional Republican support to overcome Bush's veto. It included only a few changes relative to CHIPRA 1, including stricter limits on coverage of uninsured children in moderate-income working families. This second bill failed to secure any additional votes and, as with CHIPRA 1, was vetoed by President Bush. Soon after, Congress [extended](#) the SCHIP program through March 31, 2009. Without the quick action on SCHIP reauthorization, funding for the program will expire on that date and 43 states will be out of federal SCHIP funds on April 1<sup>st</sup>.<sup>1</sup>

### **The 2009 SCHIP Debate**

In light of the growing need for affordable coverage options for children among families affected by the downturn and the rapidly approaching March 31, 2009 deadline, Congressional leaders are seeking to complete action on SCHIP reauthorization early in 2009. With the active support of the new Administration, they plan to make it one of the first bills to arrive on President Obama's desk. To this end, the House took up an updated version of [CHIPRA 1](#) on January 14, 2009 and [passed](#) it by a vote of 289 to 139, a margin even greater than for any of the 2007 bills. On January 29, 2009, the Senate passed a [similar bill](#) by a vote of 66 to 32. The differences between the House and Senate bills must now be reconciled legislation.

## Key Provisions in SCHIP Bills

The attached side-by-side provides details on the SCHIP legislation now being considered by the House (H.R. 2) and the Senate (S. 275), and, for reference, the original CHIPRA 1 legislation. As is apparent from the side-by-side, the basic architecture of the new legislation remains the same as in the bipartisan 2007 legislation. Most of the changes simply reflect the passage of time and the need to modify the effective date of various provisions, although there are some exceptions, which are described in the next section. The key provisions of the SCHIP bills, drawn from the 2007 bipartisan effort, include:

- **Significant new SCHIP funding through fiscal year 2013.** Both the House and Senate bills update and strengthen the SCHIP financing system. Specifically, they markedly increase SCHIP allotments, modernize the formula for dividing available funds among the states, and establish a mechanism for “re-basing” state allotments every few years to ensure that SCHIP funds are targeted to states that are using them for coverage of children. Both bills provide funding through the end of fiscal year 2013 and are financed largely by a \$0.61 increase in the tax on cigarettes.
- **Initiatives to enroll the lowest-income uninsured children in coverage.** Both bills include new tools, such as Express Lane eligibility, to encourage the enrollment of already-eligible uninsured children in coverage as well as an increase in federal funding for outreach. These new tools are accompanied by a performance bonus system that provides states with additional federal financial help when they significantly increase their enrollment of already-eligible uninsured children in Medicaid and adopt a specified number (4 in the House bill, 5 in the Senate) of measures to streamline enrollment and retention in both Medicaid and SCHIP.
- **Improvements in the quality of care for all of America’s children.** Both bills establish a major new initiative to improve the quality of care provided to all of the country’s children. They include the development and dissemination of new child-specific health quality measures, the creation of a new model electronic medical record for children, and demonstration projects on quality improvement and health information technology for children.
- **Changes in SCHIP eligibility rules.** Both bills provide states with a new statutory option to cover pregnant women through SCHIP. They also preserve state flexibility to decide the income eligibility level for children that need assistance in each state. The bills, though, establish a new provision that reduces the federal government’s contribution to the cost of covering children above 300 percent of the federal poverty level from the SCHIP matching rate to the Medicaid matching rate. Both bills shut down state flexibility to secure waivers to provide family-based coverage and phase-out existing SCHIP waivers that allow states to cover adults (both parents and childless adults). (As discussed in more detail below, they also include a state option to eliminate the five-year waiting period for Medicaid and SCHIP that currently applies to legal immigrant children and pregnant women. In contrast to the other changes to eligibility rules, this new option was not included in the 2007 SCHIP bills.)
- **New premium assistance options.** Both bills include provisions to reduce the barriers states face when seeking to implement premium assistance programs, as well as to ensure that premium assistance programs are cost-effective and provide children benefits that are equivalent to what they would receive if enrolled directly in a state’s SCHIP program.
- **Requirements for documentation of citizenship.** The bills extend to SCHIP the [Medicaid citizenship documentation requirement](#) established by the Deficit Reduction

Act. At the same time, they provide states with a new option to document citizenship status by tapping into existing information that already has been gathered by the Social Security Administration, potentially reducing unnecessary red-tape barriers to coverage. These changes also permit coverage to be provided while documentation is being secured.

## Major Differences from the 2007 Legislation

While the basic structure of the new SCHIP bills is taken from the bipartisan work done on SCHIP reauthorization in 2007, the bills contain some important substantive policy changes, including:

- **State option to cover legal immigrant children and pregnant women.** Both the House and Senate bills provide states with the option to eliminate the five-year waiting period now imposed on legal immigrant children and pregnant women in Medicaid and SCHIP.
- **Changes to the performance bonus structure.** A major element of the SCHIP bills is the performance bonuses for states that increase enrollment of already-eligible uninsured children (described above). Under the 2009 bills, however, states must meet much more ambitious enrollment targets before they can qualify for bonuses. The designers of the SCHIP legislation may have increased the enrollment targets to take into account increases in Medicaid enrollment that result from the economic downturn rather than state outreach and enrollment efforts.
- **Treatment of the August 17th Directive.** In August of 2007, the Bush Administration sent a letter to state health officials imposing new limitations on states covering or planning to cover uninsured children above 250 percent of the federal poverty level. This “[August 17th directive](#)” overturned a decade of well-established SCHIP policy and was immediately controversial, generating litigation and eventually a legal opinion from both the Government Accountability Office and the Congressional Research Service that it had been issued illegally. At the time it was issued, the House and the Senate already had passed their SCHIP bills,<sup>2</sup> but in conference, provisions were added to nullify the August 17th directive. Conferees replaced it with an alternative set of limitations on covering uninsured children above 300 percent of the federal poverty level. The Obama Administration already has made public its plans to [officially rescind](#) the directive early in the new Presidential term. In light of this planned action, the 2009 SCHIP bills do not include the nullification of the August 17th directive, nor do they include the substitute policies included in CHIPRA 1 and 2.
- **Other provisions.** Some of the other differences from the 2007 bills include:
  - **Dental coverage for children.** As a result of an amendment offered by Senator Snowe (R-ME) in committee, the Senate bill creates a new option for states that already cover uninsured children to 250 percent of the federal poverty level to use SCHIP funds to provide dental coverage to underinsured children. For example, a state could provide dental coverage to a child whose parents’ employer-based insurance does not cover dental benefits.
  - **New requirement to certify legal immigration status at renewal.** States already are obligated to verify the legal immigration status of any immigrants applying or renewing their eligibility for Medicaid or SCHIP, and ensure that they meet the programs’ eligibility criteria for legal immigrants. An amendment offered by Senator Grassley (R-IA) in committee and added to the final Senate

bill requires a state that opts to eliminate the five-year waiting period for legal immigrant children and/or pregnant women to demonstrate that those enrolled as a result provide evidence of lawful residence in the United States at the point of renewal.

- **Children's Access Commission.** The Senate bill creates a commission, similar to Medicare's Payment Advisory Commission, to evaluate children's access to care and payment policies in Medicaid and SCHIP. This provision was included in the House's original 2007 SCHIP bill, but not in CHIPRA 1 or 2.
- **Medicare savings.** To help pay for SCHIP reauthorization, the House bill includes a provision limiting the expansion of physician-owned specialty hospitals and disqualifying new physician-owned hospitals from billing Medicare. The provision is expected to generate \$300 million in Medicare savings through fiscal year 2013.

## Conclusion

The plan for early action on SCHIP demonstrates that Congress is committed to providing help to America's families now when they need it more than ever. By relying on the architecture of the 2007 bills as it moves forward, Congress is acting in the spirit of the bipartisan tradition of SCHIP and building on a program that has a track record of delivering concrete results for America's families.

## Endnotes

<sup>1</sup> C. Peterson, "What Happens to SCHIP After March 31, 2009?," Congressional Research Service (December 19, 2008).

<sup>2</sup> The House voted on H.R. 976 on February 16, 2007, passing the bill by a vote of 360 to 45. The Senate voted on the bill, adding amendments, on August 2, 2007, with a vote of 68 to 31. The conference agreement and final passage of the compromise legislation occurred in September 2007, after the August 17<sup>th</sup> Directive was issued.

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## Acknowledgements

This summary was prepared by Jocelyn Guyer and Dawn Horner, with the assistance from other members of the staff at the Center for Children and Families.

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**KEY DIFFERENCES AMONG MAJOR SCHIP BILLS  
 JANUARY 29, 2009**

*(This side-by-side is not intended to be a comprehensive summary of the SCHIP bills, but rather a guide to the key provisions.)*

	<b>CHIPRA I 2007 (H.R. 976)</b> (Bill vetoed by President Bush in 2007 and used as a basis for 2009 legislation.)	<b>House CHIPRA 2009 (H.R. 2)</b> (Bill passed by the House of Representatives on January 14, 2009.)	<b>Senate CHIPRA 2009 (S. 275)</b> (Bill approved by Senate on January 29, 2009.)
<b>OVERVIEW</b>			
<b>Votes</b>	Passed House – 9/25/07 (265-159) Passed Senate – 9/27/07 (67-29) Vetoed – 10/3/07 House Override – 10/18/07 (273-156)	Passed House – 1/14/2009 (289-139)	Passed Senate Finance Committee – 1/15/09 (12-7) Passed Senate – 1/29/09 (66-32)
<b>Children Covered</b>	For FY 2012, 5.8 million more children enrolled in Medicaid and SCHIP. Of these, 3.8 million otherwise would have been uninsured.	For FY 2013, 6.5 million more children enrolled in Medicaid and SCHIP. Of these, 4.1 million would have been otherwise uninsured.	For FY 2013, 6.5 million more children enrolled in Medicaid and SCHIP. Of these, 4.1 million would have been otherwise uninsured.
<b>Cost for Five Years</b>	\$35 billion over 5 years (FY 2008 – FY 2012) in new spending for SCHIP and Medicaid for children.	\$32.3 billion over 4.5 years (April 1, 2009 through FY 2013) in new spending for SCHIP and Medicaid for children.	\$32.8 billion over 4.5 years (April 1, 2009 through 2013) in new spending for SCHIP and Medicaid for children.
<b>FINANCING</b>			
<b>National SCHIP Allotments</b>	Total annual funding is set at the following levels:  2008: \$9.125 billion 2009: \$10.675 billion 2010: \$11.850 billion 2011: \$13.750 billion 2012: \$16.000 billion	Total annual funding is set at the following levels:  2009: \$10.562 billion 2010: \$12.520 billion 2011: \$13.459 billion 2012: \$14.982 billion 2013: \$17.406 billion	Same as House CHIPRA 2009.
<b>Allocation Formula</b>	In FY 2008, each state’s allotment is set at 110% of the following (whichever is higher): 1) FY 2007 spending, adjusted for health care inflation and child	Same, only dates changed. In FY 2009, each state’s allotment is set at 110% of the following (whichever is higher): 1) FY 2008 spending, adjusted for health	Same as House CHIPRA 2009.

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	<p>population growth; 2) FY 2007 allotment, adjusted for health care inflation and child population growth; or 3) projected spending for FY 2008. Then, beginning FY 2010, a state's allotment is "re-based" to reflect its actual spending on SCHIP (adjusted for health care inflation and child population growth).</p> <p>States facing a shortfall also can receive a performance-based shortfall adjustment, financed through a separate capped contingency fund, if they experience higher-than-expected enrollment.</p>	<p>care inflation and child population growth; 2) FY 2008 allotment, adjusted for health care inflation and child population growth; or 3) projected spending for FY 2009. Then, beginning FY 2011, a state's allotment is "re-based" to reflect its actual spending on SCHIP (adjusted for health care inflation and child population growth).</p> <p>States facing a shortfall also can receive a performance-based shortfall adjustment, financed through a separate capped contingency fund, if they experience higher-than-expected enrollment.</p>	
<b>Offsets</b>	\$.61 increase in federal tobacco tax.	Financed primarily by a \$.61 increase in federal tobacco tax, which generates \$31.3 billion over the 2009 to 2013 period. In addition, \$300 million over 5 years in Medicare savings is generated by limiting the expansion of physician-owned specialty hospitals and disqualifying new physician-owned hospitals from billing Medicare.	Financed primarily by a \$.61 increase in federal tobacco tax, which generates \$31.3 billion over the 2009 to 2013 period.
<b>States with Significant Medicaid Expansions Pre-SCHIP</b>	States that significantly expanded Medicaid coverage for children prior to the enactment of SCHIP can use available balances from their SCHIP	Same.	Same.



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	allotments to draw down an enhanced matching rate for children in Medicaid with family income above 133% FPL.		

**ELIGIBILITY RULES**

<b>New Expansions for Children Above 300% FPL</b>	<p>New limits imposed on expansions to children above 300% FPL.<sup>1</sup> For these children, states can receive only the Medicaid (not SCHIP) matching rate. States already covering children above 300% FPL (NJ and NY) can still receive the enhanced SCHIP matching rate.</p> <p>States covering such children must implement “best practices” designed to limit crowd out and meet ambitious standards for coverage rates of low-income children. Directs GAO and Institute of Medicine to develop best practice guidelines and measures of crowd out and coverage rates.</p>	<p>Same, only dates changed. Beginning FY 2009, states providing SCHIP to children above 300% FPL<sup>1</sup> will receive only the Medicaid matching rate, with exceptions for those states (NJ and NY) already covering these children.</p> <p>No “best practices” provisions or coverage rate requirements.</p>	Same as House CHIPRA 2009.
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<sup>1</sup> When setting their income rules, states can continue to use specific disregards, such as for work expenses. The new provisions, however, specifically bar states from receiving the SCHIP enhanced match by using “block of income” disregards (e.g. a disregard of all income between 300% and 400% FPL) to effectively expand coverage to children above 300% FPL.



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<b>Treatment of “August 17<sup>th</sup>” Directive</b>	The new rules for covering children above 300% of the FPL (described above) would replace the August 17 <sup>th</sup> directive.	Silent on August 17 <sup>th</sup> directive, leaving it open for President Obama to rescind.	Same as House CHIPRA 2009.
<b>Legal Immigrant Children and Pregnant Women (ICHIA)</b>	No provision.	Gives states the option to cover legal immigrant children and pregnant women receiving Medicaid and SCHIP during their first five years in the country, if otherwise eligible.	Same as House CHIPRA 2009. (As amendment offered by Senators Rockefeller, Snowe, Bingaman and Kerry.)  New provision (Senator Grassley amendment in committee) requires a state utilizing this option to demonstrate that those enrolled under the provision provide, at renewal, documentation or other evidence of lawful residence in the US.
<b>Pregnant Women</b>	States have option to cover pregnant women with SCHIP funds by submitting a state plan amendment. To use the option, states must already be covering pregnant women up to at least 185% FPL (or higher if a state already covers pregnant women in Medicaid at a higher income level) and meet other requirements.	Same.	Same.
<b>Parent Waivers– New Requests</b>	Bans any new waivers to cover parents with SCHIP funds.	Same.	Same.



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<b>Parent Waivers– Already Approved</b>	Existing waivers can continue for a two-year transition period. Afterwards (FY 2010), funding for parent waivers is moved out of SCHIP. If a state meets specified benchmarks in covering children, it can receive the SCHIP enhanced matching rate out of a separate, capped allotment for the first post-transition year, and a modified (reduced) enhanced matching rate in later years. If a state cannot meet the benchmarks, which become more stringent over time, it receives only the regular Medicaid matching rate out of its capped allotment.	Same, only dates changed. Existing waivers can continue through FY 2011. Available post-transition funding available through end of reauthorization time period (FY 2012 and FY 2013).	Same as House CHIPRA 2009.
<b>Childless Adult Waivers– New Requests</b>  <i>(Already prohibited at time SCHIP was debated.)</i>	Restates DRA-established ban on <u>new</u> waivers that allow SCHIP funds to be used for childless adults.	Same.	Same.
<b>Childless Adult Waivers– Already Approved</b>	Ends SCHIP funding for existing childless adult waivers after one year. For an additional year (FY 2009), states can secure federal matching funds from a temporary, capped block grant (outside of SCHIP) for childless adults who remain in coverage (rather than the	Same, only dates changed. SCHIP funding for existing childless adult waivers available until the end of FY 2010. States can secure the additional funding to cover the childless adults who remain in coverage through the capped block grant in FY 2011 and apply	SCHIP funding for existing childless adult waivers available until the end of <u>calendar year</u> 2009. There is no capped block grant for an additional year but states can apply for a Medicaid waiver to cover the childless adults who remain

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	eligible waiver population). The bill also establishes a process that states may use to request a Medicaid waiver to cover grandfathered childless adults in future years.	for a Medicaid waiver in future years.	in coverage in future years.
<b>ENROLLING ALREADY-ELIGIBLE, LOW-INCOME CHILDREN</b>			
<b>Performance Bonuses– Enrollment Simplification Requirements</b>	States that streamline their enrollment and retention procedures (see below) and increase SCHIP and Medicaid enrollment of children above a target level receive a federal bonus payment for each additional child enrolled (if he or she qualifies under eligibility rules in effect as of July 1, 2007). <sup>2</sup>  The size of the bonus payment is determined by 1) whether the child is Medicaid or SCHIP-eligible; 2) the average cost to the state of covering such a child; and 3) the extent to which a state’s enrollment exceeds target levels. The target level is based on FY 2007 enrollment in Medicaid and SCHIP,	Same as CHIPRA I in structure, but target enrollment levels and the size of bonuses have been modified.  Specifically, states that streamline their enrollment and retention procedures (see below) and increase <u>Medicaid</u> enrollment of children above a target level receive a federal bonus payment for each additional child enrolled (if he or she qualifies under eligibility rules in effect as of July 1, 2008). <sup>2</sup>  The size of the bonus payment is determined by the average cost to the state of covering such a child in Medicaid and the extent to which a	Same as House CHIPRA 2009 in structure, target enrollment levels and the size of bonuses. To be eligible, a state must implement (throughout the entire fiscal year) at least <u>five</u> out of eight simplification measures (rather than four out of seven). The addition to the list of allowable options is the use of premium assistance subsidies.

<sup>2</sup> This precludes states from receiving the bonus for eligibility expansions, as opposed to for improved enrollment of already-eligible children.

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	<p>adjusted over time by growth in a state’s child population plus 1 percentage point. The bonus payments can vary from 10% to 60% of the average state cost of enrolling a child, with the higher percentage provided to states that have been the most successful at enrolling the lowest-income eligible children.</p> <p>To be eligible for performance bonus payments, a state must implement (throughout the entire fiscal year) at least four of the following practices for children in SCHIP and Medicaid: 1) 12-month continuous eligibility; 2) elimination of the asset test (or the state must allow self-declaration when appropriate); 3) elimination of in-person interview requirements; 4) use of a joint application; 5) use of streamlined or “administrative” renewal; 6) use of presumptive eligibility; and 7) use of Express Lane option.</p>	<p>state’s enrollment exceeds target levels. The target level is based on fiscal year 2007 enrollment in Medicaid, adjusted over time by growth in a state’s child population plus an additional percentage (4 percentage points through 2009, and 3.5 percentage points for 2010, 2011, and 2012, 3 percentage points for 2013, 2014, and 2015, and 2 percentage points in future years). The bonus payments can vary from 15% to 62.5% of the average state cost of enrolling a child, with the higher percentage provided for the number of children enrolled in excess of 110% of the target level.</p> <p>Same as CHIPRA I on implementation of four of seven simplification measures.</p>	
<b>Outreach Funding</b>	\$100 million for a national enrollment campaign and outreach and enrollment grants to state and local governments and other organizations, such as safety net providers, community-based organizations, schools, etc.	Same.	Same.



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<p><b>Simplifying the Citizenship Documentation Requirement</b></p> <p><i>Until the Deficit Reduction of Act of 2005 (“DRA”) states had the flexibility to decide the best way to verify the citizenship of applicants for Medicaid. (They, however, then and now must follow specific steps to verify the immigration status of non-citizen applicants.) The DRA citizenship documentation requirement established a new, tightly-prescribed and paperwork-intensive set of rules that states must follow to document citizenship status for most children, parents, and pregnant women (nearly all seniors and people with disabilities are exempt).</i></p>	<p>Maintains the citizenship documentation requirement in Medicaid for children and non-exempt adults, but allows states to comply by sending applicants’ names and social security numbers (SSNs) to the Social Security Administration (SSA) for verification. Extends the citizenship documentation requirement (including new, less paperwork-intensive option for complying) to SCHIP.</p>	<p>Same as CHIPRA I.</p> <p>Includes CHIPRA II 2007 amendment that SSA must also determine whether declaration of citizenship or nationality is consistent with its records.</p>	<p>Same as House CHIPRA 2009.</p>

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<b>Express Lane Eligibility</b>	<p>States have option to use a finding with respect to an eligibility component from other agencies when the state evaluates whether a child is eligible for Medicaid or SCHIP (e.g., if a Food Stamp program evaluated a child's family income, the Medicaid agency could accept the Food Stamp program's finding without re-computing income or requiring the family to re-submit documentation of income.)</p> <p>States must meet two requirements to exercise Express Lane 1) comply with Medicaid and SCHIP's citizenship and nationality verification requirements; and 2) limit the entities from which Medicaid and SCHIP can borrow information to public agencies.</p>	Same.	Mostly the same. New provision (Senator Bingaman amendment in Senate) clarifies that parents can consent to their children's enrollment into health coverage through methods other than signing a formal application form.
<b>PREMIUM ASSISTANCE</b>			
<b>Coordination between Public and Private Coverage</b>	Reduces barriers for states to do premium assistance by allowing states to include the cost of covering parents in assessing cost-effectiveness of providing premium subsidies to SCHIP- and Medicaid-eligible children. States must also include administrative costs in the cost-effectiveness test. Coverage that can be subsidized must meet some	Same	Same



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	<p>conditions: 1) employers must contribute 40% of the cost; and 2) the benefit package must meet an actuarial equivalency test to the CHIP coverage or children are eligible for “wrap-around” benefits and cost-sharing protections.</p> <p>Also amends federal ERISA law to promote coordination between public and private coverage by establishing that both the loss of or gaining of Medicaid/SCHIP coverage counts as a “qualifying event” for the purposes of being eligible for employer-sponsored coverage. Employers must also share their benefits packages at state request to assess the need for wraparound services.</p> <p>A number of provisions encourage outreach on premium assistance, and the GAO is mandated to do a study on state programs by January 2010.</p>		
<b>IMPROVING QUALITY AND BENEFITS FOR CHILDREN</b>			
<b>Children’s Access Commission</b>	No provision.	No provision.	Establishes a commission, similar to Medicare’s MedPAC, to evaluate children’s access to care and payment policies in Medicaid and SCHIP.



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*(This side-by-side is not intended to be a comprehensive summary of the SCHIP bills, but rather a guide to the key provisions.)*

	<b>CHIPRA I 2007 (H.R. 976)</b> (Bill vetoed by President Bush in 2007 and used as a basis for 2009 legislation.)	<b>House CHIPRA 2009 (H.R. 2)</b> (Bill passed by the House of Representatives on January 14, 2009.)	<b>Senate CHIPRA 2009 (S. 275)</b> (Bill approved by Senate on January 29, 2009.)
<b>Other Quality Provisions</b>	Includes \$225 million for a new five-year quality initiative within HHS. The initiative includes the development, testing, and dissemination of child health quality measures; demonstration grants on quality; creation of a model electronic medical record; and federal studies and state reporting on quality.	Same.	Same.
<b>Mental Health Parity</b>	Mental health benefits are not required but if a state provides mental health or substance abuse services through SCHIP, the financial requirements and treatment limitations for those benefits cannot be more restrictive than for medical and surgical benefits. SCHIP plans that include EPSDT coverage would satisfy this new requirement.	Same.	Same.
<b>Dental Coverage</b>	Requires SCHIP plans to include coverage of dental services. State can meet this requirement by providing coverage that is equivalent to benchmark dental benefit standards. Requires HHS to implement strategies for increasing access to dental services.	Same.	Same, plus a new provision (Senator Snowe amendment in committee) that allows states to provide dental-only supplemental coverage through SCHIP to otherwise eligible underinsured children (e.g., children with private insurance who lack dental coverage).

For additional information, including bill language, see: <http://ccf.georgetown.edu/index/schipreauthorization>.

