Key Medicaid, CHIP, and Low-Income Provisions in the Senate Health Reform Bill – Patient Protection and Affordable Care Act (As of December 24, 2009)

On December 24, 2009, the Senate approved its health care reform bill, the Patient Protection and Affordable Care Act. The Congressional Budget Office estimates that under the bill's provisions, by 2019, 92 percent of the non-elderly population would have health insurance (94 percent if undocumented immigrants are excluded from the calculation). In that year, an additional 15 million individuals (mostly childless adults and parents) would obtain coverage through Medicaid and 26 million through a new health insurance Exchange.[1]

Most of the bill's reforms would go into effect January 1, 2014. The major provisions of the bill would:

- Create state health Exchanges where individuals and small employers can buy insurance through private insurers or multi-state health plans under contract with the federal Office of Personnel Management. States have flexibility to allow large employers to participate in later years, establish co-operatives, opt into a national Exchange instead, and seek waivers to utilize other reform mechanisms.
- Provide Medicaid to non-elderly individuals with income up to 133 percent of the federal poverty level (FPL) and maintain current Medicaid and CHIP coverage for children above 133 percent of the FPL.
- Provide subsidies to help people with income up to 400 percent of the FPL purchase Exchange coverage and limit their out-of-pocket costs.
- Require certain employers to pay penalties for workers who receive a premium subsidy through a state Exchange. Imposes fees on firms that have a waiting period of more than 60 days. Certain small businesses, starting in 2010, could receive tax credits to assist in purchasing coverage.
- Establish a new mandate that people with income at or above 100 percent of the FPL have coverage or face a tax penalty (with some exceptions, including if the cost of coverage exceeds eight percent of income).
- Adopt insurance market reforms, such as eliminating the practice of denying people coverage because they are sick (implemented in 2010 for children), charging different premiums for people based on their health status, or establishing lifetime or annual limits (with exceptions). Soon after the bill's enactment, creates a temporary high-risk pool to assist families denied coverage prior to these new rules going into effect.

The bill would be paid for mostly through Medicare savings and an excise tax on high cost insurance plans that exceed $8,500 for single coverage and $23,000 for family coverage (with a higher limits for retirees over age 55 and certain high-risk professions). Additional revenue provisions include fees on certain manufacturers and insurers, tax on indoor tanning services, and an increase in hospital insurance contributions for higher income taxpayers.

The following 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] Congressional Budget Office, *Cost Estimate of the Patient Protection and Affordable Care Act, Senate Amendment 2786*, December 19, 2009.

1. Medicaid and CHIP

Under the Senate bill, Medicaid and CHIP–which already are the cornerstones of coverage for millions of low-income seniors, people with disabilities, pregnant women, children, and parents–serve as key building blocks for coverage. Most uninsured individuals and families not eligible for Medicaid or CHIP would be able to purchase coverage through an Exchange.

Eligibility Changes for Adults

- **Medicaid coverage for adults under age 65 with income up to 133 percent of the FPL.**[2] Only a handful of states provide Medicaid to childless adults and while all states cover parents, they often do so at income levels well below the poverty line. Eligibility for these populations would be based a gross income standard, without any disregards.[3]

- **Federal financial assistance for newly-eligible beneficiaries.** From 2014 through 2016, the federal government would pick up 100 percent of the cost of covering newly-eligible adults.[4] In 2017 and 2018, states would receive an increase in the federal match rate (FMAP) for covering newly-eligible adults, with more support initially provided to non-expansion states.[5] Beginning in 2019 and thereafter, states with newly-eligible adults would receive the same 32.3 percentage point FMAP increase (not to exceed 95 percent).

- **Federal financial assistance for "early implementer" states.** Certain states have already expanded coverage for childless adults and parents above 133 percent of the FPL, and as a result, have no newly-eligible adults. These early implementer states would receive a temporary (2014 through September 20, 2019) 2.2 percentage point increase in their FMAP for adults under 134 percent of the FPL. Massachusetts, which has already implemented health reform, will receive an additional .5 percentage point FMAP increase to cover currently eligible adults through 2016.

- **Temporary maintenance-of-effort on existing Medicaid coverage above 133 percent of the FPL.** States would be required to maintain existing Medicaid eligibility levels above 133 percent of the FPL until 2014 (when the state Exchanges are operational). Beginning in 2011, states with budget deficits could be exempted from maintaining eligibility levels above 133 percent of the FPL. States could provide coverage to adults above the 133 percent level, and receive their regular matching rate, but must ensure that a child of an eligible parent is enrolled in coverage prior to enrolling the parent.

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[2] States would be required to maintain current Medicaid coverage up to 133 percent of the FPL until 2014, when these provisions go into effect. Excludes Medicare recipients under age 65 who also receive Medicaid. Newly eligible adults would be covered by a benchmark benefit plan, as discussed further below. Starting in April 2010, states could cover adults prior to the 2014 implementation date (note that these states would be eligible for the increased FMAP starting in 2014 since these adults would be considered "newly-eligible").

[3] The bill establishes a new Modified Gross Income (MGI) standard that will be utilized in Medicaid, CHIP, and the Exchanges. MGI is defined as an individual's or family's gross household income with some adjustments. The MGI would not apply to certain groups, including the elderly, foster children, low-income Medicare beneficiaries and those receiving SSI.

[4] Newly-eligible adults are defined as childless adults and parents who, on the date of the bill's enactment, were not previously eligible for a full Medicaid benefit package up to133 percent of the FPL. Note that Nebraska would receive full federal funding for newly-eligible adults for all fiscal years. In addition, states recovering from a major disaster, most notably Louisiana, would also receive additional federal assistance beginning in 2011.

[5] An expansion state is defined as providing coverage, on the date of the bill's enactment, to childless adults and parents with income at or above 100 percent of the FPL. Non-expansion states would receive a FMAP percentage point increase of 34.3 in 2017 and 33.3 in 2018. Expansion states would receive a FMAP percentage point increase of 30.3 in 2017 and 31.3 in 2018.

- **Optional five-year waiting period for lawfully residing immigrants remains in effect**. The bill would not change current Medicaid (and CHIP) rules that require states to establish a five-year waiting period for lawfully residing adults (with state option to waive the waiting period for children and pregnant women). Since this population would be required to obtain coverage under the bill, low-income legal immigrants not eligible for Medicaid or CHIP due only to this restriction could seek subsidized coverage through an Exchange. Undocumented immigrants would remain ineligible for Medicaid and CHIP, and could not obtain coverage through the Exchanges.

Eligibility Changes for Children

- **Medicaid coverage for children with income up to 133 percent of the FPL.** States already must provide Medicaid to children under age six with family income up to 133 percent of the FPL and those ages six through 18 with family income up to 100 percent of the FPL. In addition, all states have chosen to provide coverage above these levels through a combination of Medicaid and CHIP. In 2014, states would provide all children with gross income up to 133 percent of the FPL with Medicaid (including those currently covered through CHIP). To limit currently eligible children from losing coverage, a state would be required to set its income eligibility threshold at a level that is not less than the "effective" levels (i.e., taking into account disregards and deductions) already in place.

- **Current Medicaid and CHIP eligibility levels for children maintained above 133 percent of the FPL through at least 2019.** Today, nearly all states provide Medicaid and/or CHIP coverage to children up to 200 percent of the FPL, with 24 covering children at or above 250 percent of the FPL. States would be required (or lose their Medicaid funding) to maintain their income eligibility levels and enrollment procedures for children eligible for Medicaid and CHIP at the time of the bill's enactment. States could also expand coverage. As with children below 133 percent of the FPL, a gross income standard would apply, with states setting an eligibility threshold that takes into account disregards and deductions already in effect. The Medicaid and CHIP benefit package and cost-sharing rules would continue as under current law.

- **CHIP funding through fiscal year 2015**. The CHIP program would be funded through September 30, 2015, two years beyond its current expiration date. No new funds are authorized after 2015, although the bill's provisions expect coverage through 2019. After September 30, 2015 (or earlier if federal financing runs out), children could be enrolled in Exchange coverage that provides benefits and cost sharing comparable to what they receive in CHIP. The Secretary of HHS would be required to review and certify which plans in the Exchange provide CHIP-comparable benefits and cost sharing, however no mechanism is described in the bill for ensuring that these plans exist in the Exchange.

- **Increased federal financial assistance for CHIP**. Starting October 1, 2015, states would receive an increase of 23 percentage points (up to a maximum of 100 percent) in their CHIP match rate. In addition, the bill would extend and increase funding provided in CHIPRA for Medicaid and CHIP enrollment and renewal activities. Under the bill, $140 million (an increase of $40 million) would be available through 2015.

- **Medicaid coverage for former foster care children.** Effective January 1, 2014, former foster care children would be newly eligible for Medicaid and EPSDT benefits.

- **New state option to provide CHIP coverage to children of state employees.** Children of state employees eligible for family coverage could be enrolled in CHIP if the employee's premium and cost sharing costs exceed five percent of the family's income. To implement this option, states could not have decreased its premium contribution for family coverage below 1997 levels (adjusted for inflation).

2. Exchange Coverage and Subsidies

Families not eligible for public programs and without health coverage would shop and buy insurance through state Exchanges. Individuals and families with moderate incomes would be eligible for premium and cost sharing subsidies. The bill also allows states to offer coverage to this population through other mechanisms.

- **Premium subsides for individuals and families in the Exchange up to 400 percent of the FPL.** Refundable tax credits would be set so that the premium contribution is no more than 4 percent of income for individuals with income above 133 percent of the FPL and no more than 9.8 percent of income for individuals with income at 300 percent of the FPL up to 400 percent of the FPL.[6] There would be no cost sharing for preventive services and those with income up to 200 percent of the FPL would receive a reduction in overall cost sharing, expressed as an increase in the plan's actuarial value.[7] In addition, all plans would limit out-of-pocket costs at a maximum of $5,950 for an individual and $11,900 for a family in 2010, with decreased levels for those with lower incomes. (See Table 1.)

Table 1. Premium and Cost Sharing Subsidies in Senate Bill in 2014[8]

Percent of the FPL	Premium Limit as a Share of Income	Actuarial Value after Cost Sharing Applied	Out-of-Pocket Limit Individual/Family[9]
134%[10]	4%	90%	$1,983/$3,967
150%	4.6%	90%	$1,983/$3,967
200%	6.3%	80%	$1,983/$3,967
250%	8.1%	70%	$2,975/$5,950
300%	9.8%	70%	$2,975/$5,950
350%	9.8%	70%	$3,967/$7,933
400%	9.8%	70%	$3,967/$7,933

[6] Households with income below 134 percent of the FPL would generally be eligible for Medicaid. Lawfully residing immigrants who are not eligible for Medicaid would be eligible for subsidies. Those with income below 134 percent of the FPL would have a premium contribution level limited to 2 percent of income. The Secretary of HHS would conduct a study by 2013 on whether to apply the federal poverty level limits by geographic area to reflect variations in cost-of-living.

[7] The actuarial value is a measurement of the percentage of medical expenses paid by a health plan for a standard population. For example, a plan with an actuarial value of 70 percent would cover 70 percent of the health care expenses of an average population, and 30 percent would be picked up by individuals.

[8] The size of the credit for a person at any given income level would be tied to the premium for the second-lowest-cost basic plan in the silver benefit tier, which has an actuarial value of 70 percent. Enrollees could purchase additional coverage at their own expense.

[9] The out-of-pocket level would be tied to the yearly limit set for the Health Savings Account (HSA). The numbers provided are for 2010. Note that the HSA limits are reduced by family income as follows: 101 to 200 percent FPL by two-thirds; 201 to 300 percent FPL by half; 301 to 400 percent FPL by one-third.

[10] *op. cit.* (4).

- **Income in prior tax year used to determine eligibility for the premium subsidies.** Eligibility would be evaluated based on modified adjusted gross income in the most recent tax year, and the accuracy of the information would be verified, when possible, via federal income tax data. Procedures would be developed for people who do not file returns or who experience a change in circumstances. Under penalty of perjury, applicants would declare their citizenship and lawful residency status, which would be verified through the Social Security Administration and the Department of Homeland Security. Special rules would also be put in place for counting income of families with mixed immigration status.

- **Certain employees with offers of employer coverage eligible for Exchange and subsidies.** Employees who are offered employer-sponsored health coverage would only be allowed to enter an Exchange and receive subsidies if the coverage does not have an actuarial value of at least 60 percent or the premium costs exceed 9.8 percent of income. However, those employees (at or below 400 percent of the FPL) whose premium cost is between eight and 9.8 percent of income could apply their employer contribution toward the purchase of Exchange coverage (but receive no subsidies). Employers, whether they offer coverage of not, would pay a fee for full-time workers receiving premium subsidies in the Exchange.[11]

- **State option to establish alternative coverage options.** States could choose to receive federal funding[12] to negotiate with health plans to provide coverage (at benefit and premium cost sharing levels allowed under the Exchange) to those not eligible for Medicaid with income between 133 and 201 percent of the FPL. States could also provide coverage to lawfully residing immigrants not eligible for Medicaid with income below 201 percent of FPL. If implemented in a state, eligible persons would not be able to receive premium subsidies and coverage through the Exchange. In addition, in 2017, a state could apply for a waiver to establish its own health reform program that is comparable to that provided under the bill.

3. Coordination of Coverage between Medicaid and the Exchange

Under the Senate bill, people will have different avenues through which they will obtain coverage. The bill includes provisions on how these coverage options intersect and how people will be expected to navigate among the different pathways, most notably Medicaid, CHIP, and the Exchanges.

- **Screen and enroll procedures between Medicaid/CHIP and Exchange.** Individuals seeking coverage through either the Exchange or Medicaid/CHIP would be screened for eligibility for all programs and referred to the appropriate program for enrollment, without submitting additional materials and undergoing multiple determinations.

- **Streamlined and uniform enrollment process.** To ensure the implementation of the "no wrong door" process described above, a single, streamlined application form would be created for persons applying to either Medicaid, CHIP or premium subsidies through the Exchange.[13] The form could be submitted online, in person, by mail, or by telephone. In addition, states would be required to establish a Medicaid and CHIP enrollment website that is connected to an Exchange. The use of electronic interfaces and data matching with databases and other programs would be utilized to verify eligibility at enrollment and renewal.

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[11] In general the provisions related to the new employer requirements pertain to firms with fewer than 50 full-time workers.

[12] States would receive 95 percent of the funds that would have been paid as federal premium and cost sharing subsidies for individuals in the Exchange.

[13] A supplemental or alternative application form is allowed for those Medicaid beneficiaries whose eligibility is not determined by MGI.

- **Support for community outreach**. States would receive federal support to establish "navigators" (trade and professional organizations, unions, etc.) to assist with public education and enrollment. In addition, all hospitals that participate in Medicaid would be allowed to implement presumptive eligibility for all Medicaid populations.

- **State Medicaid agency may administer premium subsidies.** Exchanges could contract with a state Medicaid agency to determine whether an Exchange-eligible person is eligible for the premium credits.

4. Health Care Benefits and Access

The Senate bill defines benefit packages that would be available through the Exchange (and individual and small group markets) and creates a new Medicaid benefit requirement. In addition, the bill includes a number of provisions related to combating health care disparities and transforming the health care delivery system.

- **Four benefit packages available within Exchanges.** The four benefit categories (bronze, silver, gold, and platinum) would vary by actuarial value (a measurement of the percentage of medical expenses paid by a health plan for a standard population). The basic bronze plan would provide minimum essential coverage at the actuarial value of 60 percent and the platinum plan would equal 90 percent. As previously described, available cost sharing subsidies would effectively raise the actuarial value for those with income below 200 percent of the FPL. All plans would be required to provide a basic level of coverage, including preventive care and pediatric services, but specific coverage details would be determined later.

- **Specialized coverage for children.** The bill requires that all health plans cover, at no cost, the preventive care and screenings identified in Bright Futures (the American Academy of Pediatrics' "gold standard" for preventive care). Child-only health plans would also be available through the Exchange. In addition, insurers would immediately be prohibited from denying coverage to children for pre-existing conditions (the new regulations for adults would go into effect in 2014). Effective six months after the bill's enactment, individual and group policies would also be required to provide dependent coverage for children up to age 26.

- **Newly-eligible Medicaid adults would receive "benchmark" coverage.** This population would receive coverage more limited than what is usually provided under Medicaid. States currently only have the option to offer this "benchmark" coverage to some Medicaid beneficiaries as a result of the Deficit Reduction Act of 2005.

- **Catastrophic coverage for young adults.** A "young invincible" individual policy would be available for those 30 years or younger. Those who receive a hardship exemption (available plan premiums exceed 8 percent of income) from the health coverage mandate could also enroll in this plan.

- **Other key provisions impacting coverage and access to care.** The Senate bill also extends CHIPRA's quality measures for children to adults in Medicaid, supports establishment of medical home models, expands state flexibility to provide family planning coverage, and provides grants to states to develop early childhood visitation programs. In addition, the bill would reduce Medicaid Disproportionate Share Hospital (DSH) payments to states, allocate $10 billion over five years to expand community health centers and the National Health Service Corps, and provide extra Medicaid payments to states that provide in-home or community services.

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