Key Medicaid, CHIP, and Low-Income Provisions in the House Tri-Committee Health Reform Bill (Released July 14, 2009)

On July 14, 2009, the House Committees on Ways and Means, Energy and Commerce, and Education and Labor introduced a revised health reform bill, America's Affordable Health Choices Act of 2009. The Congressional Budget Office estimates that by 2015 under the bill's provisions, 94 percent of the non-elderly population would have health insurance. In that year, an additional 9 million individuals (mostly childless adults) would obtain coverage through Medicaid and 27 million through a new health insurance Exchange.

The bill would specifically:

- Strengthen the employer-based coverage system by requiring employers (with exceptions for small businesses) to either offer their workers qualified coverage and make a minimum contribution to the premium cost or pay a payroll tax (from 2 to 8 percent depending on the firm's size);
- Create a national health insurance Exchange that can be used by individuals (and some small employers) without other options to purchase coverage through a public plan or private insurers;
- Provide Medicaid to those with family income up to 133 percent of the federal poverty level (FPL);
- Create subsidies to help people with income up to 400 percent of the FPL purchase Exchange coverage and limit their out-of-pocket costs;
- Establish a new mandate that people have coverage or face a tax penalty (with some exceptions);
- Adopt insurance market reforms, such as eliminating the practice of denying people coverage because they are sick or charging different premiums for people based on their health status and other risk factors; and
- Impose a tax surcharge on those with adjusted gross income above $350,000 (for married couples, filing jointly) and $280,000 (for single individuals) to provide a revenue source.

Since many of the bill's major structural components have been addressed in detail in more general discussions of health reform, this fact sheet provides an overview of some of the bill's proposed changes to Medicaid and CHIP, as well as other provisions of particular importance to low-income families and children.

1. Medicaid and CHIP Eligibility

Under the House bill, Medicaid – which already serves as a cornerstone of coverage for millions of low-income seniors, people with disabilities, pregnant women, children and parents – is a key building block for health reform. The following provisions go into effect in 2013, unless otherwise noted.

Eligibility Changes for Adults

- **New Medicaid coverage for non-disabled childless adults under age 65 up to 133 percent of the FPL.** The federal government would finance 100 percent of the cost of enrolling these individuals in Medicaid.

- **Expanded Medicaid coverage for non-elderly parents and people with disabilities up to 133 percent of the FPL.** In all states, these categories of people are covered, but often at income levels well below the poverty line. The federal government would pick up 100 percent of the cost of covering people between a state's current income threshold and 133 percent of the FPL.

- **Maintenance-of-effort on existing Medicaid coverage above 133 percent of the FPL.** States would be required to maintain Medicaid eligibility standards, methodologies, and procedures in effect as of June 16, 2009. States would not receive additional financial support for these individuals unless they are covered under existing waivers. In addition, states must eliminate any asset test used to determine eligibility for children, parents, and many childless adults in Medicaid.

Eligibility Changes for Children

- **Children ages six to 18 up to 133 percent of the FPL are shifted to Medicaid.** States must already provide Medicaid to children under age six with family income up to 133 percent of the FPL and to school-aged children (ages six through 18) with family income up to 100 percent of the FPL. All states have chosen to provide Medicaid or CHIP above that level. Those that provide coverage to school-aged children with family income between 100 and 133 percent of the FPL through a separate CHIP program would need to shift them to Medicaid. States would receive 100 percent federal funding for the cost of covering these children. In addition, states would be required to maintain eligibility standards, methodologies, and procedures on existing Medicaid coverage for children above 133 percent of the FPL in effect on June 16, 2009.

- **Expiration of the CHIP program on September 30, 2013; CHIP children moved into Exchange plans.** The House bill allows CHIP to expire on its next reauthorization date. All children currently eligible for CHIP would become eligible for Exchange plans on January 1, 2013. The Secretary of Health and Human Services would determine whether a state and the Exchange have a good transition process in place before children are moved from CHIP to acceptable coverage. These children would receive the coverage and cost sharing provided through Exchange plans, which may not be comparable to what is now available through CHIP.

- **Short-term maintenance-of-effort on CHIP coverage**. Through January 1, 2013, states would be required to maintain their CHIP eligibility rules, methodologies, and procedures that they had in place as of June 16, 2009, including through waivers that remain in effect. The bill would allow states to limit CHIP enrollment through a cap if a state's federal funding runs out.

- **Automatic enrollment of otherwise uninsured infants into Medicaid.** The provision builds on the existing requirement that babies born to mothers on Medicaid be

automatically enrolled. The federal government would finance 100 percent of the cost of enrolling babies into this new eligibility category for 60 days, at which time there would be a determination of their eligibility for Medicaid or Exchange subsidies.

- **A 12-month guarantee of coverage for CHIP children in states with separate CHIP plans.** Stand-alone CHIP programs would be required, effective January 1, 2010, to implement 12-months continuous eligibility.

The bill makes no changes to current Medicaid and CHIP rules that provides states with the option to eliminate the five-year waiting period for lawfully residing children and pregnant women and receive federal matching funds. (Legal immigrants who are not eligible for Medicaid or CHIP due to the five-year waiting period would be eligible for subsidized coverage through the Exchange.)

2. Premium and Cost-Sharing Subsidies

The Tri-Committee bill establishes "affordability credits" to subsidize coverage for individuals and families who apply for health coverage through the Exchange. The following provisions would go into effect in 2013, when the Exchange becomes operational.

- **Affordability credits for lawfully present individuals in the Exchange up to 400 percent of the FPL.** Credits[1] would be set so that the premium contribution is no more than 1.5 percent of income for individuals with income at or below 133 percent of the FPL and no more than 11 percent of income for individuals with income at or above 400 percent of FPL. Out-of-pocket costs for everyone in the Exchange would not exceed $5,000 for an individual or $10,000 for a family; however, those receiving the premium credits would also receive a reduction in cost sharing. There would be no cost sharing for preventive services.

- **Income in prior tax year used to determine eligibility for the affordability credits.** Eligibility would be evaluated based on adjusted gross income in the prior tax year, and the accuracy of the information would be verified, when possible, via federal income tax data. Special procedures would be developed for people who do not file returns or who experience a significant change in circumstances.

2. Coordination of Coverage between Medicaid and the Exchange

Under the House bill people with limited incomes would be eligible for either Medicaid or Exchange subsidies. The bill includes provisions on how these coverage options intersect and how people will navigate between the different pathways.

- **Childless adults eligible for Medicaid have option to enroll in Exchange if privately covered for the preceding six months.** These adults applying through the Exchange would have the choice to enroll in Medicaid or the Exchange. Those choosing Medicaid would be automatically enrolled.

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[1] The size of subsidy for a person at any given income level is pegged to the average premium for the three lowest-cost basic plans in the area in which someone resides.

- **Coordination of procedures between Medicaid and Exchange.** Each state must enter a Memorandum of Understanding with the Exchange to coordinate coverage for Medicaid-eligible individuals. Traditional Medicaid beneficiaries applying through the Exchange who are determined to be eligible for Medicaid would be transferred to the appropriate state Medicaid agency. The individuals would, at state option, either be automatically enrolled in Medicaid or presumptively enrolled while the state Medicaid agency conducts a full eligibility determination. The state must use the income information provided by the Exchange.

- **State Medicaid agency may administer affordability credits.** The Exchange can contract with a state Medicaid agency to determine whether an Exchange-eligible person is eligible for the affordability credits. States taking on this function would be reimbursed.

4. Health Care Benefits and Access

The Tri-Committee bill includes a number of provisions related to combating health care disparities and transforming the health care delivery system, including the changes for Medicaid described below. In addition, the bill includes provisions for setting a standard benefit package.

- **Pediatric benefits included in the standard benefit package, but details to be determined later.** All qualified health benefits plans (except grandfathered plans) would be required to provide at least an "essential benefits package." The package must be equivalent in value to the "average prevailing employer-sponsored coverage." It must include certain pediatric services, including "well baby and well child care and oral health, vision, and hearing services, equipment, and supplies." However, a new Health Benefits Advisory Committee and the Secretary of HHS would determine specific coverage details.

- **Higher Medicaid reimbursement rates for primary care services.** The new federal minimum standard would be set at 80 percent of Medicare rates in 2010, 90 percent in 2011, and 100 percent in 2012. The cost of increasing the rates would be borne by the federal government.

- **Addition of preventive services for adults to Medicaid package.** Requires states, beginning in 2010, to provide adults with new preventive services, which could not be subject to cost sharing. States would receive their regular matching rate to provide the new coverage.

- **New federal funding for medical home pilot programs, including in Medicaid**.

- **Other provisions to improve coverage and access to care.** The Tri-Committee bill also allows states to provide optional Medicaid coverage to low-income HIV-infected individuals (through 2013), expands state flexibility to provide family planning coverage, and implements a community prevention health program.