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Division A of H.R. 3922: The CHAMPIONING HEALTHY KIDS Act

Elayne J. Heisler, Coordinator
Specialist in Health Services

Adrienne L. Fernandes-Alcantara
Specialist in Social Policy

Bernadette Fernandez
Specialist in Health Care Financing

Sarah A. Lister
Specialist in Public Health and Epidemiology

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Summary

On October 30, 2017, the House Rules Committee posted an amendment in the nature of a substitute for the Community Health And Medical Professionals Improve Our Nation Act of 2017 (CHAMPION Act, H.R. 3922). The amendment considered by the House struck the text of the CHAMPION Act and replaced it with the text of the amendment in the nature of the substitute.

The amendment in the nature of a substitute is entitled the Continuing Community Health And Medical Professional Programs to Improve Our Nation, Increase National Gains, and Help Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017 (CHAMPIONING HEALTHY KIDS Act). In revising the language of the CHAMPION Act, the CHAMPIONING HEALTHY KIDS Act includes revised language for the CHAMPION Act in Division A. Division A would extend funding for several public health programs that had received directed appropriations through FY2017. It would also make a number of changes to these programs and would provide offsets for the proposed funding extensions. Division B of this act would, among other things, extend funding for the State Children's Health Insurance Program (CHIP).

On November 1, 2017, the House Rules Committee adopted an amendment (H.Res. 601) to this bill that would lessen the amount that would be reduced from the Public Health and Prevention Fund (PPHF), one of the offsets included in Division A. The House passed the CHAMPIONING HEALTHY KIDS Act on November 3, 2017, by a vote of 242 to 174.

This report summarizes provisions in Division A of the CHAMPIONING HEALTHY KIDS Act. CRS Report R44989, *Comparison of the Bills to Extend State Children's Health Insurance Program (CHIP) Funding*, summarizes provisions in Division B.

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On October 3, 2017, the House Energy and Commerce Committee introduced the Community Health and Medical Professionals Improve Our Nation Act of 2017 (the CHAMPION Act, H.R. 3922). This bill was marked up by the committee on October 4, 2017. On October 30, 2017, the House Rules Committee posted an amendment in the nature of a substitute for H.R. 3922. The amendment considered by the House struck the text of the CHAMPION Act and replaced it with the text of the amendment in the nature of the substitute.

The amendment in the nature of a substitute is entitled the Continuing Community Health And Medical Professional Programs to Improve Our Nation, Increase National Gains, and Help Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017 (CHAMPIONING HEALTHY KIDS Act). In revising the language of the CHAMPION Act, the CHAMPIONING HEALTHY KIDS Act includes revised language for the CHAMPION Act in Division A. Division A would extend funding for several public health programs that had received directed appropriations through FY2017. It would also make a number of changes to these programs and would provide offsets for the proposed funding extensions. Division B of this act would, among other things, extend funding for the State Children’s Health Insurance Program (CHIP). On November 1, 2017, the House Rules Committee adopted an amendment to this bill that would lessen the amount that would be reduced from the Public Health and Prevention Fund (PPHF).¹ The House passed the CHAMPIONING HEALTHY KIDS Act on November 3, 2017, by a vote of 242 to 174.

This report summarizes the provisions in Division A of the CHAMPIONING HEALTHY KIDS Act that would extend funding for certain public health programs and provide offsets for these funding extensions. Division B—the extension of CHIP funding—is discussed in CRS Report R44989, *Comparison of the Bills to Extend State Children’s Health Insurance Program (CHIP) Funding*. According to Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) cost estimates for the CHAMPIONING HEALTHY KIDS Act language posted on the House Rules Committee website on October 30, 2017,² Division A is estimated to decrease federal spending by \$4.1 billion and increase revenues by \$0.7 billion, for a net savings of \$4.8 billion over the period of FY2018 through FY2027.³

¹ The amendment adopted by the House Rules Committee on November 1, 2017, is at <https://rules.house.gov/bill/115/hr-3922>.

² The cost estimate for the CHAMPIONING HEALTHY KIDS Act does not include the changes that the House Rules Committee amendment would make to the Public Health and Prevention Fund. These changes would increase the amounts that would be appropriated to the fund in FY2020-FY2026, which would presumably lessen the amount of revenue that this provision would generate.

³ The full cost estimate for the CHAMPIONING HEALTHY KIDS Act shows that the bill (including Divisions A and B) is estimated to increase federal spending by \$19.4 billion and increase revenue by \$4.7 billion, for a net cost of \$14.7 billion. (CBO and JCT, *Estimate of the Direct Spending and Revenue Effects of H.R. 3922 The CHAMPIONING HEALTHY KIDS Act, an Amendment in the Nature of a Substitute [Version HR3922-FLR-AINS_06.XML]*, as Posted on the Website of the House Committee on Rules October 30, 2017, October 31, 2017, at <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr3922amendment.pdf>). This cost estimate does not include the changes that the House Rules Committee amendment would make to the Public Health and Prevention Fund. These changes would increase the amounts that would be appropriated to the fund in FY2020-FY2026, which would presumably lessen the amount of revenue that this provision would generate.

Overview of Division A of the CHAMPIONING HEALTHY KIDS Act

Division A of the CHAMPIONING HEALTHY KIDS Act would extend funding for a number of public health programs, which are discussed briefly below. Because the bill would also make a number of changes to these programs, information for certain public health programs is provided for context. Information about the public health programs included in Division A and their funding histories is available in the following CRS reports:

- CRS Report R43937, *Federal Health Centers: An Overview*;
- CRS Report R44970, *The National Health Service Corps*;
- CRS Report RS20301, *Teenage Pregnancy Prevention: Statistics and Programs*;
- CRS Report R44662, *Health Care-Related Expiring Provisions of the 115th Congress, First Session*; and
- the “Teaching Health GME” section in CRS Report R44376, *Federal Support for Graduate Medical Education: An Overview*.⁴

For the majority of the public health programs included in this bill, FY2017 was the last year of appropriated funding. There are two exceptions: the Teaching Health Center Graduate Medical Education Payment Program and the Special Diabetes Program for Indians. Funding for these two programs was provided for the first quarter of FY2018 (i.e., through December 31, 2017) in the Disaster Tax Relief and Airport and Airway Extension Act of 2017 (P.L. 115-63). Division A of the CHAMPIONING HEALTHY KIDS Act also includes the following provisions as offsets: (1) a change to the qualified health plan grace period requirement for individuals who receive advanced premium tax credits for health insurance purchased on the exchanges and (2) reductions to the Prevention and Public Health Fund.⁵

Although other pending legislation proposes extending some of the same public health programs included in Division A of the CHAMPIONING HEALTHY KIDS Act CHAMPION Act, a comparison of those bills is beyond the scope of this report.⁶ Unless otherwise specified, all references to the “Secretary” refer to the Secretary of the Department of Health and Human Services (HHS).

⁴ Two shorter products also discuss the current funding for some of these programs; see CRS Insight IN10804, *Congress Faces Calls to Address Expired Funds for Primary Care*, and CRS Insight IN10728, *The Teaching Health Center Graduate Medical Education (THCGME) Program: Policy Considerations for Reauthorization*.

⁵ For information on qualified health plans and health insurance exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*. For more information about this fund, see CRS Report R44796, *The ACA Prevention and Public Health Fund: In Brief*.

⁶ For example, H.R. 3770, H.R. 3862, and S. 1899 would address funding for health centers and the National Health Service Corps, and H.R. 3924, H.R. 6309, S. 747, and S. 2830 would extend funding for the Special Diabetes Program.

Title I- Extension of Public Health Programs

Section 101. Extension for Community Health Centers, The National Health Service Corps, and Teaching Health Centers that Operate GME Programs

Current Law

The health center program, authorized by Section 330 of the Public Health Service Act (PHSA),⁷ provides grants to not-for-profit or state and local government entities to operate outpatient health centers. These centers are required to be located in medically underserved areas (MUAs) or to provide care to a population that is designated as underserved.⁸ Grants are awarded competitively, with some preference given to sites in rural areas. The program has a number of grant programs, including, but not limited to, grants to support health center operations, grants to enable health centers to expand services, and grants for health centers to engage in quality improvement activities.⁹ The health center program supports four types of health centers: (1) community health centers, (2) health centers for the homeless, (3) health centers for residents of public housing, and (4) migrant health centers. Community health centers (CHCs) are the most numerous because they provide care to a generally underserved population. The remaining three types are less common because each serves more targeted subpopulations of the underserved than do CHCs.

All four types of health centers are required to provide primary health services and preventive and emergency health services.¹⁰ Primary health services are those provided by physicians¹¹ or physician extenders (physicians' assistants, nurse clinicians, and nurse practitioners) to diagnose, treat, or refer patients. Primary health services include relevant diagnostic laboratory and radiology services. Preventive health services include well-child care, prenatal and postpartum care, immunization, family planning, health education, and preventive dental care.¹² Emergency health services refer to the requirement that health centers have defined arrangements with outside providers for emergent cases that the center is not equipped to treat and for after-hours care. Health centers are also required to provide additional health services that are not primary health services but are necessary to meet the health needs of the service population. This includes, but is not limited to, behavioral health services and environmental health services.

Historically, the health center program had generally been supported with discretionary appropriations; however, in 2010, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) created the Community Health Center Fund (CHCF), which provided

⁷ 42 U.S.C. §254(b).

⁸ For more information about these designations, see CRS Report R43937, *Federal Health Centers: An Overview*.

⁹ See "Grants that Support Health Centers" section in CRS Report R43937, *Federal Health Centers: An Overview*.

¹⁰ 42 C.F.R. 51c.102(h). Health centers for the homeless, health centers for residents of public housing, and migrant health centers are also required to provide additional services to meet the needs of their service populations.

¹¹ *Ibid.* The regulation further specifies that these services should be provided by primary care physicians, who are defined as physicians in family practice, internal medicine, pediatrics, or obstetrics and gynecology or, where appropriate, that these services may be provided by physician assistants, nurse practitioners, or nurse midwives.

¹² The family planning and preventive screening services that health centers provide are discussed in CRS Report R44295, *Factors Related to the Use of Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FQHCs)*.

mandatory funding for the program. The ACA appropriated a total of \$9.5 billion to the fund from FY2011 through FY2015, as follows:

- \$1 billion for FY2011,
- \$1.2 billion for FY2012,
- \$1.5 billion for FY2013,
- \$2.2 billion for FY2014, and
- \$3.6 billion for FY2015.

Funding for the CHCF was subsequently extended as part of the Medicare Access and CHIP Reauthorization Act (MACRA, P.L. 114-10), which provided \$3.6 billion for each of FY2016 and FY2017. The mandatory CHCF appropriations are provided in addition to discretionary funding for the program; however, the CHCF comprised approximately 72% of health center programs' appropriations in FY2017.¹³

The CHCF also provides mandatory funding for the National Health Service Corps (NHSC), authorized in Title III of the PHSA. The NHSC provides scholarships and loan repayments to certain health professionals in exchange for providing care in a health professional shortage area (HPSA) for a period of time that varies based on the length of the scholarship or the number of years of loan repayment received.¹⁴ This program last received discretionary appropriations in FY2011; since that time, CHCF funds have been the sole source of NHSC funding.

The ACA also created and provided mandatory funding for the Teaching Health Center Graduate Medical Education Program (THCGME). The program provides direct and indirect graduate medical education (GME) payments to support medical and dental residents training at qualified teaching health centers, which are outpatient health care facilities that provide care to underserved patients. The program was established in the ACA, which appropriated \$230 million for direct and indirect GME payments for the period of FY2011 through FY2015. Program funding was subsequently extended in MACRA, which appropriated \$60 million for each of FY2016 and FY2017 for direct and indirect GME payments for teaching health centers. MACRA funds were used to fund residents at existing teaching health center programs; no new teaching health centers were added to the program. MACRA funds ended at the end of FY2017. Program funding was extended for the first quarter of FY2018 in the Disaster Tax Relief and Airport and Airway Extension Act of 2017 (P.L. 115-63), which provided \$15 million for the first quarter of FY2018.

These three programs are administered by the Health Resources and Services Administration (HRSA) within HHS.

Provision

Community Health Center Fund

This provision would extend funding for the CHCF for FY2018 and FY2019; specifically, it would provide \$3.6 billion for health centers in each of those years.

¹³ CRS Insight IN10804, *Congress Faces Calls to Address Expired Funds for Primary Care*.

¹⁴ Health professional shortage areas (HPSAs) are defined in 42 U.S.C. §254e. See U.S. Department of Health and Human Services, Health Resources and Services Administration, "Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P)," <https://bhwh.hrsa.gov/shortage-designation>.

Health Center Programs Changes

The provision would also make a number of changes to the health center program. It would replace references to health centers providing substance abuse services with references to substance use disorder services. It would also make a number of changes to the grants available through the health center program. It would modify references to “substance abuse” to “substance use disorders” throughout the authorization of the health center program. It would delete the authorization for a number of health center grant programs that are no longer operational. Specifically, it would delete authorizations of grants for (1) Managed Care Network and Plans and (2) Practice Management Networks. It would also strike language that specified how funds under those grants programs could be used, and it would make conforming changes throughout the section to remove reference to “plans.”

Grants for Evidence-Based Models

The provision would eliminate an existing loan guarantee program and would replace the existing language with new language that would authorize the Secretary to make supplemental funding awards to existing centers to implement evidence-based models for improving access to high-quality primary care services. Evidence-based models include models related to improving the delivery of care for individuals with multiple chronic conditions, altering workforce configurations, reducing the cost of care, enhancing care coordination, expanding the use of telehealth, integrating primary care and behavioral health services, and those related to addressing emerging public health or substance use disorder issues. The provision would authorize the Secretary, when making these new supplemental grant awards, to consider whether the applicant health center has submitted a plan for continuing the proposed quality improvement activities after the supplemental funding award has ended. The Secretary would also be authorized to give special consideration to applications for supplemental activities that seek to address significant barriers to access to care in areas where provider shortages are greater than the national average.

Operating Grants

The provision would make the following changes to the operating grant program. First, it would shorten the award period from two years to one year for entities that are unable to comply with all of the health center program requirements. It would also prohibit the Secretary from making an operating grant to a noncompliant center unless the applicant can provide assurance that within 120 days of receiving grant funding it will submit an implementation plan to meet the health center program’s requirements. The provision would permit the Secretary to extend the 120-day period if the health center demonstrates good cause. Second, the provision would add language to permit operating grant funds to be used to purchase (1) data and information systems; (2) training and technical assistance; and (3) other activities that aim to reduce the costs associated with providing health services, improve health care access, enhance the quality and coordination of services that health centers provide, and improve the health status of communities.

New Access Points Grants

The provision would add a new subsection related to grants for “New Access Points and Expanded Services.” It would permit the Secretary to make these grants to health centers to establish new delivery sites and would add language giving special consideration to applicants that demonstrate that the new delivery site will be located in either a sparsely populated area or an area with a high level of unmet need relative to other applicants. The provision would also specify that when making these awards, the Secretary would be required to ensure that the ratio of

awards to health centers that serve rural populations relative to those that serve urban populations is not less than a two-to-three ratio or greater than a three-to-two ratio. The provision would also authorize the Secretary to consider when making grants where an applicant for a new delivery site would overlap the catchment area of an existing delivery site, and whether such overlap is justified based on the unmet needs of the population that the applicant proposes to serve (i.e., its catchment area).

Expanded Service Grants

The provision would add new language related to approving expanded service applications. It would authorize the Secretary to approve applications for grants that would expand the capacity of health centers to provide required primary health services or additional services. It would also authorize the Secretary to give special consideration to applicants that propose to expand services to address emerging public health or behavioral health issues through increasing the availability of additional health services in areas in which there are significant barriers to accessing care. The provision would also specify that when making these awards the Secretary would be required to ensure that the ratio of awards to health centers that serve rural populations relative to those that serve urban populations is not less than a two-to-three ratio or greater than a three-to-two ratio.

Health Centers for the Homeless

The provision would add language specifying that grants for Health Centers for the Homeless would include homeless veterans and veterans at risk of homelessness in their target service population.

Health Center Grant Applications

This provision would make changes to health center applications to specify that applicants describe the unmet health services needs of their service areas. In addition, the provision would require that applicants demonstrate that they have consulted with appropriate state and local government agencies and health care providers regarding the need for health services at the proposed delivery site. It would amend the Secretary's requirements when approving a grant to broaden the requirements associated with assessing whether the health center has made efforts to establish relationships with health care providers in its catchment area. Specifically, it would add language that would require the Secretary to consider whether the health center has made efforts to collaborate with other health care providers in its catchment areas, including local hospitals and specialty providers with the goal of increasing collaboration with these providers to reduce the non-urgent use of hospital emergency departments for non-urgent conditions.

Health Center Governance, Technical Assistance, and Auditing Requirements

The provision would specify that a health center's governing board would approve the health center director, who would be required to be directly employed by the center, and would add new language requiring the health center to have in place written policies to ensure the appropriate use of federal funds, in accordance with applicable federal statute, regulations, and the terms and conditions of the federal grant. It would restrict the funds available for technical assistance and operational support activities to an amount that would not exceed 3% of the funds appropriated for this section in a given fiscal year. It would restrict the Secretary's authority to waive a health center's auditing requirements to one year without the ability to extend the waiver into the next consecutive year.

Health Center Reporting

The provision would amend the required health center funding report, specifying which congressional committees would receive the report and adding that the report would include certain specified elements, including funding distribution by geography and grant types, information on unexpended funding and funding for loan guarantees, and information on health center closures, among others.

Health Center Research Project Participation

The provision would appropriate \$25 million for FY2018 to support the participation of health centers in the “All of Us Research Program,” part of the Precision Medicine Initiative (PMI) under PHSA Section 498E.¹⁵ This funding would be in addition to (1) funds made available to the CHCF under this provision, (2) funds previously made available to the CHCF, and (3) funds made available to the National Institutes of Health.¹⁶

Individualized Wellness Plans

This provision would strike language that authorizes grants for a pilot program to develop individualized wellness plans at not more than 10 CHCs.

National Health Service Corps Funding

This provision would extend funding for the NHSC by providing \$310 million for each of FY2018 and FY2019.

Teaching Health Center GME Funding

The provision would make several changes to the Teaching Health Center GME Program. It would permit payments to be made to support the residency training of (1) the current trainee level in existing programs, (2) new residents trained in existing programs, and (3) new residents training in new programs. With regard to newly established residency programs, the provision would give funding preference to programs in HPSAs/MUAs or programs located in rural areas. The provision would strike the \$15 million provided for the first quarter of FY2018 and would instead provide \$126.5 million for each of FY2018 and FY2019, to remain available until expended. It would also restrict the amount of funds the Secretary would be permitted to use to administer the program to 5% of the amount provided in any fiscal year.

The provision would amend the program’s reporting requirements to require additional data on (1) the volume of care that residents supported under the program provide and (2) the number and percentage of graduated residents who enter into primary care practice and the number and percentage of graduated residents who do so in an HPSA, MUA, or a rural area. The provision would also require that the HHS Secretary submit a report to Congress not later than March 31, 2019, on the direct and indirect expenses associated with the additional costs of teaching residents at teaching health centers. It defines the term “new approved graduate medical residency training

¹⁵ For information about the All of Us Research Program, see U.S. Department of Health and Human Services, National Institutes of Health, “All of Us Research Program,” <https://allofus.nih.gov/>.

¹⁶ For information about funding for the National Institutes of Health (NIH), see NIH section in CRS Report R44916, *Public Health Service Agencies: Overview and Funding (FY2016-FY2018)*.

program” and specifies that the requirements for THCGME that were in effect prior to enactment will remain in effect with respect to THCGME payments made for fiscal years prior to FY2018.

Funding Restrictions

Finally, the provision would apply existing restrictions on the use of funds for abortions (included in the Consolidated Appropriations Act, 2017 [P.L. 115-31]) to funds appropriated by this act to health centers, the NHSC, and qualified teaching health centers for FY2018 and FY2019.¹⁷

Section 102. Extension for Special Diabetes Programs

Current Law

The Special Diabetes Program for Type I Diabetes (PHSA, §330B) provides funding for the National Institutes of Health (NIH) to award grants for research into the prevention and cure of Type I diabetes. The Special Diabetes Program for Indians (PHSA, §330C) provides funding for the Indian Health Service (IHS) to award grants for services related to the prevention and treatment of diabetes for American Indians and Alaska Natives who receive services at IHS-funded facilities. These programs were created in the Balanced Budget Act of 1997 (P.L. 105-33), which transferred \$30 million annually from CHIP funds to each program from FY1998 through FY2002. The program’s funding was extended and increased in subsequent legislation. Most recently, MACRA provided \$150 million for each program for each of FY2016 and FY2017. These programs had been funded in tandem; however, the Special Diabetes Program for Indians received \$37.5 million in the Disaster Tax Relief and Airport and Airway Extension Act of 2017 (P.L. 115-63) for the first quarter of FY2018. No similar amount was provided for the Special Diabetes Program for Type I Diabetes.

¹⁷ Specifically, Division H, Title V, Sections 506 and 507 of P.L. 115-31 state that

(a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion. (b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion. (c) The term “health benefits coverage” means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement. §507. (a) The limitations established in the preceding section shall not apply to an abortion—(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. (b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State’s or locality’s contribution of Medicaid matching funds). (c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State’s or locality’s contribution of Medicaid matching funds). (d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. (2) In this subsection, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

Provision

This provision would extend funding for the Special Diabetes Program for Type I Diabetes at the current funding level (\$150 million annually) for FY2018 and FY2019. The provision would also enact an appropriation of \$150 million for each of FY2018 and FY2019 for the Special Diabetes Program for Indians.

Section 103. Extension for Family-to-Family Health Information Centers

Current Law

The Family-to-Family Health Information Centers program funds family-staffed and family-run centers in the 50 states and the District of Columbia. The Family-to-Family Health Information Centers provide information, education, technical assistance, and peer support to families of children (including youth) with special health care needs and health professionals who serve such families. In addition, the centers help ensure that families and health professionals are partners in decisionmaking at all levels of care and service delivery.¹⁸ HRSA administers this program. The program began in 2005 as part of the Deficit Reduction Act of 2005 (DRA; P.L. 109-171). The Family-to-Family Health Information Centers received an annual direct appropriation of \$3 million for FY2007, which increased to \$5 million for FY2009 through FY2017. The program's appropriation was most recently extended in MACRA.

Provision

This provision would extend funding for the Family-to-Family Health Information Centers program for FY2018 and FY2019. It would provide \$6 million in each year. The provision would also amend SSA Section 701 to require that Family-to-Family Health Information Centers be developed in the territories (as defined)¹⁹ and that at least one center be developed for Indian Tribes. It would also define the terms “Indian Tribe,” “State,” and “territory.”

Sec. 104. Youth Empowerment Program; Personal Responsibility Education

Current Law: Title V Abstinence Education Program/Youth Empowerment Program

The 1996 welfare reform law (P.L. 104-193) established a “Separate Program for Abstinence Education” under Title V of the Social Security Act.²⁰ The purpose of this program—commonly referred to as the Title V Abstinence Education Grant program—is to fund states and territories in providing abstinence education and (optionally, where appropriate) mentoring, counseling, and

¹⁸ For more information, see “Children with Special Needs,” at <https://mchb.hrsa.gov/maternal-child-health-initiatives/mchb-programs>.

¹⁹ The provision defines territory to mean Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Northern Mariana Islands.

²⁰ Section 510 of the Social Security Act (42 U.S.C. §710).

adult supervision to promote abstinence from sexual activity, “with a focus on those groups which are most likely to bear children out-of-wedlock.” Such groups are not defined in the law.

The Title V Abstinence Education Grant program is funded through mandatory spending. P.L. 104-193 provided \$50 million to the program per year for five years (FY1998-FY2002). Subsequently, the grant was funded through various extensions of that spending. Most recently, MACRA increased funding for the program to \$75 million per year for FY2016 and FY2017.

Title V Abstinence Education Grant funds must be used exclusively for teaching abstinence and may not be used in conjunction with, or for, any other purpose. The law defines the term “abstinence education” as an educational or motivational program that

- has as its exclusive purpose, teaching the social, psychological, and health gains of abstaining from sexual activity;
- teaches that abstinence from sexual activity outside of marriage is the expected standard for all school-age children;
- teaches that abstinence is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted infections (STIs), and associated health problems;
- teaches that a mutually faithful monogamous relationship within marriage is the expected standard of human sexual activity;
- teaches that sexual activity outside of marriage is likely to have harmful psychological and physical effects;
- teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society;
- teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- teaches the importance of attaining self-sufficiency before engaging in sex.

States and territories are eligible to request Title V Abstinence Education Grant funds for a given fiscal year if they submit an application for Maternal and Child Health (MCH) Block Grant funds for that same fiscal year. The MCH Block Grant, authorized under Title V of the Social Security Act, is a flexible source of funds that states use to support maternal and child health programs.²¹ All states, the District of Columbia, and six territories (American Samoa, Federated States of Micronesia, Guam, Northern Mariana Islands, Republic of the Marshall Islands, and Republic of Palau) receive MCH Block Grant funds and therefore are eligible to apply for Title V Abstinence Education funds. In FY2017, 37 states and two territories (Puerto Rico and the Federated States of Micronesia) applied for Abstinence Education funding.²² Jurisdictions can choose to make sub-

²¹ For further information, see CRS Report R42428, *The Maternal and Child Health Services Block Grant: Background and Funding*.

²² The states are Alabama, Alaska, Arkansas, Colorado, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, and Wisconsin. For further information, see HHS, Administration for Children and Families (ACF), Family and Youth Services Bureau (FYSB), “2017 Title V State Abstinence Education Program Grant Awards,” January 19, 2017, <https://www.acf.hhs.gov/fysb/resource/2017-aegp-awards>.

awards to local organizations and may focus on youth in specific geographic areas (e.g., urban, rural, suburban).²³

Abstinence Education Grant funds are allocated to each jurisdiction based on its relative proportion of low-income children nationally.²⁴ The FY2015 annual appropriations law (P.L. 113-235) included a provision that enabled HHS to reallocate FY2015 Abstinence Education funds that would have been designated for states that did not apply for the funds. These FY2015 funds were available only to the states that had applied for the funds as long as the funds were to be used for implementing “abstinence education,” as the term is defined in the law. MACRA extended this language to program funding for FY2016 and FY2017.²⁵

Title V of the Social Security Act specifies that selected sections of the act that apply to allotments made under the MCH Block Grant—including Sections 503 (Payments to States), 507 (Criminal penalty for false statement), and 508 (Nondiscrimination)—also apply to the allotments made under the Abstinence Education program. In addition, the HHS Secretary can determine the extent to which other sections, Section 505 (Application for block grant funds) and Section 506 (Reports and audits), also apply to Abstinence Education allotments.

Title V of the Social Security Act does not address evaluation activities for the Abstinence Education Grant program; however, the Balanced Budget Act of 1997 (P.L. 105-133) directed HHS to conduct evaluation activities of the Title V Abstinence Education program.²⁶

Provision

Section 104 would rename the Abstinence Education program as the Youth Empowerment program and replace existing law with new provisions. Specifically, the bill would include requirements for the Youth Empowerment program’s funding, financial allotments, educational elements, research and data, and evaluation. The effective date for these changes would be retroactive to October 1, 2017.

Funding

Section 104 would provide \$75 million in mandatory spending for each of FY2018 and FY2019 to the Youth Empowerment program. The HHS Secretary would be required to reserve, for each

²³ HHS, ACF, FYSB, *Title V State Abstinence Education Grant Program Combined FY 2016 and FY 2017 Announcement*, HHS-2016-ACF-ACYF-AEGP-1131.

²⁴ Section 510(a)(2) of the Social Security Act, which references the MCH Block Grant at Section 502(c)(1)(B)(ii). Census data are not available for the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Thus, the allocations for these three entities, when applicable, are based on the amounts allocated to them by HHS in prior fiscal years. HHS, ACF, FYSB, *Title V State Abstinence Education Grant Program Combined FY 2016 and FY 2017 Announcement*, HHS-2016-ACF-ACYF-AEGP-1131. (Hereinafter, HHS, ACF, FYSB, *Title V State Abstinence Education Grant Program Combined FY 2016 and FY 2017 Announcement*.)

²⁵ P.L. 113-235 and MACRA did not amend Title V of the Social Security Act. Rather, these laws included stand-alone provision that applied only to funding for FY2015 through FY2017.

²⁶ This was a stand-alone provision that did not amend Title V of the Social Security Act. In response, HHS undertook a multiyear evaluation that involved a study of how grantees in four states implemented abstinence education programs and a separate study that rigorously evaluated whether grantees’ programs had impacts on teen sexual abstinence and related outcomes. The impact evaluation found that youth who received abstinence education under the program did not have different outcomes than those youth in the control group. Barbara Devaney, *The Evaluation of Abstinence Education Programs Funded Under Title V Section 510: Interim Report*, Mathematica Policy Research, Inc., for HHS, ACF, Assistant Secretary for Planning and Evaluation (ASPE), April 2002; and Christopher Trenholm et al., *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report*, Mathematica Policy Research, Inc. for HHS, ACF, ASPE, April 2007.

of these two years, up to 20% of the funding for administering the program. Such administrative funding would include funding for HHS to conduct a national evaluation(s) of the program and provide technical assistance to states and territories that receive funding.

Financial Allotments

Section 104 would direct HHS to make Youth Empowerment allotments to states and territories that have applied for FY2018 and FY2019 MCH Block Grant funds. Allotments would be based on two factors. First, funding would be available based on the amount appropriated to the program minus the reservation of funds (up to 20%) for administering the program. Second, funds would be allocated to states based on their relative proportion of low-income children nationally.

Section 104 would further allow HHS to competitively award FY2018 and FY2019 funds to one or more entities within a state that had not applied for its share of funding. The entity or entities would receive the amount that would have been otherwise allotted to that state. The HHS Secretary would be required to publish a notice to solicit grant applications for the remaining competitive funds. The solicitation would need to be published within 30 days after the deadline for states to apply for MCH Block Grant funds. Eligible states would be required to apply for the Youth Empowerment funds no later than 120 days after the deadline closed for states to apply for MCH Block Grant funds.

Sexual Risk Avoidance Education

Youth Empowerment program funds would be available to a state or other entity (in a state that did not apply for funds) to implement education exclusively on sexual risk avoidance, meaning voluntarily refraining from sexual activity. States or other entities would be required to implement sexual risk avoidance education that is medically accurate and complete, age-appropriate, and based on adolescent learning and developmental theories for the age group receiving the education. In addition, sexual risk avoidance education would need to ensure that the “unambiguous and primary emphasis and context” for each of six sexual risk avoidance topics is “a message to youth that normalizes the optimal health behavior of avoiding nonmarital sexual activity.” The sexual risk avoidance topics include the following:

- The holistic individual and societal benefits associated with personal responsibility, self-regulation, goal setting, healthy decisionmaking, and a focus on the future.
- The advantage of refraining from nonmarital sexual activity in order to improve the future prospects and physical and emotional health of youth.
- The increased likelihood of avoiding poverty when youth attain self-sufficiency and emotional maturity before engaging in sexual activity.
- The foundational components of healthy relationships and their impact on the formation of healthy marriages and safe and stable families.
- How other youth risk behaviors, such as drug and alcohol usage, increase the risk for teen sex.
- How to resist, avoid, and receive help regarding sexual coercion and dating violence, recognizing that even with consent teen sex remains a youth risk behavior.

Section 104 would specify that if sexual risk avoidance education includes any information about contraception that such information is medically accurate and students understand that

contraception reduces physical risk but does not eliminate risk. In addition, sexual risk avoidance education could not include demonstration, simulations, or distribution of contraceptive devices.

Research and Data Requirements

Section 104 would specify that a state or other entity receiving funding under the Youth Empowerment program may use up to 20% of such allotment to build the evidence base for sexual risk avoidance by conducting or supporting research. Any such research would have to be rigorous, evidence-based, and designed and conducted by independent researchers who have experience in conducting and publishing research in peer-reviewed outlets. A state or other entity would be required, as specified by the Secretary, to collect information on the programs and activities funded through their allotments and submit reports to HHS on the data collected from such programs and activities.

National Evaluation

Section 104 would direct HHS to conduct one or more rigorous evaluations of the education activities funded through the Youth Empowerment program. This evaluation would be conducted in consultation with “appropriate State and local agencies.” HHS would be required to submit a report to Congress on the results of the evaluation that also included a summary of the information collected by states and then reported on to HHS.

Application of MCH Block Grant Provisions

As with the authorizing law for the Title V Abstinence Education program, Section 104 would specify that selected sections of the Social Security Act that apply to allotments under the MCH Block Grant would also apply (or could apply, per the HHS Secretary’s discretion) to allotments under the Youth Empowerment program.

Current Law: Personal Responsibility Education Program (PREP)

ACA Section 2953 established the Personal Responsibility Education Program under Title V of the Social Security Act.²⁷ The program is a broad approach to teen pregnancy prevention that seeks to educate adolescents aged 10 through 19 and pregnant and parenting youth under age 21 on both abstinence and contraceptives to prevent pregnancy and STIs. ACA provided \$75 million annually in mandatory spending for each of five fiscal years (FY2010 through FY2014). PREP authorization was most recently extended, by MACRA, for FY2015 through FY2017.

All states, the District of Columbia, and all territories are eligible for State PREP funding. Funds are allocated by formula, which is based on the proportion of youth aged 10 through 19 in each jurisdiction relative to other jurisdictions. If a state or territory did not submit an application for formula funding in FY2010 or FY2011, it was ineligible to apply for funding for each of FY2010 through FY2017. Local organizations, including faith-based organizations or consortia, in such a state or territory are eligible to competitively apply for funding. The law specifies that funding is to be provided as three-year grants to carry out programs and activities that would have otherwise been carried out by the state. In practice, HHS refers to these grants as Competitive PREP.²⁸

²⁷ Section 513 of the Social Security Act (42 U.S.C. §513).

²⁸ HHS has awarded Competitive PREP funding for FY2012 through FY2014 to organizations that declined funding in FY2010 or FY2011, and has awarded Competitive PREP funding for FY2015 through FY2017 to organizations in states that declined funding in FY2016 and FY2017.

HHS also provides PREP grants to Indian tribes and tribal organizations (known as Tribal PREP), as well as grants to implement innovative strategies (known as PREIS). Tribal PREP grants are intended to support projects that educate American Indian and Alaska Native youth, including pregnant and parenting youth, on both abstinence and contraceptives to prevent pregnancy and STIs. PREIS grants are intended to build evidence on promising teen pregnancy prevention programs for high-risk, vulnerable, and culturally underrepresented youth populations. The law specifies that these populations include youth aged 10 to 20 in foster care, homeless youth, youth with HIV/AIDS, pregnant and parenting women who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth.

Provision

Section 104 would provide \$75 million for PREP in each of FY2018 and FY2019. It would also extend to FY2019 the three-year Competitive PREP grants that were awarded for any of FY2015 through FY2017. In addition, Section 104 would specify that victims of human trafficking are considered high-risk, vulnerable, and culturally underrepresented youth for purposes of the PREIS program. The amendments would be retroactively effective as of October 1, 2017.

Title II—Offsets

Section 201. Providing for Qualified Health Plan Grace Period Requirements for Issuer Receipt of Advance Payments of Cost-Sharing Reductions and Premium Tax Credits that are More Consistent with State Law Grace Period Requirements

Current Law

ACA Section 1412(c)(2)(B)(iv)(II) provides a three-month grace period before a qualified health plan issuer can discontinue an individual's health insurance coverage for failure to pay the monthly premium. This grace period applies only to individuals who receive an advance premium tax credit through an exchange and have previously paid at least one month's full premium during the benefit year.²⁹

Provision

This provision would eliminate the reference to a three-month grace period in ACA Section 1412(c)(2)(B)(iv)(II) and insert a new subparagraph specifying a grace period before coverage is cancelled due to nonpayment of premiums. For plan years beginning before January 1, 2018, the grace period would be three months. For plan years beginning on or after January 1, 2018, the grace period would be established by state law, or if there is none, a one-month grace period. The Comptroller General would be required to submit a report to Congress on the effects of aligning grace periods under Medicaid, Medicare, and the exchanges, and the extent to which such alignment may reduce fraud, waste, and abuse in the Medicaid program.

²⁹ For information on qualified health plans and health insurance exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

Section 202. Prevention and Public Health Fund

Current Law

ACA Section 4002 established the Prevention and Public Health Fund (PPHF), to be administered by the HHS Secretary, and provided it with a permanent annual appropriation.³⁰ The PPHF is intended to support an “expanded and sustained national investment in prevention and public health programs.” In general, PPHF funds have been distributed to HHS agencies in the Public Health Service, in particular the Centers for Disease Control and Prevention (CDC). Amounts for each fiscal year are available to the HHS Secretary beginning October 1, the start of the respective fiscal year. Congress may explicitly direct the distribution of PPHF funds and did so for FY2014 through FY2018.

Under the ACA, the PPHF’s annual appropriation would increase from \$500 million for FY2010 to \$2 billion for FY2015 and each subsequent fiscal year. Congress has amended the provision two times, using a portion of PPHF funds as an offset for the costs of other activities. Annual appropriations to the PPHF in current law are as follows:

- \$500 million for FY2010;
- \$1.0 billion for each of FY2012 through FY2017;³¹
- \$900 million for each of FY2018 and FY2019;
- \$1.0 billion for each of FY2020 and FY2021;
- \$1.5 billion for FY2022;
- \$1.0 billion for FY2023;
- \$1.7 billion for FY2024; and
- \$2.0 billion for FY2025 and each fiscal year thereafter.³²

Provision

Section 202 would amend ACA Section 4002(b), repealing \$7.4 billion in appropriations from FY2019 through FY2027, by decreasing, but not eliminating, amounts appropriated to the fund for each of those fiscal years. The provision would not affect FY2018 appropriations to the fund, which have already been distributed.³³

³⁰ For more information, see CRS Report R44796, *The ACA Prevention and Public Health Fund: In Brief*.

³¹ The ACA also appropriated \$750 million to the Prevention and Public Health Fund for FY2011. This line of text was removed from the provision in P.L. 112-96 in 2012, which did not affect the availability of FY2011 funds.

³² Amounts do not reflect sequestration of funds for FY2013 and subsequent fiscal years.

³³ For more information see CRS Report R44978, *Overview of Continuing Appropriations for FY2018 (P.L. 115-56)*.

Author Contact Information

Elayne J. Heisler, Coordinator
Specialist in Health Services
eheisler@crs.loc.gov, 7-4453

Adrienne L. Fernandes-Alcantara
Specialist in Social Policy
afernandes@crs.loc.gov, 7-9005

Bernadette Fernandez
Specialist in Health Care Financing
bfernandez@crs.loc.gov, 7-0322

Sarah A. Lister
Specialist in Public Health and Epidemiology
slister@crs.loc.gov, 7-7320