



National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

**To:** State CEOs and Medicaid Directors  
**From:** Andrea Maresca  
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**Re:** Federal Legislative Update

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The 109<sup>th</sup> Congress adjourned on December 10, 2006. During the final days, the House and Senate passed several health related bills including: a stop-gap fix for the states anticipating a SCHIP shortfall; extending the Transitional Medical Assistance program, several technical corrections to the Deficit Reduction Act that include corrections to citizenship and identity verification. The Congress also dealt with the cap on provider taxes and reauthorization of the Ryan White Care Act.

This legislation will be effective once the President signs the bills into law. In addition, both bodies have begun to appoint members of the key committees for the 110<sup>th</sup> Congress and develop their agendas. This memo discusses the provisions of the health related legislation and provides a preliminary outlook for the first part of 2007.

### **Congressional Activity**

#### ***SCHIP Shortfall Legislation***

Prior to adjourning, the members of the House and Senate addressed the anticipated SCHIP shortfalls. Senate Finance Committee members Chuck Grassley (R-IA) and Max Baucus (D-MT) were able to reach an agreement with the House on an amendment to the bill reauthorizing the National Institutes of Health, the "National Institutes of Health Reform Act of 2006" (H.R. 6164). Due to budgetary constraints, Congress was unable to completely eliminate expected shortfalls. H.R. 6164 seeks to delay as long as possible the date on which any state experiences a shortfall. According to the Congressional Research Service (CRS) analysis, H.R. 6164 would delay shortfalls through the first part of May 2007.

Provisions. The SCHIP provisions of H.R. 6164 include<sup>1</sup>:

- FY2004 original allotments still unspent as of the end of FY2006 are available for redistribution to other states in FY2007. An estimated \$150 million will be available.

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<sup>1</sup> The information regarding the SCHIP provisions was obtained from the Congressional Research Service, "SCHIP Provisions of H.R. 6164 (NIH Reform Act of 2006)," December 12, 2006.

- FY2004 funds will be redistributed in the order in which states experience a monthly shortfall in FY2007. Five of the 14 projected shortfall states would receive redistributed FY2004 funds: Illinois, Maryland, Massachusetts, New Jersey and Rhode Island.
- Up to half of unspent FY2005 original allotments, as of March 31, 2007, are eligible for an initial redistribution. An estimated \$125 million would be available to shortfall states.
- There are two restrictions on the FY2005 redistribution. First, any funds a state forgoes would be capped at \$20 million per state. In addition, in order for the state to forgo these funds, the state also must have total SCHIP balances (FY2005-FY2007 original allotments) as of March 31, 2007, that are at least double what the state has projected to spend in federal SCHIP funds in FY2007.
- Unspent FY2005 funds would be distributed on a monthly basis, similar to the unspent FY2004 funds. Six of the 14 projected shortfall states would receive redistributed FY2005 funds.
- According to CRS, 16 states are projected to have unspent FY2005 balances on March 31, 2007. Of those 16 states, three (Arkansas, New Mexico and Wyoming) would not have total available balances of at least double their FY2007 projected spending. Based on current data, four states (Florida, Tennessee, Texas, and Washington) are projected to forgo the maximum amount (\$20 million) on March 31, 2007.
- In addition to the redistribution after two and a half years, the regular redistribution of unspent FY2005 will still be carried out.
- Redistributed FY2004 and FY2005 funds to shortfall states can only be used for covering individuals who were eligible in a state's SCHIP program as of October 1, 2006.
- Retrospective adjustment to the amounts of the FY2004 and FY2005 funds that are redistributed will be made. The initial redistribution amounts will be based on the latest available data, and can be revised based on the FY2007 expenditure data reported by November 30, 2007. The retroactive adjustment for the FY2005 funds forgone on March 31, 2007 can be reduced but not increased. Also, additional amounts that may be required for shortfall states because of the retrospective adjustments can only come from FY2005 original allotments still unspent at the end of FY2007.
- When paid from redistributed FY2004 or FY2005 funds, shortfall states that enrolled eligible non-pregnant adults in SCHIP will receive funds from the

redistribution pool, but they will only be eligible for the Medicaid match rate - not the higher SCHIP match rate - for these adults.

- States that had expanded their Medicaid program to cover uninsured children prior to the enactment of SCHIP are permitted to spend up to 20 percent of their FY2006 and 2007 SCHIP allotments. Eleven states qualify under this provision: CT, HI, MD, MN, NH, NM, RI, TN, VT, WA, and WI.
- Unlike in the past, Congress included only the states and the District of Columbia in the redistribution provisions. The territories were not included.

FY2007 Shortfall Outlook. H.R. 6164 does not fully address the estimated FY2007 shortfalls. Shortfall estimates range from \$870 to \$900 million. CMS projects that 14 states will have shortfalls next year although other estimates show 17 states will face shortfalls. It is unclear at this time if and how Congress will ultimately address the remaining FY2007 shortfalls. One option is to pass a reauthorization bill that provides additional funding for shortfalls, beginning in FY2008. Although the provisions redistribute an additional \$125 million for projected FY2007 shortfalls, the shortfalls remaining for the rest of the fiscal year are projected at \$716 million.

#### ***Changes to Health Savings Accounts (HSAs)***

As part of the "Tax Relief and Health Care Act of 2006," Congress included H.R. 6111, which made several changes to Health Savings Accounts (HSAs). Although the language is identical to that approved by the House Ways and Means Committee in September 2006, the legislation was never considered on the House or Senate floor. The expansion would cost the federal government an estimated \$1 billion in lost tax revenue over the next decade. Supporters believe that it will make HSAs more flexible and attractive. Opponents have cited a September 2006 GAO report that shows HSAs are being used disproportionately by high-income individuals and indicates that many of these people are using HSAs as tax shelters.

The provisions would make the following changes:

- Allow employees to make a one-time, tax-free rollover of funds from a Flexible Spending Arrangement (FSA) or Health Reimbursement Arrangement (HRA) to their HAS prior to January 2012.
- Changes the annual contribution limit to HSAs to allow contributions up to the annual statutory HSA contribution limit, which is indexed annually for inflation, regardless of the amount of their health plan deductible. The contribution limit for 2007 is \$2,850 for single coverage and \$5,650 for family coverage.
- Changes HSA contribution rules for mid-year enrollees by removing the prorated amount such enrollees could contribute to their HSAs.
- Removes the requirement that employers have to make equal contributions to all employees, regardless of their wages. Some believe that this may benefit lower-wage individuals while others cite that this is a way for employers to

- Permits a one time tax-free transfer of funds from an IRA to an HAS up to the annual contribution limit for the HSA.
- Requires the Secretary of Treasury to publish the annual indexed adjustments to HSAs by June 1st of each year.
- Allows individuals to contribute to their HSAs at the start of the year, even if they were enrolled for the previous year in an FSA with a 2 ½ month grace period provided the FSA balance is zero before the start of the grace period or any remaining FSA funds are transferred to the new HSA.

***TMA Extension, DRA Technical Fixes, and Other Health Related Provisions***

Congress also approved the “Tax Relief and Health Care Act of 2006,” (H.R 6111). In addition to extending several major tax related provisions and eliminating the 5.1 percent physician fee cut that was scheduled to go into effect in 2007, the legislation included several Medicaid and other health related provisions.<sup>2</sup>

**Transitional Medical Assistance (TMA).**

TMA was scheduled to expire on December 31, 2006. Congress extended it by six months through June 30, 2007.

**Technical Corrections to the Deficit Reduction Act of 2005 (DRA).**

Several technical amendments were made to the DRA and will be effective according to the relevant sections’ effective dates. The technical corrections to the DRA included:

- **Cost Sharing Clarifications**
  - Exempts from the general cost-sharing rules all individuals in families with income below 100% of the federal poverty line (FPL). Section 1916 of Title XIX (nominal cost-sharing provisions) would still apply to this income group, as would the comparability rule regarding amount, duration and scope of available benefits. States would still have the option to impose the special cost-sharing rules for prescribed drugs and non-emergency care provided in an emergency room to individuals in families with income below 100% FPL.
  - Exempts individuals in families with income below 100% FPL from the provisions defining enforceability of premiums and other cost-sharing. Protections regarding payment of premiums and cost-sharing in Section 1916(c)(3) and Section 1916(e) would continue to apply to this income group.
  - Applies the total aggregate cap of 5% of family income to individuals in families with income below 100% FPL for applicable cost-sharing with respect to nominal amounts, and prescribed drugs and emergency room copayments for non-emergency care.

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<sup>2</sup> The following information on H.R. 6111 was adapted from the “Managers Statement” on the bill.

- **Citizenship and Identity Verification**
  - The following changes would be effective as if included in the DRA.
  - Specifies that the documentation requirements do not apply to an individual declaring to be a citizen or national of the United States who is eligible for Medicaid:
    - and is entitled to or enrolled for Medicare benefits;
    - and is receiving (1) Social Security benefits on the basis of a disability (SSDI) or (2) SSI benefits;
    - and with respect to whom (1) child welfare services are made available under Title IV-B of the Social Security Act or (2) adoption or foster care assistance is made available under Title IV-E; or
    - on such basis as the Secretary may specify that satisfactory documentary evidence has been previously presented.
  - Requires that (1) states have procedures in effect for verifying the citizenship or immigration status of children in foster care under the responsibility of the state under Title IV-E or IV-B of the Social Security Act and (2) states specify that in reviews of state programs under IV-E and IV-B, the requirements subject to review shall include determining whether the state program is in conformity with the requirement to verify citizenship or immigration status. These requirements will be effective 6 months after the bill is signed into law.
  
- **Prescription Drug Related Provisions**
  - The definition of preferred drugs would be amended to include those that are the most (or more) cost effective prescription drugs within a class of drugs (as defined by the state).
  - In addition to separate cost-sharing provisions for prescribed drugs, it clarifies that separate cost-sharing provisions also apply to non-emergency services provided in an emergency room.
  - It clarifies that no cost-sharing for preferred drugs can be imposed on individuals exempt from service-related cost-sharing under the general cost-sharing provisions.
  - It would also clarify that no more than nominal cost-sharing amounts may be imposed for non-preferred drugs on individuals exempt from services-related cost-sharing under the general cost-sharing provisions.
  
- **Treatment of non-emergency cost-sharing.**
  - Clarifies that for non-exempt persons with income between 100-150% FPL, cost-sharing for non-emergency care in an ER may not exceed twice the applicable nominal amount (to the 5% cap).

- For persons with income below 100% FPL or who are exempt from service-related cost-sharing, cost-sharing for non-emergency care in an ER may not exceed the applicable nominal amount when no cost-sharing is imposed by the outpatient department or alternative providers.
- The 5% aggregate cap on all service-related cost-sharing for all income groups remains is still applicable.
  
- **Definition of non-emergency services** – Removes the term “the physician determines” from the definition of non-emergency services in the DRA.
  
- **State as “Remainder Beneficiary”**- Amends Section 6012 of the DRA by replacing the term “annuitant” with “institutionalized individual.”
  
- **Cost-sharing for newly eligible children with disabilities** - Exempts the new optional eligibility group for children with disabilities from the premium and service-related cost-sharing rules.
  
- **Correction of IV-B References** - Among the groups explicitly exempted from the general cost-sharing provisions for premiums and cost-sharing, the provision would change references to Title IV-B to mean child welfare services made available under Title IV-B on the basis of being a child in foster care.

**Provider Tax Provisions.** In order to pay for the TMA extension and other portions of the bill, the legislation includes a provision (Title IV, Section 403) to lower the allowable Medicaid provider tax rate from 6 percent to 5.5 percent. The 5.5 percent tax rate cap is effective as of January 1, 2008 through October 1, 2011. This is estimated to save the federal government over \$300 million in FY2007.

Previously the 6 percent allowable rate was established in regulation (paragraph (3)(i) of Section 433.68 of 42CFR). According to congressional staff, the Congress intended to ensure that CMS did not issue a regulation that would phase in a 3 percent cap on the provider tax rate, per the Administration’s FY2007 budget proposal.

### **Ryan White CARE Act**

The House and Senate passed the Ryan White HIV/AIDS Treatment Modernization Act of 2006,” (H.R. 6143). The measure reauthorizes the program for three years, and seeks to limit cuts that were scheduled to go into effect for large city AIDS programs. The provisions include:

- Amends the Public Health Service Act to maintain a metropolitan area's eligibility to receive an AIDS emergency relief grant until such area fails to meet eligibility requirements for three consecutive years.

- Amends the formula for awarding grant funds to consider the number of living names-based cases of HIV/AIDS. Provides for exemptions and adjustments for states that continue to use code-based reporting.
- Limits the amount a grant to a metropolitan area can decrease each year.
- Establishes provisions for the use or return of unobligated balances of a grant.
- Requires grant recipients to use not less than 75 percent of grant funds to provide core medical services.
- Establishes a transitional grant program for metropolitan areas with lower numbers of AIDS cases.
- Requires the Secretary to develop and maintain a list of classes of core AIDS Drug Assistance Program (ADAP) antiretroviral therapeutics.
- Provides for grants to states in need of supplemental financial assistance.
- Provides for grants to states for the universal testing of newborns for HIV/AIDS.
- Establishes a grant program for providing family-centered care involving outpatient or ambulatory care for women and children with HIV/AIDS.

### ***FY2008 Appropriations***

Congress agreed to a continuing resolution (H.J. Res. 702) to fund most government operations through February 15, 2007. In most cases, the measure will fund programs at the lowest of the House-passed, Senate passed or prior year level.

Recent reports indicate that the incoming Democratic leadership has not yet decided how to handle the remainder of FY 2007 appropriations. One option that is being considered by incoming appropriations chairmen, Congressman David Obey (D-WI) and Senator Robert Byrd (D-WV), is to fund federal programs through another continuing resolution for the remainder of FY 2007, with minor adjustments to critical programs, and start work on FY 2008 appropriations measures.

### **110<sup>th</sup> Congress: Preliminary Priorities and Outlook**

Congress faces an increasingly negative outlook with regard to the federal budget deficit. This will continue to limit efforts or require more creative thinking about funding sources on a number of health care issues important to states.

NASMD already has begun to meet with some of the key congressional staff to discuss their plans for the new Congress. At the top of their health care agenda – similar to that of NASMD and other stakeholders – is reauthorization of the SCHIP program. Congressional leaders are in the initial stages of evaluating how SCHIP

reauthorization may fit into the desire by some policymakers to expand or otherwise address uninsured children or changes to the health care system in general.

In addition, we have heard of an increased desire to conduct oversight hearings on several areas of Medicaid. For example, we anticipate oversight hearings on the new Medicaid citizenship documentation requirement and the states initiatives to implement the DRA's new cost sharing and benefit flexibility, among others.

The 109<sup>th</sup> Congress did temporarily address the physician fee payment system; however they will be forced to revisit the issue in 2007. This could have an impact on states in that a new methodology for calculating the payments or another "fix" is expected to have a significant cost.

Incoming committee chairs in the House and Senate also have indicated they are likely to review various issues related to the Medicare prescription drug program.

Legislation regarding health information technology was approved by the House and Senate this past year, but ultimately members could not reach agreement the provisions. The next Congress is expected to revisit this issue.

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