Covering Uninsured Children

The SCHIP Reauthorization Debate

Should the House Pass H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act?

Rep. Charles Rangel (NY-D)
Rep. John Boehner (OH-R)

and others . . .
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Covering Uninsured Children
The SCHIP Reauthorization Debate

“He who decides a case without hearing the other side . . . Tho he decide justly, cannot be considered just.” — Seneca

FOREWORD

Children’s health, an issue that usually inspires bipartisan cooperation, has become one of the most contested issues on this year’s congressional agenda.

The State Children’s Health Insurance Program (SCHIP) — widely considered a success — is set to expire on September 30, 2007. The program was created in 1997 to insure children in families who have too much income to qualify for Medicaid and too little to afford private insurance.

SCHIP currently covers approximately 6 million children. Like Medicaid, it functions as a partnership between the Federal Government and the States. State governments administer SCHIP programs according to broad Federal guidelines. They may use their SCHIP funds to enroll low-income children in Medicaid, create their own separate State program, or combine these two approaches. States also have considerable flexibility in designing SCHIP eligibility requirements.

All 50 States, the District of Columbia, and five territories operate SCHIP programs. On average, the Federal Government pays 70 percent of program costs and State governments pay 30 percent. Congress appropriated nearly $40 billion for SCHIP for Fiscal Years 1998 through 2007.

SCHIP has markedly reduced the number of low-income children who are uninsured. According to the Congressional Budget Office, the percentage of uninsured children between 100 and 200 percent of the Federal poverty line dropped from 22.5 percent in 1996 to 16.9 percent in 2005. In addition, States’ outreach efforts and simplified enrollment procedures for SCHIP appear to have increased the percentage of eligible children participating in Medicaid.

Now, however, the funding structure for SCHIP has come up against its limits. At least 9 million children nationwide remain uninsured, even though they are eligible for SCHIP or Medicaid. In early August, the House and Senate passed ambitious SCHIP reauthorization bills, crafted by the Democratic majority, that would significantly increase spending on the program over the next five years to provide care for most of these children. The House bill provides nearly $50 billion over that period, the Senate bill $35 billion. Both bills include new incentives to enroll more children, but impose additional restrictions on eligibility.

To save money, the House bill would change the current formula for determining Medicare payments to physicians. It would also cut spending for Medicare Advantage, which allows beneficiaries to collect Medicare benefits through private health plans. (The Senate bill makes no changes in the Medicare program.) One especially contentious provision in both measures would increase cigarette taxes — the House bill by 45 cents per pack and the Senate bill by 61 cents per pack — to offset costs.

Those favoring the SCHIP reauthorization legislation argue that it will give millions of vulnerable children the health coverage they need to grow and thrive. They view it as an investment in the Nation’s future that will save billions of dollars in health care costs down the road for diseases and illnesses that could have been prevented. House sponsors assert that the changes in Medicare will help shore up the Trust Fund and improve benefits for senior citizens.

Opponents call the legislation an unnecessary and reckless expansion that moves SCHIP in the direction of becoming a full-fledged entitlement (a program that guarantees benefits to anyone meeting certain qualifications). They contend that SCHIP has already grown beyond its original scope and cost through waivers and other exceptions, gradually crowding out the private insurance market. Many criticize the Medicare changes as sharply reducing coverage choices for beneficiaries, and the tobacco tax increase as a regressive and unreliable revenue source.

Further complicating the issue is a veto threat from President George W. Bush, who has characterized the reauthorization measures as thinly veiled attempts to create a government-run health care system. Many see the current showdown as a trial run for both Democrats and Republicans as they fine tune their health care messages for the 2008 election.

Despite the politics involved, the debate offers an important opportunity for Congress to reassess health care priorities and the relative roles of Federal and State government and public and private health insurers in providing coverage.
The State Children’s Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997 to expand health insurance coverage to uninsured children in families with income that is modest but too high to qualify for Medicaid. SCHIP is financed jointly by the Federal Government and the States, and it is administered by the States within broad Federal guidelines. Since the program’s inception, the Congress has provided nearly $40 billion for it. Approximately 6.6 million children were enrolled in SCHIP at some time during 2006, as were about 670,000 adults through waivers of statutory provisions. Under current law, SCHIP is not authorized to continue beyond 2007, and the Congress is considering reauthorization of the program this year.

SCHIP Provisions

States have considerable flexibility in designing their eligibility requirements and policies for SCHIP. In 2006, 26 States set their eligibility thresholds at 200 percent of the Federal poverty level, 15 States had thresholds above 200 percent of the poverty level, and nine had thresholds below. (The Federal poverty level for a family of three in 2007 is $17,170.) The lowest eligibility threshold in a State was 140 percent of the poverty level and the highest was 350 percent. Most States subtract a portion of the family’s earnings and certain expenses to compute a measure of net income that is used to determine a child’s eligibility for SCHIP.

States can provide SCHIP coverage by expanding Medicaid to children not eligible for that program, creating a separate program under SCHIP, or using a combination of the two approaches. In 2006, 11 States expanded Medicaid, 18 States operated a separate program under SCHIP, and 21 States used a combination approach.

States that provide SCHIP coverage by expanding Medicaid must provide the same benefits that are available under their Medicaid program and follow all other requirements of that program. States that create a separate program under SCHIP are subject to certain minimum standards, including providing a benefit package that is based on one of several specified “benchmark” insurance plans or an alternative that is actuarially equivalent or otherwise approved by the Federal Government.

Each year, the Federal funding for SCHIP is allocated among States on the basis of a formula that takes into account the number of children in low-income families in each State, the number of such children who are uninsured, and wages in the health services sector in the State relative to the national average.

States must provide matching funds for expenditures from their Federal allotments and have up to three years to spend those allotments. Funds that are not spent within three years are redistributed to States that have exhausted their allotments and are made available to those States for an additional year.

To encourage States to participate in SCHIP, the Federal Government pays a higher share of their spending on SCHIP than it pays for Medicaid. The Federal Government’s matching rate for SCHIP varies among States from 65 percent to 83 percent, while the Federal matching rate for Medicaid varies from 50 percent to 76 percent. Although Federal spending is made available on a matching basis for both programs, the nature of the programs differs significantly because SCHIP is a grant program in which Federal spending is capped in advance, whereas Medicaid is an entitlement program with no predetermined limit on spending.

Because the implementation of SCHIP occurred over several years, Federal spending on the program was lower in its initial years. As the States’ programs matured, Federal spending exceeded current-year allotments starting in 2002. Some States have been able to spend more Federal dollars than their allotment in a particular year by drawing on unspent funds from previous years and funds redistributed from other States. Yet a great deal of variation exists among States in their spending relative to their allotments: Federal spending falls short of the allotments in some States and exceeds it in others.

In recent years, some States have projected that they will exhaust their Federal funds. As a result, the Congress has

From the May 2007 Congressional Budget Office report The State Children’s Health Insurance Program.

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acted twice to provide additional funding. The Deficit Reduction Act of 2005 appropriated an additional $283 million for SCHIP in 2006, and the National Institutes of Health Reform Act of 2006 included provisions modifying the redistribution of unspent funds from previous years to provide additional funds in 2007.

The implications of exhausting the available SCHIP funds vary among States. States that provide coverage by expanding Medicaid automatically receive Federal matching payments under the Medicaid program once their SCHIP funds have been exhausted, but at the lower matching rate for Medicaid. Similarly, States that operate a combination program receive Federal matching payments under Medicaid for beneficiaries who are enrolled in the Medicaid component of their program.

In contrast, States that operate a separate program under SCHIP receive no additional Federal matching payments once their available SCHIP funds have been exhausted. However, those States can constrain their expenditures through measures such as capping enrollment or increasing premiums, which are not allowed in States that provide SCHIP coverage through an expansion of Medicaid. In addition, States that operate a separate program have the option of converting some or all of their program into an expansion of Medicaid, which would provide access to additional Federal matching funds under that program.

The Effect of SCHIP on Children’s Health Insurance Coverage

SCHIP has significantly reduced the number of low-income children who are uninsured. According to the Congressional Budget Office’s (CBO) analysis, among children living in families with income between 100 percent and 200 percent of the poverty level (the group with the greatest increase in eligibility for public coverage under SCHIP), the uninsurance rate fell from 22.5 percent in 1996 (the year before SCHIP was enacted) to 16.9 percent in 2005, a reduction of 25 percent. In contrast, the uninsurance rate among higher-income children remained relatively stable during that period.

SCHIP has also apparently contributed to an increase in insurance coverage among children below the poverty level, as States’ outreach efforts and simplified enrollment procedures for SCHIP appear to have increased the percentage of eligible children who participate in Medicaid.

Although SCHIP has significantly reduced the number of uninsured children in low-income families, the net effect on the extent of coverage is smaller than the number of children who have been enrolled in public coverage as a result of SCHIP because the increase in public coverage has been partially offset by a reduction in private coverage.

SCHIP provides an alternative source of coverage that is less expensive and that often provides a broader range of benefits than private insurance. As a result, some parents who otherwise would have enrolled their children in private coverage may prefer instead to switch their coverage to SCHIP. In addition, the extent that SCHIP makes pri-

Continued on page 256
Enrollment in the State Children’s Health Insurance Program increased rapidly during the program’s early years but has stabilized over the past several years. SCHIP programs reported total enrollment of approximately 6 million individuals — including about 639,000 adults — as of Fiscal Year (FY) 2005, the latest year for which data were available, with about 4 million individuals enrolled in June of that year.

Many States adopted innovative outreach strategies and simplified and streamlined their enrollment processes in order to reach as many eligible children as possible. Nevertheless, about 11.7 percent of children nationwide remain uninsured, many of whom are eligible for SCHIP or Medicaid. The rate of uninsured children varies widely across States, ranging from a low of 5.6 percent to a high of 20.4 percent.

SCHIP program spending was low initially but now threatens to exceed available funding. Since 1998, some States have consistently spent more than their allotments, while others have consistently spent less. In the first years of the program, States that overspent their annual allotments over the three-year period of availability could rely on other States’ unspent SCHIP funds, which were redistributed to cover excess expenditures.

Over time, however, spending has grown, and the pool of funds available for redistribution has shrunk. As a result, in at least one of the final three years of the program, 18 States were projected to have “shortfalls” of SCHIP funding — that is, they were expected to exhaust available funds, including current and prior-year allotments. To cover projected shortfalls faced by States, Congress appropriated an additional $283 million for FY 2006. As of January 2007, 14 States were projected to exhaust their allotments in FY 2007.

The State Children’s Health Insurance Program reauthorization occurs in the context of debate on broader national health care reform and competing budgetary priorities, highlighting the tension between the desire to provide affordable health insurance coverage to uninsured individuals, including low-income children, and the recognition of the growing strain of health care coverage on Federal and State budgets. As Congress addresses reauthorization, issues to consider include:

- Maintaining flexibility within the program without compromising the primary goal to cover children.
- Considering the program’s financing strategy, including the financial sustainability of public commitments.
- Assessing issues associated with equity, including better targeting SCHIP funds to achieve certain policy goals more consistently nationwide.

Children without health insurance are at increased risk of forgoing routine medical and dental care, immunizations, treatment for injuries, and treatment for chronic illnesses. Yet, the States and the Federal Government face challenges in their efforts to continue to finance health care coverage for children.

As health care consumes a growing share of State general fund or operating budgets, slowdowns in economic growth can affect States’ abilities — and efforts — to address the demand for public financing of health services. Moreover, without substantive programmatic or revenue changes, the Federal Government faces near- and long-term fiscal challenges as the U.S. population ages because spending for retirement and health care programs will grow dramatically.

Given these circumstances, we would like to suggest several issues for consideration as Congress addresses the reauthorization of SCHIP.

Maintaining Flexibility Without Compromising the Goals of SCHIP. The Federal-State SCHIP partnership has provided an important opportunity for innovation on the part of States for the overall benefit of children’s health. Providing three design choices for States — Medicaid expansions, separate child health programs, or a combination of both approaches — affords them the opportunity to focus on their own unique and specific priorities.

*From the March 1, 2007, General Accountability Office report States’ SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization.*
For example, expansions of Medicaid offer Medicaid’s comprehensive benefits and administrative structures and ensure children’s coverage if States exhaust their SCHIP allotments. However, this entitlement status also increases financial risk to States. In contrast, SCHIP’s separate child health programs offer a “block grant” approach to covering children. As long as the States meet statutory requirements, they have the flexibility to structure coverage on an employer-based health plan model and can better control program spending than they can with a Medicaid expansion.

However, flexibility within the SCHIP program, such as that available through Section 1115 [of the Social Security Act] waivers, may also result in consequences that can run counter to SCHIP’s goal — covering children. For example, we identified 15 States that have authority to cover adults with their Federal SCHIP funds, with several States covering more adults than children. States’ rationale is that covering low-income parents in public programs such as SCHIP and Medicaid increases the enrollment of eligible children as well, with the result that fewer children go uninsured.

Federal SCHIP law provides that families may be covered only if such coverage is cost-effective — that is, covering families costs no more than covering the SCHIP-eligible children. We earlier reported that the Department of Health and Human Services (HHS) had approved State proposals for Section 1115 waivers to use SCHIP funds to cover parents of SCHIP- and Medicaid-eligible children without regard to cost-effectiveness. We also reported that HHS approved State proposals for Section 1115 waivers to use SCHIP funds to cover childless adults, which in our view was inconsistent with Federal SCHIP law and allowed SCHIP funds to be diverted from the needs of low-income children.

We suggested that Congress consider amending the SCHIP statute to specify that SCHIP funds were not available to provide health insurance coverage for childless adults. Under the Deficit Reduction Act, Congress prohibited the Secretary of Health and Human Services from approving any new Section 1115 waivers to cover nonpregnant, childless adults after October 1, 2005, but allowed waivers approved prior to that date to continue.

It is important to consider the implications of States’ use of allowable flexibility for other aspects of their programs. For example, what assurances exist that SCHIP funds are being spent in the most cost-effective manner, as required under Federal law? In view of current Federal fiscal constraints, to what extent should SCHIP funds be available for adult coverage? How has States’ use of available flexibility to establish expanded financial eligibility categories and covered populations affected their ability to operate their SCHIP programs within the original allotments provided to them?

Considering the Federal Financing Strategy, Including the Financial Sustainability of Public Commitments. As SCHIP programs have matured, States’ spending experience can help inform future Federal financing decisions. The Congressional Research Service (CRS) testified in July 2006 that 40 States were now spending more annually than they received in their annual original SCHIP allotments. While many of them did not face shortfalls in 2006 because of available prior-year balances, redistributed funds, and the supplemental DRA appropriation, 14 States are currently projected to face shortfalls in 2007.

With the pool of funds available for redistribution virtually exhausted, the continued potential for funding shortfalls for many States raises some fundamental questions about SCHIP financing. If SCHIP is indeed a capped grant program, to what extent does the Federal Government have a responsibility to address shortfalls in individual States, especially those that have chosen to expand their programs beyond certain parameters? In contrast, if the policy goal is to ensure that States do not exhaust their Federal SCHIP allotments, by providing for the continuing redistribution of funds or additional Federal appropriations, does the program begin to take on the characteristics of an entitlement similar to Medicaid? What overall implications does this have for the Federal budget?

Assessing Issues Associated with Equity. The 10 years of SCHIP experience that States now have could help inform any policy decisions with respect to equity as part of the SCHIP reauthorization process. Although SCHIP generally targets children in families with incomes at or below 200 percent of the FPL (Federal poverty level), nine states are relatively more restrictive with their eligibility levels, while 14 states are more expansive, ranging as high as 350 percent of FPL.

Given the policy goal of reducing the rate of uninsured among the Nation’s children, to what extent should SCHIP funds be targeted to those States that have not yet achieved certain minimum coverage levels? Given current and future Federal fiscal constraints, to what extent should the Federal Government provide Federal financial participation above certain thresholds? What broader implications might this have for flexibility, choice, and equity across State programs?

Another consideration is whether the formulas used in SCHIP — both the formula to determine the Federal matching rate and the formula to allocate funds to States — could be refined to better target funding to certain States for the benefit of covering uninsured children. Because the SCHIP formula is based on the Medicaid formula for Fed-
The following summarizes the major provisions of H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act, which passed the full House on August 1, 2007.

Protecting Children’s Health

Ensures States Will Have Predictable Funding Streams that Track Projected Children’s Health Needs. Each State will receive a State Children’s Health Insurance Program (SCHIP) allotment for Fiscal Year (FY) 2008 based on spending estimates submitted by the State to the Secretary of Health and Human Services in 2007 increased by two factors: national health care cost increases and State population growth. Annual State allotments will grow by these two factors each year.

States will have two years to spend each year’s annual allotment. In addition, every two years, State allotments will be recalibrated to ensure funding meets children's needs.

States that experience a shortfall due to enrollment of children who are today eligible but not enrolled will receive an enrollment adjustment equal to the Federal share of the State’s average per capita cost per child.

Best Practices Performance Bonus. States that implement four out of six outreach and enrollment “best practices” and enroll new children who are currently eligible for coverage but not enrolled, will receive a “performance bonus.” Best practices include:

- Full year enrollment
- Presumptive eligibility
- Administrative renewal
- State flexibility in asset determinations
- Elimination of in-person interviews
- Joint SCHIP/Medicaid application

Protecting CHIP for Children. The CHIP statute only provides for coverage of “targeted low-income children.” The bill maintains current law regarding eligibility for CHIP, with one exception that States would have the option to cover pregnant women.

Child-Centered Benefits. Benefits for children include:

- Children are assured coverage of dental care under CHIP.
- Mental health care is treated equally with physical health care under benchmark benefits packages.
- States can provide such coverage through multiple delivery arrangements including a health maintenance organization, preferred provider organization (PPO), or other arrangement.
- The Secretary’s authority to approve “alternate” benefits packages is limited by requiring that any alternate benefit design meet or exceed existing benchmark coverage.

Quality Measures and New Commission. The Department of Health and Human Services (HHS) is required to establish a pediatric health quality program working with pediatric providers, children’s advocates, and other experts on children’s health care to develop child-centered quality and program performance measures.

A new independent commission, the Children’s Access, Payment and Equality Commission (CAPE), modeled after the Medicare Payment Advisory Commission, is established to monitor children’s access to care and services, and adequacy of provider payment under both CHIP and Medicaid. The Commission will also examine issues of health disparities and underserved areas.

Protections for Safety Net Providers. Federally qualified health centers and rural health centers services are guaran-
teed for children in CHIP and the current payment system in Medicaid is applied.

**New State Flexibility for Coverage of Children and Pregnant Women.** States are allowed to cover pregnant women and older children, as well as legal immigrant children and legal immigrant pregnant women, who otherwise meet the requirements for coverage under CHIP. States are given a new option to cover family planning services without a waiver.

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### Medicare Beneficiary Improvements

Invests in improvements for Medicare beneficiaries that include:

**Add New Preventive Benefits.** Provides Medicare with the authority to use the recommendations of the U.S. Preventive Health Services Task Force to add new preventive health benefits without congressional approval.

**Eliminates Cost-Sharing for Preventive Benefits.** Eliminates co-insurance and waives deductible for current preventive benefits and preventive benefits added in the future through the process outlined above.

**Improves Mental Health Benefits.** Reduces Medicare’s discriminatory 50 percent copayment on mental health outpatient services to the standard 20 percent copayment over a period of six years and adds additional mental health providers to Medicare so that services are more widely available.

**Offers Low-Income Protections.** Expands and improves the Low Income Subsidy (LIS) program for drugs and the Medicare Savings Programs (MSP), which help ensure affordable health care for seniors and people with disabilities with lower incomes.

**Expands Income Eligibility.** Improves the Medicare Savings Programs by making the Q1 program, which pays premiums for low-income seniors, permanent and increasing eligibility to 150 percent of poverty.

**Improves Assets Tests.** Increases the allowable resource amounts under both the MSP and LIS assets tests to $17,000 and increases them annually thereafter.

**Promotes Education and Outreach.** Enhances outreach and education for the LIS and MSP, including simplified applications and using the Social Security Offices to educate beneficiaries about the Medicare Savings Programs, and requires translation of model MSP form in 10 languages.

**Protects Consumers.** Eliminates the Part D late enrollment penalty for LIS-eligible individuals and guarantees continuous open enrollment for LIS eligible individuals.

- Allows beneficiaries to change drug plans if their drug plan formulary changes during the year. Codifies the requirement that Part D plans cover all or substantially all drugs in six important therapeutic classes of drugs. Eliminates the prohibition on coverage of benzodiazepines.

**Reduces Health Disparities.** Requires the Centers for Medicare and Medicaid Services (CMS) to collect data necessary to better track and address racial and ethnic disparities in Medicare. Creates two new demonstrations to 1) test methods for Medicare reimbursement for limited English proficiency services and 2) provide additional outreach and support for Medicare beneficiaries who were previously uninsured.

- Directs the HHS Inspector General to issue a report on Medicare provider and plan compliance with Culturally and Linguistically Appropriate Services standards.

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### Medicare Physician Payment Reform

Stabilizes physician reimbursement by eliminating the impending 2008 and 2009 fee cuts (projected to be -10 percent and -5 percent, respectively) and putting in place a positive 0.5 percent update in both 2008 and 2009.

- Establishes parameters for fixing the physician reimbursement system by making changes to the existing system, such as removing several broken components of the Sustainable Growth Rate and investing new resources into primary care and preventive services. Further, the bill establishes mechanisms to provide feedback to physicians on how their practice patterns compare with their peers’ and gives CMS additional tools to ensure that Medicare’s prices are accurate.

- The bill also initiates a nationwide demonstration project to test the practice of providing a medical home for patients in which their personal physician is paid to coordinate their care. Combined, these policies lay the foundation for a future reimbursement system that promotes quality of care and maximizes efficiency.

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### Medicare Advantage Reform

**Equitable Payment Transition.** Phases out Medical Advantage (MA) overpayments over four years to 100 percent of fee-for-service (FFS) in 2011. Phase-out is based on a blend
of the current county benchmarks adjusted for the applicable year and 100 percent of county FFS costs in the projected year.

There is no change in 2008; in 2009 the benchmarks will be a blend of two-thirds of current benchmark and one-third of 100 percent of FFS for the county; in 2010 the blend moves to one-third of current benchmark and two-thirds of FFS; and starting in 2011 benchmarks will be 100 percent of FFS.

**Enrollment Limitations.** Plans that fail to bid below the phased-down benchmarks in their counties during the transition to equitable payment will be prohibited from enrolling new members in that year.

**Repeal of MA Stabilization Fund.** Completes the full repeal of the regional PPO stabilization fund created in the Medicare Modernization Act to provide incentive payments to certain types of private plans.

**Beneficiary Protections.** Develops a Federal/State system to regulate private plan marketing and other activities, improve beneficiary protections, and provide more information about plan spending on health care services. Prohibits private plans from charging higher cost-sharing than FFS Medicare. Requires plans to meet minimum requirements regarding level of spending on medical benefits (versus administrative costs, overhead, or profit).

**Quality Improvements.** Requires all private plans to report quality data to CMS in order to measure quality of care. Develops new data to assess disparities in health care for racial and ethnic minorities. Reinstates annual report on plan efforts to reduce disparities.

**Extension of Authority for Special Needs Plans (SNPs).** Extends Dual Medicare-Medicaid SNPs and Institutional SNPs for three years with new requirements to ensure that they are enrolling their target populations.

**Rural Health Improvements.** Preserves payment equity for rural Medicare FFS providers. The bill extends otherwise expiring provisions in law that, if left unchanged, would negatively affect rural beneficiaries’ access to physicians, hospitals, home health, ambulance services, and lab services.

### Medicare Part A

Taking into account recommendations from the nonpartisan Medicare Payment Advisory Commission, the bill re-fines payments for a variety of institutional providers including skilled nursing facilities, rehabilitation facilities, long-term care hospitals, cancer hospitals, and rural and small urban hospitals.

### Medicare Part B

Updates Medicare coverage policy for a range of providers. Improvements include:

- Continuing the therapy cap exceptions process and planning for an improved payment system
- Improving coverage for speech language pathologists, nurse midwives, marriage and family therapists, and mental health counselors
- Assuring access to clinical social workers for beneficiaries in nursing homes
- Ends the ability of physicians to refer to hospitals in which they have ownership
- Reduces rental period for oxygen equipment, and eliminates first month purchase of wheelchairs
- Provides patient-education services for pre-dialysis beneficiaries, puts quality programs in place, and modernizes the end-stage renal dialysis payment system

### Other Medicare Provisions

Establishes a comparative effectiveness program to provide the information doctors and patients need to choose the best treatments, leading to better health outcomes and value nationwide. Requires the Medicare agency to design a program to require adoption of an interoperable open-source health information technology system for all Medicare providers. Ends a provision from the Medicare Modernization Act designed to arbitrarily limit Medicare’s funding.

### Medicaid

**Protections for Children With Disabilities.** Maintains access to school-based services and rehabilitation services for children with severe disabilities.

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The following summarizes the major provisions of S. 1893, the Children’s Health Insurance Program (CHIP) Reauthorization Act, which passed the full Senate on August 2, 2007.

Overview. The Children’s Health Insurance Program (CHIP) Reauthorization Act reauthorizes the popular State Children’s Health Insurance Program (SCHIP), investing an additional $35 billion over five years to strengthen SCHIP’s financing, to increase outreach and enrollment for low-income children of the working poor, to enhance premium assistance options for low-income families, and to improve the quality of health care that children receive from public programs like Medicaid and CHIP. The Act accomplishes the following priorities:

Lowering the Rate of Uninsured Low-Income Children. The CHIP Reauthorization Act provides for coverage for 6.6 million children currently enrolled in the program. Under the Children’s Health Insurance Reauthorization Act, 3.2 million children who are uninsured today will gain new coverage. Over the next five years, this bill will reduce the number of uninsured children in America by more than one third.

Strengthening SCHIP by Increasing and Targeting Funding. In recent years, many States have faced funding shortfalls, jeopardizing the stability of the program. The Congressional Budget Office predicts that 800,000 children currently covered by the program will become uninsured over the next five years without additional funds above baseline.

The CHIP Reauthorization Act improves the financing rules to ensure resources are better directed to cover eligible children by basing State funding on State spending projections. States will also have access to a contingency fund to cover unforeseen shortfalls arising from economic downturns or emergencies.

Providing States with Incentives to Lower the Rate of Uninsured Low-Income Children. Today, 6 of the 9 million American children who are uninsured are eligible for either Medicaid or SCHIP, but not enrolled. The Children’s Health Insurance Program Reauthorization Act provides incentives for States to lower the rate of uninsured children by enrolling eligible children in SCHIP and Medicaid.

Improving State Tools for Outreach and Enrollment. The bill would provide $100 million in new grants to fund outreach and enrollment efforts that increase participation of eligible children in both Medicaid and SCHIP. Outreach will range from national efforts to raise awareness of SCHIP, to efforts targeting children in rural areas with high populations of eligible but unenrolled children and higher incidence of racial and ethnic disparities of coverage, to targeted efforts to find and enroll eligible Native American children.

The bill also creates a $49 million demonstration allowing up to 10 States to implement “express lane” enrollment for low-income children already eligible for benefits.

Improving the Quality of Health Care for Low-Income Children. The CHIP Reauthorization Act establishes a new framework for improving the quality of health care for children, creating a quality initiative within the Department of Health and Human Services charged with developing and implementing quality measures and improving state reporting of quality data.

Reducing Racial and Ethnic Disparities in Coverage and Quality. The CHIP Reauthorization Act includes initiatives that will reduce racial and ethnic health care disparities, by improving outreach to minority populations including Native Americans and providing new funding for State translation and interpretation services.

Prioritizing Children’s Coverage. In the past decade, SCHIP has been expanded to include some childless adults, parents, and pregnant women. The bill eliminates childless adult coverage within two years, eliminates future state waivers for parents, and lowers the Federal re-
imbursement for existing parent populations. This will encourage States to direct limited SCHIP resources to targeted low-income children. States have an additional option to cover pregnant women as a State option as well as maintaining the options to cover them through a state waiver or through regulation.

**Improving Access to Critical Benefits.** The Children’s Health Insurance Program Reauthorization Act improves access to mental health services by requiring States that offer mental health services to provide coverage for those services on par with medical and surgical benefits covered under SCHIP.

The bill also provides $200 million in new grants for states to improve accessibility and strengthen dental coverage for children.

**Reducing Administrative Barriers.** This bill creates a new option for states to choose in implementing citizenship documentation requirements and extends to CHIP the requirement to establish citizenship. The bill also encourages states to standardize enrollment procedures, and to eliminate requirements for face-to-face interviews to complete enrollment in public health programs by requiring states to detail efforts to lower administrative barriers to enrollment.

**Improving Access to Private Coverage Options through New Premium Assistance Rules.** The bill expands on current premium assistance options for States. The bill allows States to offer a premium assistance subsidy for qualified, cost-effective employer-sponsored coverage to all targeted low-income children who are eligible for child health assistance and who have access to such coverage, and also changes the Federal rules governing employer-sponsored insurance to make it easier for States to offer premium assistance programs.

**Maintaining State Flexibility.** The bill also retains State flexibility to set eligibility levels based on the cost of living in each State, but it responds to concerns about eligibility being too close to middle-class levels by lowering Federal matching rates for children covered above 300 percent of the Federal poverty level.

**Financing.** Consistent with the 1997 law that created SCHIP, the Children’s Health Insurance Program Reauthorization Act is paid for with new revenue from a $.61 per-pack increase in the excise tax on cigarettes and a corresponding proportional increase on all tobacco products.

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**Bush Administration Statement on S. 1893**

The Administration strongly supports reauthorization of the State Children’s Health Insurance Program (SCHIP). In fact, the President would sign reasonable legislation to reauthorize SCHIP today. The President’s budget includes a proposed $5 billion expansion, a 20 percent increase in funding. However, the President has several concerns about S. 1893 and the Senate approach to SCHIP Reauthorization. If S. 1893 were presented to the President in its current form, he would veto the bill.

S. 1893 expands the SCHIP program and changes the focus from those who cannot afford coverage to include families with incomes of up to $83,000 per year or even more. This bill essentially extends a welfare benefit to middle-class households. The funding levels provided in the first five years under S. 1893 are far more than necessary to accomplish the goal of covering low-income children.

At the same time, S. 1893 sets SCHIP on an unsustainable course by expanding and then drastically underfunding the program in the future by at least $60 billion. The legislation balloons the allotments to $16 billion in 2012 and then reduces the allotments to $3.5 billion in 2013. Such a dramatic decline in allotments is highly unlikely and nothing more than an irresponsible budgetary gimmick. In the period 2013-2017, according to the Congressional Budget Office, SCHIP funding and enrollment under the bill would be lower than under current law, which could cause millions of children to lose coverage over the long term.

The bill discourages States from efficiently managing their allotments by increasing SCHIP allotments at a growth rate well above their projected spending and by creating new funding sources in addition to State allotments. The legislation would create two new funds that appear to encourage States to overspend their budgets. The legislation purposefully sets excessive and unnecessary allotment levels that are designed to spill over into the new “Incentive Fund.”

The bill is inconsistent with the principle of choice for American consumers and instead goes too far in federalizing health care. A competitive private market for health insurance is better policy than a government-run system that would mean lower quality, longer lines, and fewer options for patients and their doctors.
The State Children’s Health Insurance Program (SCHIP) — created as Title XXI of the Social Security Act by the Balanced Budget Act of 1997 — is set to expire at the end of Fiscal Year 2007 (September 30). While reauthorization of SCHIP previously has been a chance to review and refine the program, this year, rising rates of uninsured children, combined with new budget constraints, has made a normally bipartisan issue one of the most controversial on the congressional agenda.

**House Action**

On July 27, 2007, the House Ways and Means Committee approved H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act — to reauthorize and expand SCHIP — by a 24-to-17 party-line vote. The Energy and Commerce Committee, which shares jurisdiction over the program, was deadlock on the bill and unable to report it to the full House.

On August 1, the House passed H.R. 3162, which increases spending on SCHIP by $47.4 billion over five years, by a vote of 225 to 204. The Congressional Budget Office estimated that the additional spending would add 7.5 million uninsured children to the current 6 million covered by the program.

To save money, the House bill would change the current formula for determining Medicare payments to physicians. It would also cut spending for Medicare Advantage, which allows beneficiaries to collect Medicare benefits through private health plans. One especially contentious provision would increase cigarette taxes by 45 cents per pack.

**Senate Action**

The Senate followed suit on August 2, passing a narrower, $35 billion expansion of the program by a vote of 68 to 31. The Senate Finance Committee had approved the bill, 17 to 4, on July 9. The Senate plan potentially would cover an additional 6.1 million children. It relies on a 61-cents-per-pack cigarette tax increase to offset costs, but would make no changes in the Medicare program.

**Outlook**

President Bush has threatened to veto the reauthorization bill on the basis that it would lead to a “massive expansion of the Federal role” in health care. On July 30, the White House released a statement on the Senate bill that said:

The bill is inconsistent with the principle of choice for American consumers and instead goes too far in federalizing health care. A competitive private market for health insurance is better policy than a government-run system that would mean lower quality, longer lines, and fewer options for patients and their doctors.

Conferees meeting to resolve differences in the House and Senate versions will have to find common ground on revenue and other issues to try to fashion a bill that is either veto-proof or is more acceptable to the Administration.
I rise in support of this great piece of legislation that this august body has the privilege of supporting.

Let me extend an olive leaf to my friends on the Republican side, because it just wouldn't be fair for you to be going home thinking that people will be talking about politics and process when the bottom line is: Where were you when this government, as big as it is, wanted to protect 11 million kids in health insurance? That's going to really be the bottom line.

And if you think that government is really so big that $50 billion is just too much money to invest in these little kids, then kind of think about what you're willing to invest in Afghanistan, in Baghdad, in improving its schools and its hospitals.

And think of what we get back. Just think of what we get back in preventing these kids from getting diseases and illnesses that would not only cost us billions of dollars in health care, but the lost competition, the inability to learn and to be productive. What a heck of an investment this is, even for our United States Government, to be concerned with 11 million Americans becoming healthy, better educated, and competitive.

This is not a question of Democrats being so dumb, so stupid, so apolitical that we want to hurt our own folks. Unlike children, they vote. And every organization that has dedicated themselves to older Americans for health services has endorsed this: the hospitals, the doctors, the nurses, the Catholics, the Protestants, the Jews, the gentiles. People who are concerned about human lives are concerned that we do these things.

What do you think we are? We were born yesterday? No. I don't know what the President [George W. Bush] intends to do, but you don't have to hurt this President anymore. You don't have to do this to yourselves.

Just think about your explanations: The bill wasn't ready; it didn't come out of committee. I don't know. How are you going to pay for it in 2012? Or maybe some of you youngsters have to think about it. But just think about how many people are going to get health care between now and 2012 before we look at the President's tax cuts. Somehow they kind of broke it off at 2010. So it's not the first time people had these creative ideas.

But let me suggest this to you: This bill expires on September 30. Now, I don't know whether they have town hall meetings on the other side or not, but I would hate to be at...
Representative Boehner, of the Eighth District of Ohio, was first elected to the U.S. House of Representatives in 1990. He was on the Union Township (Ohio) Board of Trustees from 1981 to 1985, where he served as President of that Board in 1984, and was a member of the Ohio House of Representatives from 1984 to 1990. He is the House Minority Leader. The following is from the August 1, 2007, House floor debate on H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act.

The State Children’s Health Insurance Program (SCHIP) was created 10 years ago by a Republican Congress, along with our Democrat colleagues and a Democrat President. It clearly was a very bipartisan process from the beginning, and as we reauthorize this important program that Republicans, Democrats, the White House, everyone supports, I am saddened that we are here today with a very partisan bill done in a very partisan way.

I know on our side, [Rep. Joe] Barton [TX-R], [Rep. Jim] McCrery [LA-R], and their respective committees wanted to work with our Democrat colleagues to develop a bill that we could all vote for. But that process never even got started. While there may have been some hearings in the Ways and Means Committee on this bill, there were no hearings in the Energy and Commerce Committee. We were presented with a 488-page bill the night before the markup. Now we have brought this to the floor without a markup in committee, no amendments allowed to be offered by the minority, and a limited time for debate.

The result of this flawed process is a bill that expands government-run health care beyond anything that any one of us could have imagined over the last 10 years.

Last November, the American people sent us a message here in Congress, but I don’t think that message was “I want you to cut my Medicare and I want you to raise taxes.

When you look at the bill that we have before us, we have $193 billion worth of cuts to Medicare, a program to provide health insurance for our seniors. We are going to cut this $193 billion over 10 years, and we are going to raise tobacco taxes, which affects the poorest of America’s citizens, and lay more of this tax burden on their backs.

In my district alone, some 14,267 seniors are going to have their Medicare costs increased, and about 73 percent of that number are likely to lose their Medicare Advantage Program altogether. That is not what the voters sent us here to do; and, believe me, the seniors in my district who take advantage of this very valuable program don’t want to lose their benefits which will result from the passage of this bill.

And so I say to my colleagues, we have a flawed bill on the floor today; and the flawed bill is the result of a flawed process. As I said last night to all of my colleagues, we represent nearly half of the American people. We have a right to be heard. We have a right to participate. And through the process over the last couple of weeks we have been denied the right to be involved in the process, denied the right today to be involved in trying to amend the

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one of them when they explain why there is not going to be insurance for these six million, and additional five. I’d hate for them to say how they were reading the bill because they didn’t participate.

There are things that we can improve upon. And [Rep. Jim] McCrery [LA-R] and I work every day to see whether we can do a better job on communication. But don’t you let our lack of communication interfere with having coverage for 11 million kids who deserve better than what we’ve given them in terms of the debates and the discussion on this historical piece of legislation.

So we have the opportunity to join with hundreds of Americans that are concerned about our young people, our old people, a better America. Our educators, our teachers want to do this. I cannot think of anything that’s more important for our national security and our national defense than investing in these young people who carry the torch of freedom for the generations that follow us.

But if you don’t do this, if they find themselves without health care, if their parents cannot be productive on the job because they’re worried about their kids and not being able to get to a clinic, if they can’t enjoy the preventive care that you enjoy and I enjoy and our children and grandchildren enjoy, you explain it, that we weren’t talking to each other, we didn’t cooperate, and the program just expired.

No. I don’t want you to go that way. I don’t even think the President wants to go that way. I want you to think about the bottom line: 11 million kids, an improved Medicare system, $15 billion helping older Americans that don’t have the funds to get insurance, $5 billion for those in the rural areas that don’t have access to health care. This is what we’re doing.

You may not have liked the roadmap, but you can’t walk away from what we’ve done. You can never say anything that’s wrong about helping children. So let us try to think about how we end this up, because come this November people will be asking the questions.

I don’t think it’s going to be on process. I don’t think it’s going to be how long you kept us up at night. I don’t think it’s going to be how many parliamentary maneuvers we had. I don’t think it’s whether we missed our Easter recess. Did you let this program expire and were you there when the children called on you?

I hope we can count on your vote.

Honorable John Dingell
United States Representative, Michigan, Democrat

Representative Dingell, of the Fifteenth District of Michigan, was first elected to the U.S. House of Representatives in 1955. He served as Wayne County (Michigan) Assistant Prosecuting Attorney from 1953 to 1955. He chairs the Energy and Commerce Committee. The following is from the August 1, 2007, House floor debate on H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act.

The legislation before us is really very simple. The issues before us are not procedure. Rather they are: Are we going to take care of our kids?

For this Congress, this is perhaps the greatest opportunity we will have. We have three responsibilities to the country and to our kids: See that they are properly nourished, see

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Boehner,

Later today, Republicans will offer a motion to recommit this bill, the only option that we have. And that motion to recommit will do this: It will reauthorize the SCHIP program for one year. There will be no Medicare cuts involved in this program, no benefits will go to illegal immigrants, and we will see to that in the motion to recommit.

Fourth, it will have a sense of the Congress that this bill should go back to the committee and, over the course of the next year, have the Republicans and Democrats on the respective committees work together to produce a bipartisan product that the President [George W. Bush] can sign into law. I think that is a responsible course of action.

Honorable Joe Barton
United States Representative, Texas, Republican

Representative Barton, of the Sixth District of Texas, was first elected to the U.S. House of Representatives in 1984. He was a White House Fellow in the U.S. Department of Energy from 1981 to 1982 and a consultant with Atlantic Richfield Company from 1982 to 1984. He is the Ranking Minority Member on the House Energy and Commerce Committee. The following is from the August 1, 2007, House floor debate on H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act.

Today the Democratic majority will make claims that they support reauthorizing the SCHIP program and, by implication, that Republicans do not. I, for one, fully support reauthorizing the State Children’s Health Insurance Program. I also believe we should ensure that the program is covering the population it was intended to serve, and that’s low-income children who don’t have health insurance. It isn’t for adults or for bureaucrats who think adults should pretend to be children. It isn’t for men and women making $100,000 salaries. And it shouldn’t be an incentive to pull families out of private health insurance coverage and into a public welfare program.

States have used the gaping loopholes in the current SCHIP program to expand coverage to include adults and people with the kinds of salaries that are still a dream to most working people. Our friends on the majority think those are blessings, not problems, and that explains why they’ve written legislation that makes the list of blessings longer instead of shorter.

Their bill is the first giant leap towards government-run, universal health care since “Hillarycare” [the Clinton Administration’s failed health insurance reform proposal] collapsed under the weight of its own bureaucracy and deception. More bureaucracy? They’re for it. More welfare? They’re for it. Rationing health care? They’re for it. A blank check? They’re for it. In reality, the check isn’t exactly blank. The CBO [Congressional Budget Office] indicates that the cost of this Democratic welfare bill will top $200 billion, and that’s only for Federal taxpayers. The States’ share of SCHIP will cost the State taxpayers another $300 billion.

The majority would spend hundreds of billions of dollars saying that they are trying to cover low-income children who don’t have insurance. That’s not what CBO says. Accord-

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that they are properly educated, and see to it that they have the health care that they need so that they can be meaningful contributors to the future of this county.

The Children's Health and Medicare Protection Act, the CHAMP Act, is a good piece of legislation. It expands and improves a most successful program, bipartisan in character, created in 1997. That program has cut the rate of uninsured children by a full third. Some States have been able to ensure as many as 60 percent of the children who previously had no health insurance.

This bill is about taking care of our kids. It is about taking care of the future of the country. The legislation before us accomplishes two critical goals. It will provide health care to as many as 12 million children. And it will allow our elderly to continue seeing their own doctors.

Today, six million children get their health care through this program. With this legislation, five million previously uninsured children will be able to see doctors, receive immunizations, get dental care and other coverage.

This legislation requires that children receive priority in coverage. It allows States to cover pregnant women, recognizing that healthy moms make for healthy babies.

While I am certain that my Republican colleagues on the Committee on Energy and Commerce understand this point — because our wonderful clerk read the bill to them — I will restate it for others listening:

The CHAMP Act does not allow one Federal dime to be spent on illegal aliens. You will find this prohibition in Section 135 of the bill.

Nor does the bill create a “government-run” health care system. Coverage under the Children's Health Insurance Program and Medicaid are provided primarily through private insurance — all but two States use some form of managed care for their programs. Nothing here would change that. And the newly covered children are exactly the same as those now covered.

The CHAMP Act also secures Medicare for the future. This past Monday marked the 42nd anniversary of President [Lyndon] Johnson signing Medicare into law. The CHAMP Act shores up the Medicare Trust Fund, improves benefits for seniors, and protects their ability to choose their own doctors.

These reforms will effectively provide low-income seniors on Medicare with an additional $1,200 in their pockets.

The CHAMP Act is an act of fiscal responsibility. This year, seniors in traditional Medicare will pay nearly three-quarters of a billion dollars in excess premiums to finance overpayments to HMOs [health maintenance organizations]. Those overpayments will accelerate the insolvency of the Medicare Trust Fund. The CHAMP Act adds three years to the life of the Trust Fund.

I am well aware that President Bush has pledged to veto counterpart legislation in the Senate that is much more modest in its ambitions, and I have received my own veto letter from the Secretary of the Department of Health and Human Services. They stand on one side of the debate.


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ing to the Congressional Budget Office, of the newly eligible individuals, 60 percent already had private health insurance coverage.

Democrats say they are not raising the eligibility levels for SCHIP in this bill. They fail to mention that they allow States to determine income and they also do away with the block-grant nature of the program by providing States with swollen Federal matching funds, even for families making above $200,000 a year.

Further evidence that this bill is not about low-income children is that their bill actually allows for bonus payments to States if they eliminate asset tests. It looks like they do want welfare for the rich — and the richer, the better. I ask, should a millionaire’s child be on SCHIP or Medicaid? I don’t think the American people believe so, but the majority’s bill encourages it.

Yesterday on the floor, some Members spoke about how this bill would pay for services for illegal immigrants. With no true way to refute that assertion, the majority, in the managers’ amendment that was released after midnight this morning, added a new section that states that no Federal funding can go towards paying for care for illegal immigrants. That was a nice restatement of current law, but it does not change the fact that this bill eliminates the requirement that States verify a person’s citizenship before they are enrolled. If we don’t verify citizenship, this new section is meaningless. The bill even eliminates the five-year period that legal immigrants must wait before being enrolled in Medicaid, effectively inviting more illegal immigration.

During the morning session, Member after Member of the majority rose to say that this bill is about children. I ask my colleagues to show me where this bill limits this “children’s health program” to children. They can’t, because the bill will continue the discredited practice of siphoning off money from children’s health care to buy health care for adults.

The majority also says this isn’t kids versus senior citizens, but Democrats pay for their enormous expansion by cutting $200 billion from Medicare. The Democratic bill makes a particular target of the senior citizens who picked Medicare Advantage and takes over $150 billion away from them. That means more than 8 million of our seniors will have their choice in health care coverage sharply restricted. This bill disproportionately harms rural and low-income Medicare beneficiaries in particular since it cuts payments in these areas so drastically that plans will be driven out of these markets.

The draconian cuts that the Democrats expect the Medicare Advantage program to take will obliterate the benefit.

These plans are an important option for low-income and minority beneficiaries — 57 percent of enrolled beneficiaries have incomes less than $30,000. These plans can reduce cost-sharing relative to traditional Medicare. These plans also offer better access to care — more than 80 percent of plans provide coverage for hospital stays beyond the traditional Medicare benefit, and more than 75 percent cover routine eye and hearing tests. Over 98 percent of beneficiaries can enroll in a plan offering preventive dental benefits.

These are our most vulnerable seniors. Yet, the Democrats would cut their benefits to pay for the higher-income children and adults. They made this decision with no legislative hearings and developing the bill behind closed doors. My friends in the majority claim that they have had seven hearings on this. I would like to set the record straight that the Energy and Commerce Committee held one hearing on SCHIP back in February to discuss the general program and did not discuss anything that is incorporated in this bill. They did not even invite the people who administer SCHIP at the Department of Health and Human Services to testify.

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“A vote against this bill is a vote to deprive 6 million children of health care.”

Dingell,
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pro-life thing the Congress can do right now is ensure that the State Children’s Health Insurance Program is reauthorized.”

A vote against this bill is a vote to deprive 6 million children of health care. A vote against this bill is a vote to continue the plunder of the Medicare Trust Fund by bloated private interests. A vote against this bill is a vote to deny seniors in Medicare additional benefits.

We have had a good debate. I believe the Members have become understanding of not only the situation but of the legislation before us.

The legislation before us is really very simple. The issues before us are not procedure. Rather, they are: Are we going to take care of our kids?

For this Congress, this is perhaps the greatest opportunity we will have. We have three responsibilities to the country and to our kids: See that they are properly nourished, see that they are properly educated, and see to it that they have the health that they need so they can be meaningful contributors to the future of this country.

It is not only a humanitarian and compassionate concern of this country, it is the future of the country.

I know the President has indicated that he thinks that this is bad legislation. I grieve that he has come to that conclusion. He has no reason to do so.

First of all, we have the pay-fors. We have taken care of the cost of this. We are seeing to it that, first of all, a modest tax on tobacco comes into play.

Second, we are seeing to it that HMOs that are getting as much as 30 percent more than other HMOs are going to get 100 percent of what other HMOs get, no more, no less.

We are not taking anything away from senior citizens. I think we are just taking it out of the pocket of a few people who have too much in the HMO business.

I would point out that there are a number of misunderstandings that have been stated here. It has been said this is going to raise costs and it is going to raise the amount that is paid to individual recipients. Not so. This is a program which is going to be governed by the costs which were fixed when the legislation was first offered and first introduced and first put into law under the leadership of, for example, [former Speaker of the House] Newt Gingrich [GA-R] and [former House Majority Leader] Dick Armey [TX-R]. So it is not fiscally irresponsible.

The legislation is going to do something else. It is not going to take care of illegals, nor is it going to engage in any weird practices. If there are waivers given, and they can be given, they will be given in the same fashion as they were given before, and that is by this Administration saying this is something that is justified, justifiable, and proper and which will help kids. I will note that they have not been overly generous in giving those particular waivers.

So what we have a chance to do today, my friends and colleagues, is to take care of the kids, to support those who are least able to look to their own well-being and who are most defenseless, and to suit them best for a healthy, growing adult life so they may contribute to a better, richer, stronger, and safer America.

We are doing something else. We are seeing to it that we are compassionate, and we may best be judged by that because, in doing that, we are best looked as by being those who really care for those who have the least.

I urge my colleagues to vote for the CHAMP legislation. It is good. It is in the public interest.

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Where have the Democrats been? They claim that this is of the highest priority, yet they sat on it until they could create an artificial crisis and then blame Republicans for daring to read their bill. I question why they would treat the reauthorization of SCHIP as a last-minute concern.

I urge Members to vote against this bad bill so we can reauthorize this program in the responsible, transparent, and open way that the powerful Democrat leadership promised to conduct the business of the Nation.

Honorable Jim McCrery
United States Representative, Louisiana, Republican

Representative McCrery, of the Fourth District of Louisiana, was first elected to the U.S. House of Representatives in 1988. He served as Assistant Shreveport City Attorney from 1979 to 1980, and as Legislative Director to then-U.S. Representative Buddy Roemer (LA-R) from 1981 to 1984. He is the Ranking Minority Member on the Ways and Means Committee. The following is from the August 1, 2007, House floor debate on H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act.

As my colleague, the ranking member of the Energy and Commerce Committee [Rep. Barton], said earlier this afternoon, we in the minority want to reauthorize the Children’s Health Insurance Program. Our motion to recommit, which we will offer later today, will do that.

SCHIP should be about a bipartisan program. We think it should focus on low-income children. That was the concept when both parties agreed to create this program back in 1997. But the bill that is on the floor today loses sight of that focus, and, therefore, we cannot support it.

The bill that is before us today, without amendment, raises taxes by at least $54 billion. We believe it raises those taxes to fund a massive expansion of government-controlled health care. This is not just about helping low-income children. This bill today seems to be spending government funds to help lower middle-class, upper middle-class, even wealthy, perhaps, families to opt out of private health coverage and go to government health coverage.

With this bill before us today, in addition to having a substantial increase on the tobacco tax, they try to hide — at least it appeared that the majority tried to hide — a secret tax increase on health insurance plans.

When it came before the Ways and Means Committee, we did have a markup. We did have the opportunity to explore this bill, at least the part that was in the jurisdiction of the Ways and Means Committee. We discovered this tax increase. We discovered it in the fine print. It is a tax on health insurance policies.

Well, what is that going to do? It is going to raise the cost of private health insurance. Maybe that is what the majority wants, to raise the cost of private health insurance, to drive even more people from private insurance into government health care.

This new tax is going to generate money sufficient to accumulate to about a $3 billion pot of money over the next 10 years. That is a substantial sum of money. And, as we have
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Sheila Jackson Lee
United States Representative, Texas, Democrat

Representative Jackson Lee, of the Eighteenth District of Texas, was first elected to the U.S. House of Representatives in 1994. She served on the Houston City Council from 1990 to 1994. She sits on the Foreign Affairs Committee, the Judiciary Committee, and the Homeland Security Committee, where she chairs the Subcommittee on Transportation Security and Infrastructure Protection. She also cochairs the Congressional Children’s Caucus. The following is from the August 1, 2007, House floor debate on H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act.

I rise today in strong support of the Children’s Health and Medicare Protection Act of 2007. This important legislation commits $50 billion to reauthorize and improve the State Children’s Health Insurance Program, SCHIP, and it also makes critical investments in Medicare to protect the health care available to our Nation’s senior citizens. I strongly urge my colleagues to join me in supporting this excellent bill.

SCHIP was created in 1997, with broad bipartisan support, to address the critical issue of the large numbers of children in our country without access to health care. It serves the children of working families who earn too much money to qualify for Medicaid, but who either are not able to afford health insurance or whose parents hold jobs without health care benefits.

Children without health insurance often forgo crucial preventative treatment. They cannot go to the doctor for annual checkups or to receive treatment for relatively minor illnesses, allowing easily treatable ailments to become serious medical emergencies. They must instead rely on costly emergency care. This has serious health implications for these children, and it creates additional financial burdens on their families, communities, and the entire Nation.

This year alone, 6 million children are receiving health care as a result of SCHIP. However, funding for this visionary program expires September 30. Congress must act now to ensure that these millions of children can continue to receive quality, affordable health insurance. President Bush has employed rhetoric in support of this program while on the campaign trail, stating in 2004, “In a new term, we will lead an aggressive effort to enroll millions of poor children who are eligible but not signed up for government health insurance programs.” Unfortunately, however, in practice, both the Administration and my colleagues on the other side of the aisle in Congress have proposed significant cuts in the program. If these are approved, millions of children will lose health coverage.

As chair of the Congressional Children’s Caucus, I can think of few goals more important than ensuring that our children have access to health coverage. It costs us less than $3.50 a day to cover a child through SCHIP. For this small sum, we can ensure that a child from a working family can receive crucial preventative care, allowing them to be more successful in school and in life. Without this program, millions of children will lose health coverage, further straining our already tenuous health care safety net.

Additionally, through this legislation, we have an opportunity to make health care even more available to America’s children. The majority of uninsured children are currently eligible for coverage, either through SCHIP or through Medicaid. We must demonstrate our commitment to identifying and enrolling these children, through both increased funding Continued on page 246
seen from past experience, a tax like this, while it may not be big at first, it is awfully hard to get rid of, and it is awfully easy to increase.

This legislation also cuts Medicare funding by about $200 billion. It effectively eliminates the Medicare Advantage program. Now, I know the majority is going to say no, no, no, it doesn’t cut Medicare by $20 billion. We add back some Medicare benefits, so the net is not nearly that much.

But for the people whose programs are going to be cut, they see it as a cut. They don’t understand this “net” thing. Medicare Advantage is going to be cut substantially, and Medicare Advantage programs will go away in most rural parts of this country and in a great many inner-city areas serving low-income populations. This bill would effectively eliminate options for millions of seniors who have depended on Medicare Advantage to get better benefits and lower costs for their health care.

In addition, the bill cuts $7.2 billion in home health care benefits and $6.5 billion in nursing home care benefits. These are cuts that are real. They are going to be felt by people utilizing those services.

These cuts are not necessary. I want to stress, these cuts are not necessary to cover needy children. The majority has deliberately chosen to reduce Medicare funding for some of our neediest seniors in order to expand SCHIP to cover anyone up to the age of 21 — including, I have heard here today, people up to 300 percent of poverty, 400 percent of poverty.

I would tell my colleagues that have said that, they are wrong. This bill doesn’t say you can go up to 300 percent or 400 percent of poverty. It says you can go anywhere you want to. You can cover anybody. If a State chooses under this bill, they can not only choose to cover people of unlimited income, $100,000, $150,000, $200,000. They are entitled to the money.

There is also a bonus program in this bill that says if you get a new enrollee, a new child, maybe he comes from having private insurance, maybe he doesn’t, but if he is new to this program, you are going to get a bonus, which means you are going to get an even higher Federal share to fund that new enrollee.

The State can waive the income eligibility as high as they want. So we create a new entitlement program that guarantees States they can get as much money as they want to cover anybody they want under their government health care program. That is what this bill is all about. That is why the minority is intent on stopping its passage today and getting a better alternative for reauthorization for low-income children.

This bill is about expanding government health care. Nothing more, nothing less. The minority’s motion to recommit will reauthorize SCHIP in its bipartisan form. I urge all of us to wait until that motion comes up, vote for that, and then we will truly have a good program for low-income children in this country.

I think there are enough questions that were raised today about exactly what is and is not in this bill to warrant this House taking more time to get it right.

The motion to recommit that we will offer will give this House that opportunity because we in the motion to recommit ask the committee to report back forthwith, which means that this House can today pass what is in our motion to recommit. And in that motion to recommit we will reauthorize the current SCHIP for one year, and we will do a fix for the doctors’ reimbursement for one year.

That will allow this House to give the appropriate amount of time to discover what is and what is not in this legislation that the majority has presented us today and figure out,

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and a campaign of concerted outreach. This legislation provides States with the tools and incentives they need to reach these unenrolled children without expanding the program to make more children eligible.

In my home State of Texas, as of June 2006, SCHIP was benefiting 293,000 children. This is a decline of over 33,000 children from the previous year. We must continue to work to ensure that all eligible children can participate in this important program. To this end, Texas Governor Rick Perry [R] signed legislation in June to, among other things, create a community outreach campaign for SCHIP.

In addition to reauthorizing and improving SCHIP, this legislation also protects and improves Medicare. Due to a broken payment formula, access to medical services for senior citizens and people with disabilities is currently in jeopardy. Physicians who provide health care to Medicare beneficiaries face a 10 percent cut in their reimbursement rates next year, with the prospect of further reductions in years to come looming on the horizon.

The budget proposed by the Bush Administration does not help these doctors, or the patients that they serve.

I believe that senior citizens and individuals with disabilities deserve access to quality and affordable health care. Currently, there are 35 million seniors without private health plans, and, at current rates, the Medicare Trust Fund will be depleted early because of excess payments to HMOs. This legislation reverses Republican efforts to privatize Medicare, and it ensures that seniors will have access to the doctors of their choice.

This is extremely important legislation providing for the health coverage of 11 million low-income children, as well as protecting the health services available to senior citizens and persons with disabilities. I strongly support this bill, and I urge my colleagues to do the same.

Honorable Chris Van Hollen
United States Representative, Maryland, Democrat

Representative Van Hollen, of the Eighth District of Maryland, was first elected to the U.S. House of Representatives in 2002. He served in the Maryland House of Delegates from 1990 to 1994 and in the Maryland Senate from 1994 to 2002. He sits on the Ways and Means Committee and the Committee on Oversight and Government Reform. He also chairs the Democratic Congressional Campaign Committee. The following is from the August 1, 2007, House floor debate on H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act.

I rise in strong support of the CHAMP Act, the Children’s Health and Medicare Protection Act.

The CHAMP Act reauthorizes and improves the very successful State Children’s Health Insurance Program, SCHIP. Created in 1997 by Congress with broad bipartisan support, SCHIP currently covers 6 million children who otherwise would have no access to health insurance. Despite its many successes, there are still more than 6 million children who are eligible for SCHIP, but not yet enrolled in the program. This bill seeks to cover those vulnerable children.

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perhaps in a bipartisan way, the best manner in which to proceed on a long-term basis with SCHIP.

I would ask those fiscal conservatives in the majority, some of whom have in good conscience complained about some of the actions of the former majority, there are signs in the hall talking about the national debt, and I ask those Members to think before they vote for this bill. Do they really want to establish a new entitlement program that is open-ended in this country, that is not properly funded? It is funded with a tobacco tax.

That is going to be a decreasing source of revenue for this country, not increasing. It is funded with changes to the Medicare program, cuts to the Medicare Advantage program. That is not going to have long-lasting consequences? So, really, I want those people who are concerned about the deficit and the debt to think before they vote for this bill.

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**Honorable Dave Weldon**

United States Representative, Florida, Republican

Representative Weldon, of the Fifteenth District of Florida, was first elected to the U.S. House of Representatives in 1994. He was Lake Worth City (Florida) Commissioner from 1977 to 1983 and Vice-Mayor from 1983 to 1984, and served in the Florida House of Representatives from 1990 to 1992 and in the Florida Senate from 1992 to 1994. He sits on the Appropriations Committee. The following is from the August 1, 2007, House floor debate on H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act.

I rise to express my opposition to the bill before us. As a physician who still sees patients, I find this piece of legislation to be completely unacceptable and extremely irresponsible.

The Democrat majority, under the guise of providing insurance to uninsured lower-income children, has chosen to expand the State Children Health Insurance Program far beyond its original intent of insuring low-income children. What is worse, they’ve chosen to pay for it by cutting benefits for seniors and other Medicare beneficiaries by more than $157 billion.

They have rushed this 500-page bill to the House floor without first allowing the committees of jurisdiction to fully debate and amend the bill. They introduced their bill last night just before midnight. Shortly after midnight, they added a 45-page amendment. This morning they made this available to Members of the House. Now they have only allowed two hours of debate and denied Members of Congress any opportunity to offer amendments to the bill. In fact, they are brazenly complaining that by giving Members time to read the bill, it would unnecessarily delay moving this bill forward.

What is so offensive about suggesting that Members of Congress have an opportunity to read the bill before being asked to vote on it? Why the rush? Why the secrecy? Why are they shutting down the legislative process and rushing this bill through before anyone can read it?

They don’t want the 780,000 seniors in the State of Florida — including over 40,000 seniors in my congressional district — to know that their Medicare benefits will be cut in order to provide health insurance to non-U.S. citizens, including illegal immigrants, and millions of children who already have health coverage.

They don’t want 8 million seniors enrolled in Medicare Advantage plans across this Nation to know that their benefits are being cut so that SCHIP can be expanded to sub-

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“... I want those people who are concerned about the deficit and the debt to think before they vote for this bill.”
Van Hollen, 
continued from page 246

Unfortunately, President Bush’s proposal seeks to turn back the clock and take us in the wrong direction. The President has proposed funding SCHIP at a rate that does not even take into account any increases for inflation or population growth. Under the President’s proposal, more than 1.5 million children will lose SCHIP coverage and many States, including Maryland, will continue to face funding shortfalls. Indeed, the nonpartisan Congressional Budget Office, CBO, has confirmed that the President’s proposal would be too little to keep covering the children who are currently enrolled in SCHIP.

In contrast to President Bush’s proposal, this bill will extend coverage to an additional 5 million children who are currently eligible for SCHIP but are not yet enrolled. I am also pleased that the bill provides for guaranteed dental coverage in SCHIP. Good oral health care is integral to the health of children and no child should have to suffer because they cannot access adequate dental care. No family should have to suffer the loss of a child because they lack access to dental care, as happened in the tragic case of Deamonte Driver, a 12-year-old Marylander who died earlier this year when an infection from an untreated abscessed tooth spread to his brain. I am also pleased that this bill provides important mental health coverage for children.

The reauthorization and improvement of SCHIP will benefit the approximately 136,000 children who are currently enrolled in Maryland’s CHIP and prevent Maryland from facing further funding shortfalls in its SCHIP allotment, as has been the case in recent years.

The CHAMP Act will also provide essential funding to Maryland to enroll 68,000 children in families with incomes under 200 percent of the Federal poverty level who remain uninsured. It will also provide Maryland with a new option to cover more than 65,000 children who are aging out of Medicaid and SCHIP. And because of the bill, Maryland will have an increase in its SCHIP allotment of $99.7 million from last year, allowing it room to reach additional eligible but uninsured children.

Not so long ago, President Bush promised to expand coverage of SCHIP to include eligible children who are not yet enrolled. In his September 2004 speech to the Republican National Convention, the President stated — and I am quoting here, “America’s children must also have a healthy start in life. In the new term, we will lead an aggressive effort to enroll millions of poor children who are eligible but not signed up for the government’s health insurance programs. We will not allow a lack of attention, or information, to stand between these children and the health care they need.”

Now, the President has reversed course. In his July 10, 2007, speech in Cleveland, Ohio, he forgot his 2004 pledge and stated, “I mean, people have access to health care in America. After all, you just go to an emergency room.”

I hope the President will reconsider his position and help Congress provide health insurance to 11 million children who are one of the most vulnerable segments of our society.

In addition to reauthorizing SCHIP, the CHAMP Act makes improvements in Medicare that will strengthen that important program. The legislation reduces overpayments to Medicare Advantage plans, which are paid, according to nonpartisan CBO and other independent entities’ analysis, on average, 12 percent more than the cost of care in traditional Medicare. This will increase Medicare’s solvency by two years. In addition, the legislation prevents the impending physician reimbursement cuts and provides positive updates in 2008 and 2009. Also, the bill will increase Medicare beneficiaries’ access to preventive services by eliminating copayments and deductibles for current and future preventive benefits and authorizing Medicare to add additional preventive services.

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They want to hide from America’s seniors the fact that Medicare benefits are being cut in order to subsidize health care benefits to a new group of “children” who happen to be between 18 and 25 years of age.

They don’t want seniors to know that budget experts in Congress estimate that nearly one-half of the children who will be signed up to SCHIP after this bill passes — using money that is being cut from Medicare — are simply dropping their private health care coverage in order to get the Federal subsidy under SCHIP.

Earlier this year, I was troubled by the fact that Democrats planned to significantly expand SCHIP, and I offered an amendment in the House Appropriations Committee that would have focused the program so that States would first be required to ensure that all children in homes earning below 200 percent of the poverty level were covered. My amendment was rejected by the Democrat majority in that committee, who said they opposed it because my amendment would focus the program on serving uninsured children. They made it clear that they had no intent of focusing this program on lower-income children, but rather planned to expand the program to those well above the poverty level and to include adults and non-citizens.

What else is in this bill that they are trying to hide from the American people?

They repeal the requirement that individuals must prove citizenship in order to enroll in Medicaid and SCHIP. This opens the program to fraud and the enrollment of illegal immigrants. In 2006, the inspector general (IG) of the Department of Health and Human Services found that 46 States allowed anyone seeking Medicaid or SCHIP to simply state they were citizens. The IG found that 27 States never sought to verify that enrollees were indeed citizens. CBO estimates that repealing this requirement will cost $1.9 billion.

The bill provides a bonus payment to States that choose not to implement an asset test for those enrolling in SCHIP. In other words, a family could hold assets of as much as $1 million (a house, car, mutual fund) but could still qualify for SCHIP if their income for that year fell within the amount allowed for SCHIP enrollment. For example, a family of four living in a $1 million home in New York with an annual income of $80,000 could qualify for enrollment in SCHIP. And if New York does this — they get a bonus.

It is my understanding that this 500-plus-page bill imposes a tax on private health insurance. Certainly, they want to hide that from the American people.

It is clear that they don’t want the American people to know that they are creating a massive new entitlement program just at the time when the financial strains of the Social Security and Medicare entitlements are being stretched as baby boomers retire. They are putting this Nation on a path to bankruptcy by creating a huge new entitlement program that they have no way of sustaining long-term. This is the wrong time to be saddling the American taxpayers with a gigantic new program.

Additionally, I am concerned that this bill fails to secure the seniors’ long-term access to quality physicians. The 1997 Budget Act (a bill I voted against) created a formula that has resulted in payment to doctors being cut. As a result, today some doctors (typically the best doctors with the busiest practices) are starting to refuse to see new Medicare patients. This SCHIP bill does not fix this problem. It provides doctors with a 1 percent increase over two years, then cuts doctor reimbursement by 12 percent in 2010 and 12 percent in 2011, or 23 percent over two years. The effect of these cuts could be devastating, with many doctors facing the possibility of losing money when they see Medicare patients.

“It is clear that they don’t want the American people to know that they are creating a massive new entitlement program . . .”
The CHAMP Act also increases the tobacco tax by 45 cents to a total of 84 cents. Increasing the tobacco tax will save billions in health costs and is one of the most effective ways to reduce tobacco use, especially among children. In short, raising the tobacco tax will prevent thousands of children from starting to smoke and the proceeds of the tax will be used to expand health coverage for children. That is a win-win result.

The clock is ticking. I urge all of my colleagues to vote for this much-needed legislation.

Honorable Diana DeGette
United States Representative, Colorado, Democrat

Representative DeGette, of the First District of Colorado, was first elected to the U.S. House of Representatives in 1996. She was a member of the Colorado House of Representatives from 1992 to 1996 and Assistant Minority Leader from 1994 to 1995. She is Vice Chair of the Energy and Commerce Committee and Cochair of the Congressional Diabetes Caucus. She is also a Deputy Whip. The following is from the August 1, 2007, House floor debate on H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act.

As co-chair of the bipartisan Congressional Diabetes Caucus, one of the largest House Caucuses, with over 250 members, I want to highlight the increased investment in diabetes research included in the Children’s Health and Medicare Protection Act. As the single most costly chronic disease in the United States, diabetes places a tremendous economic burden on our country, costing more than $132 billion annually and accounting for one out of every three Medicare dollars.

Diabetes inflicts an enormous personal toll on individuals and their families. Individuals with diabetes have more than twice the prevalence of disability from amputation, loss of vision, and other serious complications, such as stroke, kidney failure, and heart disease. Even with continuous and vigilant management, patients are still susceptible to developing serious, long-term complications.

Absent a significant Federal investment in conquering this disease, the personal and economic toll of diabetes will continue to grow. It is estimated that one out of every three children who are born in the year 2000 will develop diabetes during their lifetime.

Despite this alarming trend, real advances are being made and tremendous research opportunities exist, in large part due to the Special Statutory Funding Program for Type 1 Diabetes Research, which was originally created as a provision of the State Children’s Health Insurance Program in 1997. This program has produced tangible results that are improving people’s lives today as we continue towards our ultimate goal of a cure. However, unless this program is reauthorized, there will be a 35 percent reduction in Federal support for type 1 diabetes research.

Chairman Dingell, I want to thank you for including a one-year extension at current funding levels for this program. I know that difficult choices had to be made to accomplish multiple goals within a tight budget, and your support for this critical program is greatly appreciated.

It is important to note, however, that because the program has previously provided continuity of funding over multiple years, the National Institutes of Health has been able...
The result will be seniors will not be able to see a doctor.

I could go on about the additional cuts to Medicare, including cuts to the following Medicare benefits: home health, end-stage renal disease, oxygen therapy, imaging services, dialysis, and skilled nursing facilities. By cutting Medicare and spending the money elsewhere, this bill will make the challenge of securing the long-term solvency of Medicare even more difficult.

This bill goes far beyond the bill passed by the Senate, and the President has vowed to veto the House bill. This bill should be sent back to committee and debated in regular order. America’s seniors, uninsured children, and the American taxpayer deserve better.

Honorable Bob Etheridge
United States Representative, North Carolina, Democrat

Representative Etheridge, of the Second District of North Carolina, was first elected to the U.S. House of Representatives in 1996. He served on the Harnett County (North Carolina) Commission from 1973 to 1976 and as Chairman from 1975 to 1976. He served in the North Carolina House of Representatives from 1978 to 1988 and as North Carolina Superintendent of Public Instruction from 1988 to 1996. He sits on the House Agriculture Committee, where he chairs the Subcommittee on General Farm Commodities and Risk Management. He is also a member of the Budget Committee and the Homeland Security Committee. The following is from the August 1, 2007, House floor debate on H.R. 3162, the Children’s Health and Medicare Protection (CHAMP) Act.

I rise reluctantly in opposition to the Children’s Health and Medicare Protection Act. I fully support the goals of this legislation — to provide health care to millions of uninsured children, to improve Medicare benefits for our seniors, and to help rural areas provide health care. Unfortunately, however, I cannot support legislation that unfairly impacts the Second District and all of North Carolina with the burdens of this cost.

I have been a long-time supporter of the State Children’s Health Insurance Program, and I am proud that the Budget Committee on which I serve authorized the increase reflected in this bill. I support reauthorizing and strengthening SCHIP, without which nearly 6 million children will lose access to health care. In North Carolina, NC Health Choice provides cost-effective and high-quality health services to 250,000 at-risk children. An additional 180,000 uninsured children in North Carolina are eligible for coverage, and the $50 billion in the budget I helped write would enable more of these children to be covered.

It is also vital that we enable physicians to provide health services, in SCHIP, Medicaid, and Medicare. This legislation implements a two-year fix that enables doctors to continue their participation in the program without going bankrupt. Without this fix, North Carolina physicians will lose $460 million for the care of elderly and disabled patients over the next two years and face a 1.6 percent geographic cut above the baseline reductions in other parts of the country.

I appreciate Medicare physicians who have made many sacrifices to continue to cover the Medicare population, and without a fix this year doctors may start dropping out and refuse to see Medicare patients. We must maintain our commitment to universal coverage for our Nation’s seniors and people with disabilities.

“America’s seniors, uninsured children, and the American taxpayer deserve better.”

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to support longer-term, innovative research projects that have led to significant advances. Such efforts would not be continued if the program was not extended for multiple years.

I am committed to continuing my work with Chairman Dingell and the rest of my colleagues on this issue to ensure that we can adequately fund this program in upcoming years.

Honorable Mark Udall
United States Representative, Colorado, Democrat

Representative Udall, of the Second District of Colorado, was first elected to the U.S. House of Representatives in 1998. He served in the Colorado House of Representatives from 1996 to 1998. He serves on the Committee on Science and Technology, where he chairs the Science, Space, and Aeronautics Subcommittee. He also sits on the Armed Services Committee and the Natural Resources Committee. The following is from the August 1, 2007, House floor debate on the Children's Health and Medicare Protection (CHAMP) Act.

Dr. Martin Luther King, Jr. said, “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” The CHAMP Act addresses many problems that we currently have in our health care system. It does not end health care inequality, but it will increase coverage for low-income children, and it will stave off payment cuts for hardworking physicians, while increasing choices for seniors and strengthening traditional Medicare.

I believe that health care should be a right, not a privilege, and this act is a step in the right direction. The Children's Health Insurance Program is set to expire on September 30, 2007. This year, 6 million children have health care because of CHIP. If Congress does not act, these 6 million will no longer have access to quality, affordable health insurance. This legislation also provides coverage for an additional 5 million children who currently qualify but who are not yet enrolled under CHIP. These children are in working families with parents who either can't afford insurance or have jobs that lack health care benefits.

Despite claims by some, this bill does nothing to “expand” CHIP. Instead, it maintains current eligibility requirements for CHIP. The majority of uninsured children are currently eligible for coverage — but better outreach and adequate funding are needed to identify and enroll them. This bill gives States the tools and incentives necessary to reach millions of uninsured children who are eligible for, but not enrolled in, the program.

It has been said that the CHAMP Act creates an entitlement for illegal immigrants. But, in fact, the CHAMP Act does not change existing law, which states that undocumented immigrants are not eligible for CHIP or regular Medicaid. And the CHAMP Act explicitly states that it provides no Federal funding for Medicaid or CHIP for undocumented immigrants and requires audits of all State programs to ensure that Federal funds are not being spent on undocumented children.

The CHAMP Act will protect and improve Medicare by increasing fiscal responsibility and ensuring access to doctors for seniors and those with disabilities. Currently, experts agree that Medicare Advantage (MA) plans receive, on average, 12 percent more than the cost of care in traditional Medicare. Overpayments to certain plans can exceed 50 percent. By phasing out these overpayments over the next four years, the Congressional Budget Office

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Etheridge, continued from page 251

There are many other positive provisions in this legislation: fixes that strengthen the Medicare trust fund, provide more access to preventative care, and provide lower premiums for many seniors; extensions for important rural health care initiatives that ensure access to care for people across the country, especially in the Second District of North Carolina; support for the Special Diabetes Programs, which provide essential funding for research and innovative diabetes prevention activities for thousands of children in communities throughout the country; parity for mental health coverage under Medicare. The list goes on and on. I understand what these improvements mean to the people of North Carolina, and I wholeheartedly support them.

These provisions have a cost, however, and as important as these priorities are we also must value the principle of fairness. I do not support smoking, and I have never smoked, but this bill is not fair to those who grow or use tobacco. The cigarette tax is regressive, falling hardest on those who can least afford it. Although it is a national tax, it also unevenly impacts the country, with North Carolina and a few other States footing the bill for the benefits the CHAMP Act seeks to deliver. North Carolina's citizens pay over 4 percent of the costs of this legislation while receiving about 2 percent of the benefit.

Researchers at North Carolina State University estimate that North Carolina's economy would lose at least $540 million a year through the tax's indirect impact as well. North Carolina's tobacco farmers grow a legal crop. These hardworking farm families have suffered greatly from transformations in the global economy. Because my district is the second largest tobacco-producing district in the country, H.R. 3162 disproportionately affects my constituents who work hard to be able to pay their bills and provide a better life for their children. This just doesn't pass the fairness test.

Honorable Mary Bono
United States Representative, California, Republican

Representative Bono, of the Forty-Fifth District of California, was first elected to the U.S. House of Representatives in a special election in April 1998 to fill the seat left vacant by the death of her husband, Representative Sonny Bono. She was a restaurant manager from 1986 to 1990. She serves on the Energy and Commerce Committee. The following is from the August 1, 2007, House floor debate on H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act.

I would like to express my strong support for the State Children's Health Insurance Program, or SCHIP; and the need for this program to be reauthorized. But, unfortunately, I must also state my opposition to the proposals that we have before us on the floor today.

Since its enactment in 1997, SCHIP has been a tremendous success. SCHIP has been adopted in one form or another in every State across the Nation. In my own State of California, we have enacted a combination of SCHIP Medicaid to optimize coverage in the State. This program is better known as Healthy Families and currently provides coverage to more than 800,000 children. I strongly support the coverage that currently exists in California and voice my continued commitment to maintaining that coverage.

I was heartened to see the bipartisan compromise that emerged from the Senate Health, Education, Labor, and Pensions Committee earlier this month and that is currently being

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estimates that billions of dollars will be saved each year, while increasing the solvency of Medicare and simultaneously reversing the catastrophic 10 percent payment cuts to physicians who serve Medicare patients. By reducing overpayments to Medicare Advantage plans, wasteful spending will be reduced while increasing patient access to physicians.

Medicare Advantage plans originally sought to give beneficiaries more choices at a lower cost. However, overpayments to MA plans do not increase benefits but rather pay for the administrative costs, marketing costs, and profits for private plans. The CHAMP Act levels the playing field by decreasing premiums for those enrolled in traditional Medicare.

By curbing the overpayments to Medicare Advantage plans, this legislation decreases the cost for preventative health services for seniors, eliminating co-payments and deductibles for these vital services while saving lives and money. Further, this bill includes $3 billion for the rural health care safety net. This ensures access to quality care for those in rural America.

The health of our children is vital to the success of our society. The CHAMP Act will raise the Federal tobacco tax by 45 cents. According to the Campaign for Tobacco-Free Kids, a 45 cent increase means that 1,381,000 fewer children will take up smoking. Adults, too, would be less likely to smoke, which means fewer smoking-related illnesses and lower health costs. Estimates are that this tobacco tax increase will result in long-term health savings of $32.4 billion and 669,000 fewer smoking-related deaths.

I am proud to vote for this bill that seeks to protect those that are most vulnerable in our society by increasing health insurance coverage for low-income children and protecting and improving coverage for those enrolled in Medicare and Medicaid.
debated on the Senate floor. This legislation ensures that States will have adequate Federal funding to continue their existing programs, while allowing others to expand coverage to more children. The bill also allows States to cover pregnant women and includes provisions to transition childless adults into Medicaid. CBO estimates that this bill will lead to the coverage of 3 and a half million new children.

All this was done at $15 billion less than the SCHIP portion of the proposal that we have before us today. While I recognize that the Senate proposal is still a work in progress, I am supportive of many of the principles laid forth in this legislation and appreciate the flexibility with which States are allowed to continue operating this program.

This CHAMP Act that is before us includes many provisions that are positive and attempt to address some very real and very serious problems facing the health care community. I know that my own State would benefit greatly from the Adult Day Health Care Services provision within the bill and would allow California and seven other States to continue operating their longstanding and successful programs. There are provisions that will amend Medicare Part D to aid patients relying on the AIDS Drug Assistance Program, or ADAP, to pay for their drugs.

Perhaps most importantly, this legislation also includes a two-year update for payments to physicians under the Medicare fee schedule. If current law is allowed to move forward doctors will be forced to absorb a nearly 10 percent cut in reimbursements. As the daughter of a doctor, I am sympathetic to this cause and have been supportive of efforts to stave off devastating cuts that have been pending in years past. I strongly believe that the problems we face as a result of the sustainable growth rate deserve our full and careful attention. I do not, however, believe that this is the vehicle to do so.

While I support many, if not most of the provisions in this bill, I have a responsibility to vote for programs and policies that are necessary for the public and affordable for the taxpayer. This bill is typical of what we have come to expect from a Congress that refuses to put limits on what they are willing to support and ask the taxpayers to fund.

To help pay for the obscene $90 billion price tag of this legislation, cuts have been proposed to hospital payments, inpatient rehabilitation services, skilled nursing facilities, and home health care services, to name a few. I am very alarmed that a lion’s share of these cutbacks will be felt by Medicare Advantage and the 8 million Medicare beneficiaries currently enrolled. In Riverside County alone, nearly 50 percent of Medicare beneficiaries have chosen to participate in a Medicare Advantage plan, more than 100,000 seniors. The bill that we have before us today will put each of us in the position of having to choose between children and seniors.

As I have often stated, SCHIP must be reauthorized; 6.6 million children who are currently enrolled will find their coverage jeopardized if Congress does not act. We have long known that September 30 was looming, and instead of acting, the leadership of the various committees of jurisdiction have chosen to wait until the eleventh hour, and not just act on SCHIP but to create a veritable Christmas tree of major health care policy reforms with no legislative hearings. We can and should act on behalf of SCHIP. I encourage my colleagues in the House to follow the example of the Senate and consider a bill that is clean and focused and allows members to vote their conscience on coverage for children.

“This bill is typical of what we have come to expect from a Congress that refuses to put limits on what they are willing to support and ask the taxpayers to fund.”
private coverage less important for some low-income families, parents might be more inclined to take jobs that offer higher cash wages rather than health insurance. Moreover, if employers of low-wage workers believe that SCHIP reduces the value of private health insurance in attracting employees, some might reduce their contribution to the premiums for family coverage, reduce the benefits offered, stop offering family coverage, or stop offering insurance altogether.

Considerable potential thus exists for increases in SCHIP coverage to be partially offset by a reduction in private coverage. For example, about 60 percent of the children who were eligible for the program were covered by private insurance in the year before the program was enacted. But measuring the extent to which enrollment in SCHIP has actually been offset by a reduction in private coverage is difficult. Estimates vary depending on the measure that is used. Moreover, studies have obtained widely varying estimates depending on the data sources and methods used.

On the basis of a review of the research literature, CBO concludes that the most reliable estimates currently available suggest that the reduction in private coverage among children is between a quarter and a half of the increase in public coverage resulting from SCHIP. In other words, for every 100 children who enroll as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.

The available evidence, which is quite limited, suggests that the bulk of the reduction in private coverage occurs because parents choose to forgo private coverage and enroll their children in SCHIP (because of better benefits, lower costs, or some combination thereof), rather than employers deciding to drop coverage for such children. No studies have estimated the extent to which SCHIP reduces private coverage among parents, so the available estimates probably underestimate the total reduction in private coverage associated with the introduction of SCHIP.

Changes to the program may generate different effects on private coverage than those estimates suggest; in general, expanding the program to children in higher-income families is likely to generate more of an offsetting reduction in private coverage (and therefore less of a net reduction in uninsurance) than expanding the program to more children in low-income families. (Over the course of 2005, an average of nearly 2 million children were apparently eligible for SCHIP but remained uninsured.) Policymakers are exploring options to increase participation among eligible children.

### SCHIP Reauthorization

For the allocation formula that determines the amount of funds a State will receive each year, several analysts, including CRS, have noted alternatives that could be considered. These include altering the methods for estimating the number of children at the State level, adjusting the extent to which the SCHIP formula for allocating funds to States includes the number of uninsured versus low-income children, and incorporating States’ actual spending experiences to date into the formula. Considering the effects of any one or a combination of these — or other — policy options would likely entail iterative analysis and thoughtful consideration of relevant trade-offs.

### House Bill Summary

**Transition from Welfare to Work.** Extends for two years the Transitional Medical Assistance program, which is scheduled to sunset at the end of September.

**Option for Family Planning.** Provides States with a new option to offer family planning services to women.

**Adult Day Health Care.** Protects beneficiaries who currently receive adult day health care from having that care terminated.

**Puerto Rico.** Increases resources for Puerto Rico and the U.S. Territories for Medicaid and provides additional funding for data programs in those areas.

**Medicaid Drug Rebate.** Increases the rebate provided from drug manufacturers to the Medicaid program by 5 percent.

#### Revenues

Establishes a new $.45 Federal tax on tobacco products. Exempts fuel excise taxes for ambulance fuel.
The 110th Congress
(Information below as of September 7, 2007)

The U.S. Senate
Total Membership, 100:
49 Democrats
49 Republicans
1 Independent Democrat
1 Independent

Presiding Officer:
Vice President
Richard B. Cheney

President Pro Tempore:
Robert C. Byrd (WV)

Floor Leaders:
Majority Leader
Harry Reid (NV)
Minority Leader
Mitch McConnell (KY)

Party Whips:
Majority Whip
Richard Durbin (IL)
Minority Whip
Trent Lott (MS)

The U.S. House of Representatives
Total Membership, 435:
232 Democrats
201 Republicans
2 Vacancies

Presiding Officer:
Speaker of the House
Nancy Pelosi (CA)

Floor Leaders:
Majority Leader
Steny Hoyer (MD)
Minority Leader
John Boehner (OH)

Party Whips:
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