



Summary of Medicaid, CHIP, and Low-Income Provisions in Health Care Reform

Health reform will provide coverage to 32 million uninsured people, adopt broad-reaching reforms in insurance practices, make major new investments in public health, and reduce the federal deficit.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (Public Law 111-148), which is designed (with its companion set of amendments in H.R. 4782) to provide coverage to 32 million uninsured people, adopt broad-reaching reforms in insurance industry practices, make major new investments in public health, and reduce the federal deficit. By 2019, 92 percent of the non-elderly population is expected to have health insurance (94 percent if undocumented immigrants are excluded from the calculation). In that year, an additional 16 million individuals will obtain coverage through Medicaid and CHIP and 29 million will obtain coverage through new health insurance Exchanges.¹

Most of the health reforms will go into effect January 1, 2014. (See box on next page for more immediate changes.) The law:

- Creates state-based health Exchanges where individuals and small employers can buy insurance through private insurers or through multi-state health plans under contract with the federal Office of Personnel Management. States can: allow large employers to participate beginning in 2017, establish co-operatives, opt into a national Exchange, and/or seek waivers to utilize other reform mechanisms.
- Provides Medicaid to non-elderly individuals with income up to 133 percent of the federal poverty level (FPL) and preserves Medicaid and CHIP coverage for children above 133 percent of the FPL.
- Provides tax credits to help people with income up to 400 percent of the FPL purchase Exchange coverage and limit their out-of-pocket costs.
- Establishes a new mandate that people with gross income above the federal tax-filing threshold obtain insurance or face a tax penalty (with some excep-

tions, including if the cost of coverage exceeds eight percent of income).

- Requires employers with 50 or more full-time workers to pay penalties for employees who receive a premium subsidy through a state Exchange. Provides tax credits to small businesses to purchase coverage for their employees.
- Adopts insurance market reforms, such as eliminating the practice of denying people coverage because they are sick, charging different premiums for people based on their health status, and establishing annual or lifetime benefit limits. Creates a high-risk pool in 2010 to assist families denied coverage prior to the new rules going into effect (in 2014).
- Establishes a number of health care delivery and access, quality, wellness, and prevention initiatives, makes investments in community health centers, and addresses fraud and waste in Medicaid and Medicare. Also implements Medicare reforms, including the addition of annual exams and other preventive services at no cost (beginning in 2011) and the gradual closure of the “doughnut hole” in drug coverage (rebates and discounts to seniors starting in 2010 until its full elimination by 2020).

The Congressional Budget Office (CBO) estimates that health reform will cost \$938 billion over 10 years (2010-2019) and will be fully paid for, primarily through Medicare savings, new Medicare taxes for high-income households, and fees on certain manufacturers and insurers. Additional revenue will be obtained through an excise tax, starting in 2018, on insurance plans exceeding \$10,200 for single coverage and \$27,500 for family coverage (with higher thresholds for retirees and employees in high-risk professions).

The following describes some of health reform changes to Medicaid, CHIP, and other provisions of importance to low-income families and children.

Medicaid and CHIP

Under health reform, Medicaid and CHIP serve as key building blocks for coverage by establishing a federal ceiling at 133 percent of the FPL for everyone and maintaining existing coverage for children.

Eligibility Changes for Adults

- **Medicaid coverage for non-elderly adults up to 133 percent of the FPL.**² Currently, 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.³ Beginning January 1, 2014, states will need to cover parents and childless adults up to 133 percent of the FPL. Newly-eligible adults will be covered by a "benchmark benefit" plan. To promote coordination, the gross income standard that will be used for the premium tax credits available in the Exchanges also will apply to most existing Medicaid eligibility groups.⁴ A standard five percent of income disregard will be built into the gross income test for Medicaid to compensate for the loss of other, existing Medicaid disregards.⁵

- **Federal financial assistance for those newly-eligible.** For calendar years 2014 through 2016, the federal government will pick up 100 percent of the cost of covering newly-eligible adults (defined as childless adults and parents up to 133 percent of the FPL who, as of December 1, 2009, were not eligible for comprehensive coverage through Medicaid or a state plan). In subsequent years, the increased federal match rate (FMAP) will be: 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and future years. (See Table 1; page 3.)

- **Federal financial assistance for expansion states.** Certain states have already expanded coverage for childless adults and parents up to or above 100 percent of the FPL, and as a result, have few, if any, newly-eligible adults. These states⁶ will receive a bump in their FMAP for childless adults so that by 2019 they will receive the same enhanced match rate for childless adults up to 133 percent of the FPL as other states. Specifically, each expansion state will receive an increase equal to 50 percent of the gap between its regular Medicaid match rate and the enhanced match rate provided to other states in 2014, 60 percent in 2015, 70 percent in 2016, 80 percent

Provisions For Children And Families Effective Beginning This Year

March 23, 2010 (date of enactment)

- States must at least maintain the Medicaid and CHIP coverage and enrollment procedures that they have now.
- Small employers receive tax credits covering 35% (50% by 2014) of health care premiums.

By June 24, 2010

- A temporary high-risk pool established for qualified uninsured people with pre-existing conditions.

After September 23, 2010 (as a new health plan year begins)

- Young adults can remain on their parents' health plan until age 26.
- Children with insurance can no longer be denied coverage for pre-existing conditions.
- Insurance plans can no longer impose lifetime caps or restrictive annual limits on coverage, and cannot rescind coverage when a person becomes ill.
- New plans must provide free preventive services to enrollees.

in 2017, 90 percent in 2018, and 100 percent in 2019 and future years. All states will receive their regular FMAP for parents eligible for coverage under the rules in place on March 23, 2010. (See Table 1.)

- **Temporary maintenance-of-effort on existing Medicaid coverage.** As a condition of receiving federal Medicaid funding, states must maintain existing Medicaid eligibility levels and enrollment procedures (in effect on March 23, 2010) for parents and childless adults until January 1, 2014. However, beginning in 2011, states with budget deficits can seek an exemption from maintaining adult eligibility levels above 133 percent of the FPL. States still have the flexibility to expand, or continue to provide, coverage to adults above 133 percent.

- **Optional five-year waiting period for lawfully residing immigrants remains in effect.** Health reform will 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). Legal immigrants, not eligible for Medicaid or CHIP, can obtain coverage in the Exchange and receive premium and cost-sharing subsidies based on their income. Undocumented immigrants will remain ineligible for Medicaid and CHIP, and cannot obtain coverage through the Exchanges.

Under health reform, Medicaid and CHIP serve as key building blocks for coverage.

CHIP is maintained through at least 2019 and states can continue to expand coverage to children under the program as under current law.

Eligibility Changes for Children

- **Medicaid coverage for children 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 (although all states have chosen to provide coverage above these levels through Medicaid and/or CHIP). Under health reform, states will be required to provide Medicaid to children with family income up to 133 percent of the FPL (including those in separate CHIP programs).⁷ As with adults, a gross income standard with a uniform five percent disregard will apply in order to simplify coordination with the premium tax credits.
- **Medicaid and CHIP eligibility levels for children maintained above 133 percent of the FPL.** Today, nearly all states provide Medicaid and/or CHIP coverage to children up to 200 percent of the FPL, with 25 states covering children at or above 250 percent of the FPL.⁸ As a condition of receiving federal Medicaid funding, states cannot scale back their income eligibility levels and enrollment procedures in place on March 23, 2010 for children eligible for Medicaid and CHIP. The new gross income standard with a five percent income disregard will also apply. The Medicaid and CHIP benefit package and cost-sharing rules will continue as under current law.
- **CHIP continued through at least 2019; funding through fiscal year 2015.** CHIP is maintained through 2019 and states can continue to expand coverage to children under the program as under current law.

Funding for the program is provided through September 30, 2015 (fiscal year 2015), two years beyond its current expiration date. If a state runs out of federal CHIP funding, children can be enrolled in Exchange plans with comparable coverage. The Secretary of Health and Human Services will be required to review and certify which plans in the Exchanges provide CHIP-comparable benefits and cost sharing.

- **Increased federal financial assistance for CHIP in fiscal year 2016.** Starting October 1, 2015, states will receive an increase of 23 percentage points (up to a maximum of 100 percent) in their CHIP match rate. In addition, funding provided in CHIPRA for Medicaid and CHIP enrollment and renewal activities will increase by \$40 million (for a total \$140 million) and now be available through 2015.

- **Medicaid coverage for former foster care children.** Children up to age 26 who "age-out" of foster care will be eligible to continue receiving Medicaid (and EPSDT benefits).

- **Children of state employees eligible for CHIP.** To date, children eligible for family coverage through a state health care employee plan have been excluded from CHIP, even when they meet the eligibility criteria. Now states can enroll such children in CHIP under certain conditions, including if a state agency has not decreased its annual premium contribution for family coverage below 1997 levels (adjusted for inflation). Alternatively, a state can apply this provision on a case-by-case basis for children where the annual aggregate amount of premiums and cost sharing a family pays exceeds five percent of income.

Table 1: Enhanced Match Rates for Adults in 2014 and Beyond

CALENDAR YEAR	NEWLY-ELIGIBLE PARENTS & CHILDLESS ADULTS (up to 133% FPL)	CHILDLESS ADULTS IN EXPANSION STATES ONLY*	
		Regular FMAP + [(Newly-Eligible Enhanced Match Rate - Regular FMAP) x Transition Percentage]	
		Transition Percentage used to Calculate Enhanced Match	Example: State with 60% Original FMAP
2014	100%	50%	80%
2015	100%	60%	84%
2016	100%	70%	88%
2017	95%	80%	88%
2018	94%	90%	90.6%
2019	93%	100%	93%
2020 on	90%	100%	90%

* This enhanced match rate will only apply to states that have expanded coverage for childless adults and parents up to or above 100 percent of the FPL. These states can also receive the enhanced match rate for newly-eligible parents and childless adults between their current eligibility level and 133 percent of the FPL. However, all states will receive their regular match rate for parents who qualify for coverage under the eligibility rules in place on March 23, 2010.

Families without health coverage will be able to shop and buy insurance through state-based Exchanges.

Exchange Coverage and Tax Credits

Families without health coverage who are not eligible for public programs will be able to shop and buy affordable insurance through state-based Exchanges.

- **Subsidies for individuals and families in Exchanges up to 400 percent of the FPL.** Refundable tax credits will be set so that the premium contribution in 2014 is no more than 3 percent of income for individuals with income at 133 percent of the FPL and no more than 9.5 percent of income for individuals with income from 300 percent of the FPL up to 400 percent of the FPL. After 2014, the percentages will be adjusted to reflect annual changes in income and premium costs. There will be no cost sharing for preventive services and those with income up to 250 percent of the FPL will receive a reduction in their cost sharing, expressed as an increase in the plan's actuarial value.⁹ In addition, all plans will limit out-of-pocket costs at \$5,950 for an individual and \$11,900 for a family in 2010, with decreased levels for those with lower incomes.¹⁰ (See Table 2.)

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

- **Certain employees with offers of employer coverage eligible for Exchange and tax credits.** Employees who are offered employer-sponsored health coverage will 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 9.5 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 can apply their employer contribution toward the purchase of Exchange coverage (but receive no subsidies).¹¹ Employers with more than 50 employees, whether they offer coverage or not, will pay fees if a full-time worker receives premium tax credits in the Exchanges.

- **State options to establish alternative coverage reforms.** States can choose to negotiate with health plans to provide coverage (at benefit and premium cost sharing levels allowed under the Exchanges) to those not eligible for Medicaid with income between 133 and 201 percent of the FPL. These states will receive 95 percent of the federal funds that would have been paid toward Exchange subsidies. States can 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 will not be able to receive subsidies and coverage through the state-based Exchanges. In addition, beginning in 2017, a state can apply for a waiver to establish its own health reform program that is comparable to that provided under health reform.

Table 2: Premium Tax Credits and Cost Sharing Subsidies in 2014

PERCENT OF THE FPL	PREMIUM LIMIT AS A SHARE OF INCOME	ACTUARIAL VALUE AFTER COST SHARING APPLIED	OUT-OF-POCKET LIMIT (Individual/Family in 2010)
Below 133%	2%	94%	\$1,983/\$3,967
133%	3%	94%	\$1,983/\$3,967
150%	4%	94%	\$1,983/\$3,967
200%	6.3%	87%	\$2,975/\$5,950
250%	8.05%	73%	\$2,975/\$5,950
300-400%	9.5%	70%	\$3,967/\$7,933

Notes: The premium limit will increase on a sliding scale between the different income tiers. Households with income below 133 percent of the FPL will generally be eligible for Medicaid. Lawfully residing immigrants who are not eligible for Medicaid or CHIP will be eligible for subsidies.

After September 23, 2010, children with employer-based coverage can no longer be subject to pre-existing conditions. Health plans will also be required to add dependent children up to age 26 to their parents' health plan.

Coordination of Coverage Between Medicaid and CHIP

Under health reform, people will have different avenues through which they will obtain coverage. A number of procedures will be established for how people will navigate among the different pathways, most notably Medicaid, CHIP, and the Exchanges.

- **Screen and enroll procedures between Medicaid, CHIP, and the Exchanges.** Individuals seeking coverage through an Exchange, Medicaid, or CHIP will be screened for eligibility for all programs and referred to the appropriate program for enrollment. This "no wrong door" concept will ensure that persons will not have to submit duplicative materials or undergo multiple enrollment procedures.
- **Streamlined and uniform enrollment process.** To ensure the implementation of the "no wrong door" process described above, a single, streamlined application form will be created for persons applying to either Medicaid, CHIP, or premium tax credits through the Exchanges. The form will be submitted online, in person, by mail, or by telephone. In addition, states will be required to establish a Medicaid and CHIP enrollment website that is connected to a state-based Exchange. The use of electronic interfaces and data matches with existing databases and other programs will be utilized to verify eligibility at enrollment and renewal.
- **Support for community outreach.** States will receive federal support to establish "navigators" (eligible entities include trade and professional organizations, unions, etc.) to assist with public education and enrollment. In addition, hospitals that participate in Medicaid will be allowed to implement presumptive eligibility for all Medicaid populations.
- **State Medicaid agencies can administer premium tax credits.** State-based Exchanges can contract with a state Medicaid agency to administer the process for determining whether an Exchange-eligible person is eligible for the premium credits.

Health Care Benefits and Access

Health reform defines benefit packages that will be available through the Exchanges (and individual and small group markets) and creates a new Medicaid benefit requirement. In addition, health reform will include a number of initiatives aimed at 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) will 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 will provide minimum essential coverage at the actuarial value of 60 percent and the platinum plan will have an actuarial value of 90 percent. As previously described, available cost-sharing subsidies will effectively raise the actuarial value for those with income below 200 percent of the FPL. All plans will be required to provide a basic level of coverage, including preventive care and pediatric services, but specific coverage details will be determined later.
- **Specialized coverage for children.** New health plans, that become effective after September 23, 2010, must provide free preventive care and screenings identified in Bright Futures (the American Academy of Pediatrics' "gold standard" for preventive care). Child-only health plans will also be available through the Exchanges. In addition, for health plan years beginning after September 23, 2010, children with employer-based coverage can no longer be subject to pre-existing conditions (for adults this provision will go into effect in 2014). During the same time period, health plans will be required to add dependent children up to age 26 to their parents' health plan (but only if the child is not eligible for a qualified employer-sponsored plan).
- **Higher Medicaid reimbursement rates for primary care.** In calendar years 2013 and 2014, states will receive 100 percent federal funding for the cost of increasing Medicaid reimbursement rates up to Medicare levels for specific primary care services provided by certain physicians. CBO estimates this change will cost the federal government \$8.3 billion over 10 years and will have a positive effect on Medicaid reimbursement rates even after 2014.

Health Care Benefits and Access (cont'd)

- **Newly-eligible Medicaid adults will receive “benchmark” coverage.** This population will 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 will be available in the Exchanges 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 can also enroll in this plan.
- **Other key provisions impacting coverage and access to care.** Health reform 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, health reform will reduce Medicaid Disproportionate Share Hospital (DSH) payments to states, allocate \$10 billion over five years to expand community health centers, and provide extra Medicaid payments to states that provide in-home or community services.

Endnotes

1. Congressional Budget Office, "Cost Estimate of H.R. 4872, Reconciliation Act of 2010," March 20, 2010. CBO's 32 million uninsured estimate accounts for those gaining coverage through the Exchange and Medicaid/CHIP adjusted for a net change in those receiving employment-based and individual market coverage.
2. Excludes Medicare recipients under age 65 who also receive Medicaid. States can cover adults up to 133 percent of the FPL prior to the 2014 implementation date. These states will be eligible for the increased FMAP starting in 2014 since these adults will be considered newly-eligible.
3. Georgetown Center for Children and Families, "Eligibility Levels in Medicaid & CHIP for Children, Pregnant Women, and Parents," (March 1, 2010). <http://ccf.georgetown.edu/index/cms-file-system-action?file=statistics/eligibility%20by%20state.pdf>
4. Health reform establishes a new Modified Adjusted Gross Income (MAGI) standard, consistent with tax policy, which will be utilized in Medicaid, CHIP, and in

determining premium tax credits. MAGI is an individual's or family's gross household income with some adjustments. The MAGI will apply to newly-eligible individuals, as well as those who qualify under existing eligibility with exceptions for the elderly, foster children, low-income Medicare beneficiaries and those receiving SSI.

5. The five percent income disregard will streamline the process states use for determining eligibility by effectively changing the eligibility level. For example, for the 133 percent of the FPL Medicaid ceiling, instead of states applying deductions per applicant they will apply a uniform eligibility level of 138 percent of the FPL.

6. These states appear to include Arizona, Washington DC, Delaware, Hawaii, Massachusetts, Maine, Minnesota, New York, Pennsylvania, Vermont, Washington, and Wisconsin.

7. The health reform legislation does not address the match rate for children in separate CHIP programs that will be eventually be moved to Medicaid. The CHIP statute however may make it possible for states to receive their current CHIP-enhanced match for these children.

8. Georgetown Center for Children and Families, "Enacted and Implemented Eligibility Levels for Children," (March 1, 2010). <http://ccf.georgetown.edu/index/cms-file-system-action?file=statistics/eligibility%20expansions%20by%20state.pdf>

9. 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 will cover 70 percent of the health care expenses of an average population, and 30 percent will be picked up by individuals.

10. The out-of-pocket level will be tied to the yearly limit set for the Health Savings Account (HSA). The numbers provided are for 2010. 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. It is not clear if the reduction applies to families with income at or below 100 percent of the FPL.

11. The upper percentage amount will most likely be 9.5 percent to correspond to amendments made to the percentage limit for “affordable coverage.”

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

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