Key Medicaid, CHIP, and Low-Income Provisions in H.R. 3962: The Affordable Health Care for America Act of 2009 (As of November 3, 2009)

On October 29, 2009 (with amendments on November 3, 2009), the House released its revised health reform bill, the Affordable Health Care for America Act of 2009. The Congressional Budget Office estimates that under the bill's provisions, by 2015, 94 percent of the non-elderly population would have health insurance (96 percent if undocumented immigrants are excluded from the calculation). In that year, an additional 13 million individuals (mostly childless adults and parents) would obtain coverage through Medicaid and 19 million through a new health insurance Exchange.[1]

Most of the bill's reforms would go into effect in 2013. The bill would specifically:

- Require employers with annual payrolls above $500,000 to offer their workers coverage and contribute to the premium cost (at least 72.5 percent for an individual and 65 percent for a family). Employers not offering this coverage must pay a payroll tax ranging from 2 to 8 percent, depending on the firm's size. Certain small businesses could receive tax credits to assist in purchasing coverage.
- Create a national health Exchange where individuals without other coverage options (and some small employers) can buy insurance through a public plan or private insurers. States could set up their own Exchanges and establish co-operatives.
- Provide Medicaid to those with family income up to 150 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.
- Impose a tax surcharge on those with adjusted gross income above $1 million (for married couples, filing jointly) and $500,000 (for single individuals) to provide a revenue source.

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 children and families.

[1] Congressional Budget Office, *Preliminary Analysis of H.R. 3962*, October 29, 2009. Note that analysis pertains to the October 29, 2009 version of the bill.

1. Medicaid and CHIP

Under the House bill, Medicaid serves as a cornerstone of coverage for millions of lower income adults, pregnant women, and children. Uninsured individuals and families not eligible for Medicaid would be eligible for Exchange coverage, including children currently receiving coverage through separate CHIP plans. The following provisions go into effect in 2013, unless otherwise noted.

Eligibility Changes for Adults

- **Medicaid coverage for adults under age 65 up to 150 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. The Secretary of Health and Human Services (HHS) would establish the methodology used in determining income for childless adults (with current methodologies remaining in place for other populations).

- **Increased federal support for covering adults in Medicaid**. In 2013 and 2014, the federal government would pick up 100 percent of the cost of covering childless adults up to 150 percent of the FPL and parents between a state's current income threshold and 150 percent of the FPL.[3] This percentage would decrease to 91 percent in 2015 and beyond. In addition, the bill extends (from the end of 2010 until June 30, 2011) the American Recovery and Reinvestment Act (ARRA) provision that provides fiscal relief to states by temporarily increasing their federal Medicaid matching rate if they do not reduce Medicaid eligibility.

- **Maintenance-of-effort on existing Medicaid coverage above 150 percent of the FPL.** The handful of states that provide coverage to some adults above 150 percent of the FPL would be required to maintain Medicaid eligibility standards, methodologies, and procedures currently in effect. States would not receive additional financial support for these individuals. In addition, states must eliminate any asset test used to determine eligibility, except for those receiving long-term care services.

- **Five-year waiting period rules for lawfully residing immigrants remain 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 (retaining the state option to provide coverage for children and pregnant women within the five year waiting period). Low-income lawfully residing immigrants not eligible for Medicaid or CHIP due to this restriction would be required to seek subsidized coverage through the Exchange. Undocumented immigrants would remain ineligible for Medicaid and CHIP, and could not obtain subsidies through the Exchange (although they can purchase unsubsidized coverage).

[2] Excludes Medicare recipients under age 65 who also receive Medicaid.
[3] States providing coverage to childless adults and parents under 150 percent of the FPL through 1115 Medicaid waivers or state funding would receive the enhanced match for these populations.

Eligibility Changes for Children

- **Medicaid coverage for children ages 0-18 up to 150 percent of the FPL, starting in 2014.** 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 Medicaid up to 150 percent of the FPL. Those children currently receiving coverage through CHIP below 150 percent of the FPL would be shifted to Medicaid. A state would receive its current CHIP matching rate to cover these children.[4]

- **Current Medicaid coverage (including CHIP-funded Medicaid expansions) for children maintained above 150 percent of the FPL.** Today, nearly all states provide Medicaid and/or CHIP coverage to children up to 200 percent of the FPL, with 16 covering children at or above 300 percent of the FPL. States would be required to maintain the coverage they provide to children through Medicaid above 150 percent of the FPL. This includes states that expanded Medicaid using CHIP funding. A state would continue to receive its current CHIP matching rate to cover these children.[5]

- **Expiration of the CHIP program December 31, 2013; children in separate CHIP programs moved into Exchange plans the next day.** Beginning January 1, 2014 (a year after the Exchanges are operational), children in separate CHIP programs would be eligible for coverage through Exchange plans. Until that time, states would be required to maintain their current CHIP eligibility rules, methodologies, and procedures (although a state could establish a waiting list if its federal funding runs out) and CHIP-eligible children would be ineligible for Exchange plans. The Secretary of HHS would submit a report by the end of 2011 to Congress on how to ensure that the Exchange coverage (benefits and cost sharing) is comparable to an average CHIP plan and that appropriate transfer procedures exist.

- **Automatic enrollment of 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 provide an increased matching rate (100 percent in 2013 and 2014, 91 percent in 2015 and beyond) for enrolling uninsured newborns for 60 days, while their eligibility is determined. Those children without acceptable coverage at the end of 60 days would be deemed eligible for Medicaid (with states receiving their regular matching rate).

Enrollment and Administrative Procedures

- **A 12-month guarantee of coverage for CHIP children in states with separate CHIP plans.** Until termination of CHIP on December 31, 2013, stand-alone CHIP programs would be required, effective January 1, 2010, to implement 12-months continuous eligibility for children with family income below 200 percent of the FPL. Also prevents

[4] States would receive the matching rate level they currently receive for CHIP, but the payments would be made under Medicaid.
[5] Ibid.

states from establishing waiting periods in their CHIP programs for children who are under age 2, in families losing private health coverage due to unemployment, or in families that pay more than 10 percent of income for coverage.

- **Medicaid enrollment out-stationing expanded to all hospitals and locations other than state/county offices.**

2. Exchange Coverage and Subsidies

Families (and some small businesses) without health coverage would shop and buy insurance through a national Exchange (accessible online). Those with moderate incomes would be eligible for premium and cost sharing subsidies. The following provisions would go into effect January 1, 2013, when the Exchange becomes operational.

- **Affordability subsidies for individuals and families in the Exchange up to 400 percent of the FPL.** Subsidies[6] would be set so that the premium contribution is no more than 3 percent of an individual's or family's modified adjusted gross income (as defined by the IRS) at 150 percent of the FPL and no more than 12 percent at 400 percent of the FPL.[7] There would be no cost sharing for preventive services and those receiving the premium credits would receive a reduction in overall cost sharing, expressed as an increase in the plan's actuarial value.[8] In addition, all plans would limit out-of-pocket costs at a maximum of $5,000 for an individual and $10,000 for a family, with decreased levels for those with lower incomes. (See Table 1.)

Table 1. Premium and Cost Sharing Subsidies in House Bill in 2013

Percent of the FPL	Premium Limit as a Share of Income	Actuarial Value after Cost Sharing Applied	Out-of-Pocket Limit Individual/Family
133% or below[9]	1.5%	97%	$500/$1,000
150%	3.0%	93%	$1,000/$2,000
200%	5.5%	85%	$2,000/$4,000
250%	8.0%	78%	$4,000/$8,000
300%	10.0%	72%	$4,500/$9,000
350%	11.0%	70%	$5,000/$10,000
400%	12.0%	70%	$5,000/$10,000

[6] 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.
[7] The subsidies could only be applied to the basic health care plan in the first two years. After that, they could be applied to higher cost plans, with the individual paying any cost differences.
[8] 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.
[9] Individuals with income below 150 percent of the FPL who are eligible for Medicaid would be ineligible for the subsidies.

- **Income in prior tax year used to determine eligibility for the affordability credits.** 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. Special procedures would be developed for people who do not file returns or who experience a significant 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.

3. 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.

- **Coordination of procedures between Medicaid and Exchange.** Each state must enter a Memorandum of Understanding (MOU) with the Exchange to coordinate coverage for Medicaid-eligible individuals. Those individuals or families applying through the Exchange that are determined to be eligible for Medicaid would be transferred to the appropriate state Medicaid agency. The state would not conduct another redetermination of eligibility (with an exception for parents and children if required as part of the MOU.)

- **State Medicaid agency may administer affordability credits.** The Exchange could 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 House bill defines benefit packages that would be available through the Exchange. In addition, it includes a number of provisions related to increasing access.

- **Three benefit packages available within Exchange.** The three benefit categories (basic, enhanced, and premium) would vary by actuarial value.[10] The basic plan would provide an "essential benefits package" at the actuarial value of 70 percent.[11] All plans would be required to offer at least the basic benefit plan, which includes pediatric benefits. The pediatric services are defined as well baby and well child care and oral health, vision, and hearing services, equipment, and supplies.

- **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 initially be fully borne by the federal government, and would be reduced to 91 percent in 2015 and beyond.

[10] The House bill also allows insurers to offer a premium-plus plan that would provide additional benefits, such as adult dental or vision services, for an extra cost.
[11] As noted previously, the actuarial value would increase for those receiving cost sharing subsidies.

- **Addition of preventive services for adults to Medicaid package.** Requires states, beginning July 1, 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**. Under a five-year pilot program, states could operate a medical home model for beneficiaries, including medically fragile children, and receive enhanced administrative funding.
- **Other provisions impacting coverage and access to care.** The House 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, allows Medicaid to cover nurse home visitation services for first-time pregnant women and mothers with children under two, and provides a 75 percent federal matching rate for translation and interpretation services provided to Medicaid-eligible adults for whom English is not the primary language. In addition, the bill would reduce Medicaid Disproportionate Share Hospital (DSH) payments to states.

CCF is an independent, nonpartisan research and policy center based at Georgetown University's Health Policy Institute whose mission is to expand and improve health coverage for America's children and families.

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