Key Medicaid, CHIP, and Low-Income Provisions in the House Tri-Committee Health Reform Bill

On June 19, 2009, the House Committees on Ways and Means, Energy and Commerce, and Education and Labor introduced a draft health reform bill. Like other major health reform proposals, it seeks to expand coverage, control costs, and improve quality. Its specific provisions include:

- Strengthening the employer-based coverage system by requiring employers (with exceptions for small businesses) to either offer coverage to their workers and contribute to the premium cost or pay a tax equal to eight percent of the employer's payroll;
- Creating a national "Exchange" that can be used by individuals (and some small employers) without other options to purchase coverage through a public plan or private insurers;
- Expanding Medicaid;
- Providing subsidies or "affordability credits" to help people purchase Exchange coverage and limit their out-of-pocket costs;
- Adopting 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
- Creating a new mandate that people have coverage or face a tax penalty.

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 Changes

The House bill is designed to strengthen and expand the Medicaid program, which already serves as a cornerstone of coverage for millions of low-income seniors, people with disabilities, pregnant women, children and parents. As such, some provisions make dramatic changes to Medicaid and CHIP and will need further specification in order to determine their impact on children and low-income families.

Eligibility Changes for Adults

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

- **Expanded Medicaid coverage for parents and people with disabilities under age 65 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 eligibility standards, methodologies, and procedures in effect as of June 16, 2009 (coverage through Section 1115 waivers is exempted).

Eligibility Changes for Children

- **Children (ages six to 18) up to 133 percent of the FPL shifted to Medicaid.** States must already provide Medicaid to children under age six with family income up to 133 percent of the FPL. In addition, states are already required to provide Medicaid to school-aged children (ages six through 18) with family income up to 100 percent of the FPL, and all states have chosen to provide Medicaid or CHIP above that level. Therefore, those that provide CHIP to school-aged children with family income between 100 and 133 percent of the FPL 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.

- **Short-term maintenance-of-effort on CHIP coverage**. Through September 30, 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.[1]

- **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, after which time children receiving, or eligible for, CHIP would be covered through Exchange plans. The bill, however, does not specify whether the coverage and cost-sharing protections provided by Exchange plans will be comparable to what is now available through CHIP, nor does it describe in detail how the transition process would occur.

- **Automatic enrollment of otherwise uninsured infants into Medicaid during their first year of life.** 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.

2. Coordination of Coverage between Medicaid and the Exchange

The House bill would allow Medicaid beneficiaries to enroll in coverage through the Exchange under specific circumstances. This is a significant change in how Medicaid has operated, and the bill does not answer all of the questions about how it might work.

- **Beginning in 2018, traditional Medicaid beneficiaries allowed to enroll in Exchange plans at state request if certain conditions are met.** Traditional Medicaid beneficiaries include children, parents, pregnant women, and people with disabilities. To implement this option:

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[1] The Tri-Committee bill appears to have intended to allow states to take steps (possibly including enrollment caps) to limit their CHIP programs to those for whom federal matching funds are available, but due to an apparent drafting error it is not possible to fully understand the intent. See Section 1803(a)(2).

- **A state must demonstrate its ability to provide wrap-around benefits** (i.e., provide coverage of items and services that would be covered in Medicaid, but that are not covered by the Exchange plan) to the traditional Medicaid beneficiaries.

- **Exchange plans must be deemed capable of supporting this population before they can begin enrolling**.

- **Childless adults eligible for Medicaid have option to enroll into Exchange plans under certain circumstances.** This provision would only apply to childless adults who had been enrolled in private coverage during the preceding six months.

- **Per capita payments made by states for Medicaid beneficiaries entering the Exchange.** The size of the payment would be based on the cost of providing the individual with an affordability credit in the Exchange (see below) multiplied by the share of costs that the state would pay, on average, for such a person if he or she instead remained in Medicaid.[2]

- **Coordination procedures between Medicaid and Exchange.** The bill would coordinate coverage for Medicaid-eligible individuals who are also eligible to enroll in the Exchange. Specifically, non-traditional beneficiaries who apply through the Exchange could be automatically enrolled into Medicaid and traditional beneficiaries could either be, at state option,:

  - Enrolled automatically in Medicaid, or
  - Presumptively enrolled in Medicaid for 90 days while the state Medicaid agency conducts a full eligibility determination, using the income information provided by the Exchange.

  In addition, all Medicaid-eligible individuals, whether they initially chose to enroll in the Exchange or not, could change their mind during a yearly open enrollment period. The bill, however, leaves far more open the question of coordinating enrollment for people who apply through the Exchange but are only eligible for Medicaid. For example, would that person need to reapply for coverage at a Medicaid office?

3. Premium and Cost-Sharing Affordability Credits

The Tri-Committee bill establishes "affordability credits" to subsidize coverage for individuals and families with income up to 400 percent of the FPL.

- **Affordability credits for lawfully present individuals in the Exchange up to 400 percent of the FPL.** Credits[3] would be set so that the premium contribution is no more than one percent of income for individuals with income at or below 133 percent of the

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[2] Note also that if a state is in the top 50 percent of states in reducing uninsured rates between now and 2013, it would receive a permanent 50 percent reduction in the size of its per capita payment obligation for Medicaid beneficiaries who go into the Exchange.

[3] 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.

FPL and no more than 10 percent of income for individuals with income at 400 percent of FPL. In addition, limitations on out-of-pocket costs would be put into place on a sliding scale up to 400 percent of the FPL. For those with income at or below 133 percent the limit would be set at $250 per individual and $500 per family (adjusted annually).[4]

- **Eligibility for the affordability credits determined by the Exchange, or another designated agency such as a state Medicaid agency.** 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.

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 certain grandfathered individual and employer-sponsored plans) would be required to provide at least an "essential benefits package." This package would include certain pediatric services, such as well baby and well child care, oral health, vision, and hearing services, equipment, and supplies, however further details would be determined by a new Health Benefits Advisory Committee and the Secretary of HHS.

- **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.** The federal government would provide the CHIP enhanced matching rate to states for the cost of providing new preventive services, which could not be subject to cost sharing.

- **New federal funding for medical home pilot programs**. Up to $1.235 billion would be set aside over the next five years.

- **Enhanced funding for Medicaid eligibility systems.** States would be provided with 90 percent administrative matching funds for designing and implementing stronger Medicaid eligibility systems and up to a 75 percent match for ongoing operation of the systems.

- **Other provisions to improve coverage and access to care.** The Tri-committee bill also calls for coverage of tobacco cessation services, optional coverage of nurse home visitation services, an expansion in state flexibility to provide family planning coverage, and improvements in coverage of school-based services.

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[4] Out-of-pocket costs for everyone in the Exchange would not exceed $5,000 for an individual or $10,000 for a family.