



CENTER FOR CHILDREN AND FAMILIES

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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).
- **New state option to provide CHIP to children of state employees.** To date, children of state employees have been excluded from CHIP even when they meet the eligibility criteria, but now states can choose to enroll such children in CHIP. States can implement this option for its employees 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. For additional information, contact (202) 687-0880 or childhealth@georgetown.edu.

FOCUS *on* Health Reform



MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM PROVISIONS IN THE NEW HEALTH REFORM LAW

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (P.L. 111-148), into law. The Health Care and Education Affordability Act of 2010 which included changes to the new law was signed on March 30, 2010. Overall, the new law includes an individual requirement to obtain health insurance, a significant Medicaid expansion and subsidies to help low-income individuals buy coverage through newly established Health Benefit Exchanges. The following summary examines the provisions related to Medicaid and the Children's Health Insurance Program (CHIP) included in the new health reform law.

Medicaid Coverage and Financing.

The new law expands Medicaid to a national floor of 133% of poverty (\$14,404 for an individual or about \$29,326 for a family of four in 2009) to help reduce state-by-state variation in eligibility for Medicaid and also include non-Medicare eligible adults under age 65 without dependent children who are currently not eligible for the program. Children currently covered by CHIP between 100% and 133% of poverty would be transitioned to Medicaid coverage. These changes help to provide the base of seamless and affordable coverage nationwide through Medicaid for those with incomes up to 133% of poverty and then subsidies for coverage for individuals with incomes between 133% and 400% of poverty through state-based Health Benefit Exchanges. Individuals eligible for Medicaid would not be eligible for subsidies in the state exchange. For most Medicaid enrollees, income would be based on modified adjusted gross income without an assets test.¹

The new law provides full federal financing for those newly eligible for Medicaid for 2014-2016; 95% FMAP for 2017; 94% FMAP for 2018; 93% FMAP for 2019 and 90% FMAP for 2020 and beyond. Those newly eligible include individuals with income above a states' eligibility level on the date of enactment (March 23, 2010) and 133% of poverty, those not eligible for full benefits, benchmark or benchmark equivalent coverage in Medicaid, individuals eligible for a capped program but not enrolled or on a waiting list and those covered in a non-Medicaid state funded program. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for currently Medicaid eligible non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020).² States are required to maintain eligibility in place on the date of enactment of the legislation (March 23, 2010) for children in Medicaid and CHIP through 2019 and for adults in Medicaid until 2014 (when coverage through new Health Benefit Exchanges is expected to be available).

Children's Health Insurance Program (CHIP).

The legislation provides funding for CHIP through 2015 (an additional two years compared to current law), continues the authority for the program through 2019 and requires states to maintain eligibility standards for children in Medicaid and CHIP through 2019. CHIP eligible children who cannot enroll in the program due to federal allotment caps must be screened to determine if they are eligible for Medicaid and if not would be eligible for tax credits in a plan that is certified by the Secretary by April 2015 to be comparable to CHIP in the exchange.

¹ There is a special deduction to income equal to five percentage points of the poverty level raising the effective eligibility level to 138% of poverty. The legislation maintains existing income counting rules for the elderly and groups eligible through another program like foster care, low-income Medicare beneficiaries and Supplemental Security Income (SSI).

² It appears that AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI are expansion states. Expansion states that do not have new eligibles and are not using Disproportionate Share Hospital (DSH) payments for coverage under a waiver would receive a 2.2 percentage point increase in FMAP for individuals who are not newly eligible up to 133% of poverty. This provision appears to apply to Vermont.

Benefits and Access.

The new law provides all newly-eligible adults with a benchmark benefit package or benchmark-equivalent that meets the minimum essential health benefits available in the Exchange. The new law increases Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014 with 100% federal financing for the increased payment rates. The new law also broadens the scope of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include all eligible individuals (not just children), establishes the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency, and includes funding for pilot programs for medical homes and accountable care organizations.

Duals and Long-Term Care.

The new law establishes the Community First Choice Option in Medicaid to allow states to provide community-based attendant supports and services to individuals with incomes up to 150% of poverty who require an institutional level of care through a state plan amendment (SPA) and provides states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. The new law requires the Secretary to improve coordination of care for dual eligibles through a new office within the Centers for Medicare and Medicaid Services. The legislation also establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Cost Estimates.

The Congressional Budget Office (CBO) estimates that the legislation will increase Medicaid/CHIP coverage by 16 million from a baseline of 35 million by 2019 with a federal Medicaid/CHIP federal cost of \$434 billion from 2010 to 2019 due to coverage related changes. CBO estimates that the coverage related changes in the legislation will increase state spending over baseline spending by \$20 billion over the 2010 to 2019 period. Other significant federal Medicaid costs over the 2010 to 2019 period are related to: improving payments to primary care practitioners (\$8.3 billion) and the Community First Choice Option (\$6.09 billion). Significant federal Medicaid savings over the 2010 to 2019 period are related to: Medicaid prescription drug coverage (-\$38.14 billion) and reductions in Medicaid disproportionate share hospital (-\$14.0 billion).

A more detailed analysis of Medicaid and CHIP provisions in the new legislation follows. A comprehensive side-by-side of this legislation in addition to other health proposals can be found at <http://www.kff.org/healthreform/sidebyside.cfm>.

SUMMARY OF MEDICAID AND CHIP PROVISIONS IN THE NEW HEALTH REFORM LAW

This summary compares the Medicaid and CHIP provisions in the Patient Protection and Affordable Care Act (P.L. 111-148) along with changes made to the law by The Health Care and Education Reconciliation Act of 2010. This analysis focuses on Medicaid coverage and financing changes; how Medicaid and CHIP interface with a new health insurance exchange, and other Medicaid benefits and access changes. A more comprehensive side-by-side of the new health reform law can be found at: <http://www.kff.org/healthreform/sidebyside.cfm>.

Pre-Reform Law		Patient Protection and Affordable Care Act (P.L. 111-148)
Status		The Patient Protection and Affordable Care Act was signed by President Obama on March 23, 2010. The Health Care and Education Reconciliation Act of 2010, which made changes to the Patient Protection and Affordable Care Act was signed by President Obama on March 30, 2010.
Overall approach to expanding access to coverage		Requires most individuals to have health insurance through a combination of public and private coverage expansions. Expands Medicaid to 133% of the poverty level in 2014 and maintains CHIP and Medicaid for children through 2019. Creates state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals / families with income between 133-400% of poverty and creates separate exchanges through which small businesses can purchase coverage.
Medicaid eligibility for children, pregnant women, parents and individuals with disabilities	Individuals must meet categorical and income standards to be eligible for Medicaid. The federal government sets minimum eligibility standards and states have flexibility to expand coverage beyond these minimum levels for most groups. States must cover children under age 6 with family income below 133% federal poverty level (FPL); children age 6 to 18 with family incomes below 100% FPL. Current eligibility for Medicaid and CHIP: 4 states <200% FPL 23 states 200 – 250% FPL 24 states >250% FPL States must cover pregnant women with income below 133% FPL. 11 states at 133-184% FPL 16 states 185% FPL 24 states >185% FPL	<ul style="list-style-type: none"> Establishes a minimum Medicaid coverage threshold for children ages 6 to 19 and parents with incomes up to 133% FPL based on modified adjusted gross income with special adjustment of 5 percentage points to bring effective income eligibility to 138% FPL. Eligibility is determined without an assets or resource test (Implementation: January 1, 2014). Maintains eligibility levels in place on the date of enactment (March 23, 2010) for parents through 2014 and for children through 2019 and allows states the option to provide Medicaid coverage to individuals with incomes above 133% of poverty at regular state matching rates.

Current Law

Patient Protection and Affordable Care Act (P.L. 111-148)

<p>Medicaid eligibility for children, pregnant women, parents and individuals with disabilities (continued)</p>	<p>States must cover parents below states' July 1996 welfare levels.</p> <p>For Parents: 39 states <133% FPL 12 states > or = 133% FPL</p> <p>State must cover most elderly and persons with disabilities receiving Supplemental Security Income (SSI) and certain low-income Medicare beneficiaries.</p>	<p>• Establishes a new eligibility category for all non-pregnant, non-Medicare eligible childless adults under age 65 who are not otherwise eligible for Medicaid and requires minimum Medicaid coverage at 133% FPL based on modified adjusted gross income (MAGI) with special adjustment of 5 percentage points to bring effective income eligibility to 138% FPL. Eligibility is determined without an assets or resource test (Implementation: January 1, 2014).</p>
<p>Eligibility for adults without dependent children</p>	<p>Adults without dependent children are not included in the categories of people states can cover through Medicaid under current rules. States can only cover these adults if they obtain a waiver or create a fully state-funded program.</p> <p>As of 2009, 5 states provide coverage to childless adults that is comparable to Medicaid, 15 states only provide coverage more limited than Medicaid, and an additional 4 states solely provide premium assistance with employment-related eligibility requirements.</p>	<p>• Creates a state option to cover childless adults through a Medicaid State Plan Amendment (Implementation: April 1, 2010).</p> <p>• Maintains coverage levels in place on the date of enactment (March 23, 2010) until 2014 and allows states the option to provide Medicaid coverage to individuals with incomes above 133% of poverty at regular state matching rates.</p> <p>• Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.</p>
<p>Determination of Income</p>	<p>In general, states also have flexibility to determine income and resource methodologies for purposes of determining Medicaid eligibility.</p>	<p>• Bases eligibility on modified adjusted gross income (MAGI) with no asset or resource test. MAGI includes total income plus tax exempt interest and foreign earned income. Applies a special adjustment of 5 percentage points to bring effective income eligibility to 138% FPL.</p>

Current Law

Patient Protection and Affordable Care Act (P.L. 111-148)

<p>Determination of Income (continued)</p>		<ul style="list-style-type: none"> • Maintains existing income counting rules for the elderly and groups eligible through another program like foster care, low-income Medicare beneficiaries and Supplemental Security Income (SSI). Does not affect eligibility determinations made through Express Lane Eligibility. Requires states to establish equivalent income thresholds to implement the MOE requirements for children using MAGI that ensures that individuals eligible on January 1, 2014 do not lose coverage. MAGI would not apply to beneficiaries enrolled as of January 1, 2014, until March 31, 2014 or their next re-determination date. (Implementation: January 1, 2014)
<p>Other coverage</p>	<p>Medicaid provides a range of assistance for low-income Medicare beneficiaries. For individuals dually eligible for Medicare and Medicaid, Medicaid pays for all Medicare premiums and cost-sharing plus wrap around coverage; for Qualified Medicare Beneficiaries (QMBs) Medicare eligibles at or below 100% FPL Medicaid pays for all Medicare premiums and cost-sharing charges; for Specified Low-Income Medicare Beneficiaries (SLMBs) between 100% FPL and 120% FPL; Medicaid pays for Medicare Part B premiums, and for Qualifying Individuals 1 (QI1s) between 120% FPL and 135% FPL Medicaid pays Medicare Part B premiums but the benefit is subject to an annual funding cap.</p> <p>States have many other optional coverage categories such as: medically needy (individuals spend-down to eligibility levels by deducting medical expenses); waiver coverage for home and community based services or family planning; and uninsured women with breast or cervical cancer screened by CDC. There is a 2 year waiting period for Medicare for individuals with disabilities.</p>	<ul style="list-style-type: none"> • Establishes Medicaid coverage (with EPSDT benefits) for children under age 26 who were in foster care when they turned 18 (Implementation: January 1, 2014). • Creates a state option to provide Medicaid coverage for family planning services through a State Plan Amendment to certain low-income individuals up to the highest level of eligibility for pregnant women (Implementation: Upon enactment). • Requires states to report annually beginning January 2015 on changes in Medicaid enrollment by population, outreach and enrollment processes and other data to monitor enrollment and retention of Medicaid eligible individuals. Then HHS would report findings to Congress beginning in April 2015 annually on a state-by-state basis. • Permits all hospitals participating in Medicaid (with state verification of capability) to make presumptive eligibility determinations and allows hospitals and other providers to make presumptive eligibility determinations for all Medicaid eligible populations (Implementation: January 2014).
<p>Maintenance of Eligibility (MOE)</p>	<p>While states generally have flexibility to change optional eligibility levels the American Recovery and Reinvestment Act (ARRA) that provided additional funding for states in the form of an enhanced FMAP requires states to maintain eligibility levels and enrollment procedures from July 1, 2008 to be eligible for enhanced funds.</p>	<ul style="list-style-type: none"> • Requires states to maintain current income eligibility levels in place on the date of enactment (March 23, 2010) for children in Medicaid and CHIP through September 30, 2019. • Requires states to maintain Medicaid eligibility levels for adults in place on the date of enactment (March 23, 2010) until the Secretary determines that the state exchanges are fully operational (expected to be January 1, 2014). • Exempts states from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL starting in January 2011 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. • Conditions Medicaid payments on compliance with the maintenance of eligibility requirements.

Patient Protection and Affordable Care Act (P.L. 111-148)	
Current Law	Patient Protection and Affordable Care Act (P.L. 111-148)
<p>Role of CHIP</p> <p>Enacted in 1997 to cover low-income uninsured children who were not eligible for Medicaid. Provides an entitlement to funding for states, not for beneficiaries. CHIP was reauthorized through 2013 in February 2009 with expanded funding, new coverage options, new tools to increase enrollment, fiscal incentives to cover more children, new benefit requirements and new quality initiatives.</p>	<ul style="list-style-type: none"> * Extends authorization and funding for CHIP through 2015 (2 years beyond the current authorization) and requires states to maintain income eligibility levels in place on the date of enactment (March 23, 2010) for Medicaid and CHIP through 2019. * Requires that CHIP eligible children who cannot enroll in CHIP due to federal allotment caps must be screened to determine if they are eligible for Medicaid and if not would be eligible for tax credits in a plan that is certified by the Secretary by April 2015 to be comparable to CHIP in the exchange. * Provides for a 23 percentage point increase in the CHIP match rate up to a cap of 100% beginning in October 1, 2015. * Does not extend the CHIPRA enrollment bonuses beyond 2013. * Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if the state premium contribution for family coverage is less than 1997 levels (adjusted for inflation) or if the employee's premiums and cost sharing exceeds 5 percent of the family's income (Implementation: Upon Enactment). * Extends and increases funding provided in CHIPRA for Medicaid and CHIP enrollment and renewal activities from \$100 million through 2013 to \$140 million through 2015.
<p>Medicaid/CHIP financing</p> <p>Medicaid financing is shared across state and federal governments. The federal matching percentage for each state (officially known as the Federal Medical Assistance Percentage, or FMAP) varies by state according to a formula set in statute that relies on states per capita income. On average the federal government pays for 57% of Medicaid costs, but this varies from a floor of 50 percent to a high of 76 percent in 2010; however, states are receiving an enhanced FMAP as a result of the American Recovery and Reinvestment Act (ARRA). ARRA provided states with an enhanced federal match (FMAP) to help states support Medicaid during an economic downturn when demand for Medicaid increases and states can least afford to support their programs.</p>	<ul style="list-style-type: none"> * Provides full federal funding (100% FMAP) for individuals newly eligible for Medicaid (includes those not eligible for full benefits, benchmark or benchmark equivalent coverage in Medicaid, those eligible for a capped program but not enrolled or on a waiting list and those covered in a non-Medicaid state funded program) for 2014-2016; 95% FMAP for 2017; 94% FMAP for 2018; 93% FMAP for 2019 and 90% FMAP for 2020 and beyond. * Phases in increase in the FMAP for expansion states for current Medicaid coverage of non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020). Expansion states are those that currently cover adults (parents and childless adults) at or above 100% FPL (through Medicaid or state-funded health programs) that is not dependent on access to employer coverage or employment and not limited to premium assistance, hospital-only benefits, a high-deductible plan or alternative benefits under Section 1938. It appears that AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI are expansion states.

Current Law

Patient Protection and Affordable Care Act (P.L. 111-148)

<p>Medicaid/CHIP financing (continued)</p>		<ul style="list-style-type: none"> Provides for a 2.2 percentage point increase in FMAP for individuals who are not newly eligible up to 133% of poverty for expansion states that do not have new eligibles and are not using Disproportionate Share Hospital (DSH) payments for coverage under a waiver would receive a 2.2 percentage point increase in FMAP. This provision appears to apply to Vermont. Limits state's ability to increase the share of Medicaid expenditures from political sub-divisions (like counties) beyond what was in place as of December 31, 2009 to be eligible for an increase in the FMAP. Provides a special adjustment to the FMAP for certain states recovering from a major disaster (Implementation: January 1, 2011). Clarifies that states must maintain Medicaid and CHIP eligibility to continue to receive Medicaid funding.
<p>CBO scoring for Medicaid</p>		<ul style="list-style-type: none"> Increases Medicaid/CHIP coverage by 16 million from 35 million by 2019. Estimates Medicaid/CHIP costs for coverage to increase by \$434 billion from 2010 to 2019. Estimates state spending on Medicaid and CHIP would increase by about \$20 billion over the 2010 to 2019 period as a result of the coverage provisions. Other significant federal Medicaid costs over the 2010 to 2019 period are related to: Improving payments to primary care practitioners (\$8.3 billion) and the Community First Choice Option (\$6.0 billion). Significant federal Medicaid savings over the 2010 to 2019 period are related to: Medicaid prescription drug coverage (-\$38.1 billion) and reductions in Medicaid disproportionate share hospital (-\$14.0 billion).
<p>Medicaid interface with the exchange</p>		<ul style="list-style-type: none"> Requires states to: enable individuals to apply or renew Medicaid coverage through a website with electronic signature; establish procedures to enable individuals to apply for Medicaid, CHIP or the Exchange through a State-run website that must be in operation by January 1, 2014; conduct outreach to enroll vulnerable and underserved populations in Medicaid and CHIP. (Enrollment website must be operational by January 1, 2014) Allows the state Medicaid and CHIP agency to enter into an agreement with the Exchange to determine eligibility for premium subsidies to purchase coverage through the exchange.
<p>Medicaid benefits and delivery system</p>	<p>Medicaid covers a broad range of acute and long-term care services. States must cover certain mandatory services but are permitted to cover important services that are "optional". Medicaid benefits have been designed to serve low-income and high-need populations.</p> <p>Medicaid provides comprehensive coverage for children through the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit.</p>	<ul style="list-style-type: none"> Provides all newly-eligible adults with a benchmark benefit package or benchmark-equivalent that meets minimum essential health benefits available in the Exchange (including prescription drugs and mental health parity at actuarial equivalence to the benchmark). Populations exempt from mandatory enrollment in these benchmark plans (including the elderly, persons with disabilities and pregnant women) would remain exempt.

Current Law

Medicaid benefits and delivery system (continued)

Some services covered that are typically not included in private plans are transportation, durable medical equipment, case management, personal care and institutional long-term care.
 Medicaid is required to cover and pay for services provided by Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC). Medicaid also contracts with other providers not typically in private insurance networks (like school health clinics).
 States have the option under current law to provide services for Medicaid beneficiaries through managed care arrangement or through fee-for-service. On average, 64.1% of Medicaid enrollees are in managed care.

Patient Protection and Affordable Care Act (P.L. 111-148)

- Provides states with a 1% increase in the FMAP for preventive services recommended by the US Preventive Services Task Force with a grade of A or B and recommended immunization for adults if offered with no cost sharing (Implementation: January 1, 2013).
- Requires coverage for smoking cessation for pregnant women without cost sharing (Implementation: October 1, 2010)
- Eliminates smoking cessation drugs, barbiturates, and benzodiazepines from excluded drug list (Implementation: January 1, 2014).
- Requires coverage for free standing birth center services (Implementation: upon enactment except if state legislation is required).
- Allows Medicaid eligible children to receive hospice services concurrent with other treatment.
- Allows states to provide coordinated care through a health home for individuals with chronic conditions. Provides 90% match for 2 years for health home services including care management, care coordination and health promotion, transitional care, patient and family support and referral to community and social support services and use of HIT where feasible and appropriate. Provides \$25 million for the Secretary to award for planning grants (Implementation: January 1, 2011).
- Increases payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014 and provides 100% federal financing for the difference in rates based on rates applicable on July 1, 2009. Primary care services are defined as evaluation and management services service codes and services related to immunizations.
- Broadens the scope of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include adult services (including duals) and clarifies the topics for review including eligibility policies, enrollment and retention processes, coverage policies, quality of care, and interactions with Medicare and Medicaid. (Provides appropriations of \$11 million for FY 2010 with \$9 million from Medicaid and \$2 million from CHIP)
- Establishes the CMS Innovation Center designed to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to foster patient-centered care, improve quality, and slow Medicare costs growth. Payment reform models that improve quality and reduce the rate of costs could be expanded throughout the Medicare, Medicaid, and CHIP programs (Implementation: January 1, 2010).

Provider payment rates

State Medicaid programs have broad flexibility to set provider payment rates and rates vary across states. On average, hospital fees are estimated to be 5% below Medicare rates, physician fees 40% below and managed care rates about 15% below Medicare rates. On average across the country, Medicaid fees for primary care physicians are at 66% of Medicare fees.
 CHIPRA established the Medicaid and CHIP Payment and Access Commission (MACPAC) to examine payment policies and access for children and report to Congress.

Current Law

Patient Protection and Affordable Care Act (P.L. 111-148)

<p>Demonstrations and pilots</p>		<ul style="list-style-type: none"> * Authorizes \$100 million in grant funding for states to establish programs for Medicaid beneficiaries to cease tobacco use, control weight, lower cholesterol, lower blood pressure and/or avoid or improve management of diabetes. (Implementation: January 1, 2011) * Establishes a bundled payment demonstration project for up to 8 states for acute and post-acute care (Implementation: January 1, 2012 to December 31, 2016). * Establishes a global payments demonstration project for up to 5 states from 2010 to 2012 for large safety-net hospital systems (Implementation: Fiscal year 2010 through 2012). * Establishes demonstration projects in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (Implementation: January 1, 2012 – December 31, 2016). * Authorizes a demonstration for stabilization of emergency medical conditions by Institutions for Mental Disease for individuals 21 to 65 who require stabilization in these settings as required by the Emergency Medical Treatment and Active Labor Act (EMTALA). Today, these hospitals are denied payment for care that is required under the EMTALA rules (Implementation: (Appropriations of \$75 million for fiscal year 2011 through 2015). * Requires the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP (Implementation: Issue regulations 180 days post enactment).
<p>Long-term care</p>	<p>Medicaid is the primary provider of long-term care services. Medicaid provides care for 1 million nursing home residents and 2.8 community-based residents and pays for over 40% of all long-term care services in the U.S.</p>	<ul style="list-style-type: none"> * Establishes the Community First Choice Option in Medicaid to allow states to provide community-based attendant supports and services to individuals with incomes up to 150% FPL with disabilities who require an institutional level of care through a state plan amendment (SPA). Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program (Implementation: October 1, 2011). * Provides states with new options for offering home and community-based services through a Medicaid State Plan Amendment rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and a higher level of need and permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan (Implementation: October 1, 2010). * Creates the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports with \$3 billion in federal matching funds (Implementation: October 1, 2011 through September 30, 2015).

Current Law

Patient Protection and Affordable Care Act (P.L. 111-148)

<p>Long-term care (continued)</p>		<ul style="list-style-type: none"> • Extends the Medicaid Money Follows the Person Rebalancing Demonstration program through 2016 and requires that individuals reside in a nursing home for not less than 90 consecutive days (Implementation: 30 days after enactment). • Allocate \$10 million per year for 2010 through 2014 to continue the Aging and Disability Resource Center initiatives. • Includes protections against spousal impoverishment in Medicaid HCBS (Implementation: January 1, 2014 for five years). • Includes a Sense of the Senate that Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals care they need and that care should be available in the community in addition to institutions. • Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of \$50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out (Implementation: January 1, 2011).
<p>Duals</p>	<p>Medicaid provides assistance to 8.8 million low-income aged and disable who are dually eligible for Medicare (18% of Medicare beneficiaries). Medicaid provides assistance with Medicare premiums and cost-sharing and covers</p>	<ul style="list-style-type: none"> • Establishes the Federal Coordinated Health Care Office (CHCO) within CMS to align Medicare and Medicaid financing, benefits, administration, oversight rules, and policies for dual eligibles (Implementation: March 1, 2010). • Clarifies Medicaid demonstration authority for coordinating care for the duals for up to 5 years.
<p>Quality and program integrity</p>	<p>Most states use managed care to implement quality initiatives. Most states have pay-for-performance programs and report quality data through HEDIS and CAHPS.</p> <p>States have the primary responsibility for Medicaid program integrity through efficient administration of the program and through Medicaid fraud and abuse control units (MFUCs). The Deficit Reduction Act (DRA) of 2005 created the Medicaid Integrity Program (MIP) which increased federal resources and required CMS to devise a national strategy to combat Medicaid fraud, waste, and abuse. Appropriations for the MIP are now at \$75 million per year.</p>	<ul style="list-style-type: none"> • Establishes the Medicaid Quality Measurement Program to establish priority for the development and advancement of quality measures for adults in Medicaid. Sets deadlines for development of measures, standardization of reporting formats, and requires a report to Congress (January 2014 and then every 3 years). • Prohibits federal payments to states for Medicaid services related to healthcare acquired conditions (Implementation: Through regulations effective July 1, 2011). • Establishes procedures for screening, oversight, and reporting requirements for providers and suppliers that participate in Medicaid, Medicare, and CHIP. Imposes a fee on providers and suppliers for screening purposes (Implementation: varies based on whether an existing provider/supplier or a new provider/supplier; fee begins in 2010).

Current Law

Patient Protection and Affordable Care Act (P.L. 111-148)

Quality and program integrity (continued)

- * Requires CMS to include Medicare, Medicaid, CHIP, VA, DOD SSA and IHS the integrated Data Repository (IDR) and requires the Secretary to enter into data-sharing agreements with these agencies to identify waste, fraud and abuse. Allows DOJ to access the IDR to conduct law enforcement activities.
- * Extends the 60 days that states have to repay the federal share of a Medicaid overpayment to one year or 30 days after an amount is determined through the judicial processes (Implementation: Upon enactment).
- * Authorizes the Secretary to withhold matching payments when states do not report enrollee encounter data through MMIS in a timely way.
- * Terminates provider participation in Medicaid and CHIP if a provider is terminated under Medicare or other state or child health plan.
- * Excludes certain providers from Medicaid and CHIP due to ownership control or management affiliations with individuals or entities that have been excluded from participation or have unpaid overpayments.
- * Requires additional data reporting to MMIS to detect waste, fraud and abuse (Implementation: January 1, 2010).
- * Requires billing agents, clearinghouses and alternative payees to register under Medicaid.
- * Mandates state use of national correct coding initiative (Implementation: October 1, 2010).
- * Permits states to impose a moratorium on enrollment of providers or suppliers under Medicaid and CHIP that are identified as being at high-risk for fraud, waste, and abuse.
- * Expands the use of Civil Monetary Penalties (CMP) to individuals who order a medical service when they are not enrolled as a provider in a Federal health care program, to individuals who make false statements on applications or contracts to participate in a Federal health care program, and to individuals who are aware of an overpayment and do not return it. Each violation is subject to up to a \$50,000 penalty.
- * Increases funding for health care fraud and abuse control funding by \$10 million per year (Implementation: Fiscal year 2011 through 2020).
- * Requires states to implement fraud, waste, and abuse programs by January 1, 2011.
- * Reduces aggregate DSH allotments by \$.5 billion in 2014; \$.6 billion in 2015; \$.6 billion in 2016; \$1.8 billion in 2017; \$5 billion in 2018; \$5.6 billion in 2019 and \$4 billion 2020. Requires the Secretary to develop a methodology to distribute the DSH reductions that imposes the largest reduction in DSH for states with the lowest percentage of uninsured, imposes smaller reductions for low-DSH states and accounts for DSH allotments used for 1115 waivers. Provides DSH allotments for TN and HI.

DSH Medicaid disproportionate hospital share (DSH) payments are supplemental payments that states can use for reimburse hospitals that serve high levels of Medicaid and uninsured patients. Federal DSH funds are capped and represent about 5% of all Medicaid spending.

Current Law

Patient Protection and Affordable Care Act (P.L. 111-148)

<p>Prescription drugs</p>	<p>Manufacturers must provide rebates to state Medicaid programs, but drugs purchased through managed care organizations are not subject to the rebate program. Medicaid payments to pharmacists include acquisition costs and dispensing fees. The DRA made changes to the way Medicaid pays pharmacists and CMS issued a rule (known as the AMP Rule) in July 2007. A U.S. District Court issued a preliminary injunction against this change.</p>	<ul style="list-style-type: none"> Increases the Medicaid drug rebate percentage for brand name drugs from 15.1% to 23.1% (except for clotting factor and drugs for pediatric indications increase to 17.1%), increases the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price, extends the drug rebate to Medicaid managed care plans (excludes 340B programs), and limits the total rebate liability to 100% AMP with revenue due to the federal government. For purposes of applying the additional rebates, a new formulation of a drug is a line extension of a single source or innovator multiples source drug that is an oral solid dosage form of the drug (Implementation: January 1, 2010 except for rebates for managed care plans which is effective upon enactment). Calculates the Federal Upper Limit as no less than 175% weighted average AMP for therapeutically equivalent multiple source drugs (Implementation: 180 days after enactment).
<p>Territories</p>	<p>Medicaid programs in the territories are subject to spending caps. The FMAP is statutorily set at 50% for the territories.</p>	<ul style="list-style-type: none"> Increases spending caps for the territories by \$7.3 billion from 2014 through 2019 and allows each territory to establish a Health Benefits Exchange. Requires the territories to cover childless adults up to the eligibility standards in place for parents and exempts the costs of new coverage in counting toward the spending caps.
<p>Sources of information</p>		<p>www.democraticleader.house.gov/</p>

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FOCUS *on* Health Reform



MEDICAID AND CHIP HEALTH REFORM IMPLEMENTATION TIMELINE

This timeline highlights the implementation dates for Medicaid and the Children's Health Insurance Program for provisions in the Patient Protection and Affordable Care Act (P.L. 111-148) which was signed on March 23, 2010 along with changes made to the law by The Health Care and Education Reconciliation Act of 2010 which was signed on March 30, 2010. While major expansions to Medicaid occur in 2014, there are many other health reform provisions that become effective between 2010 and 2014. A timeline reflecting key implementation dates for provisions beyond Medicaid and CHIP can be found at: <http://www.kff.org/healthreform/8060.cfm>.

A summary of the new health reform law compared to pre-reform law for Medicaid and CHIP can be found at: <http://www.kff.org/healthreform/7952.cfm>.

2010

- Creates a state option to cover childless adults through a Medicaid State Plan Amendment (April 1).
- Creates a state option to provide Medicaid coverage for family planning services to certain low-income individuals through a Medicaid State Plan Amendment up to the highest level of eligibility for pregnant women (March 23).
- Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if certain conditions are met (March 23).
- Requires coverage for smoking cessation for pregnant women without cost sharing (October 1).
- Requires coverage for free standing birth center services (March 23 except if state legislation is required).
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans (January 1 except for rebates for managed care which are effective March 23, 2010).
- Provides funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid) (January 1 except for managed care rebates which is effective upon enactment).
- Provides states with new options for offering home and community-based services through a Medicaid State Plan Amendment rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and a higher level of need and permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan (October 1).
- Establishes a global payments demonstration project for up to 5 states from 2010 to 2012 for large safety-net hospital systems (October 1).
- Authorizes a demonstration for stabilization of emergency medical conditions by Institutions for Mental Disease for individuals 21 to 65 who require stabilization in these settings as required by the Emergency Medical Treatment and Active Labor Act (EMTALA). Today, these hospitals are denied payment for care that is required under the EMTALA rules with \$75 million in funding (Available October 1, 2010 through December 31, 2015).
- Establishes the CMS Innovation Center designed to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to foster patient-centered care, improve quality, and slow Medicare costs growth. Payment reform models that improve quality and reduce the rate of costs could be expanded throughout the Medicare, Medicaid, and CHIP programs (By December 31).
- Establishes the Federal Coordinated Health Care Office (CHCO) within CMS to align Medicare and Medicaid financing, benefits, administration, oversight rules, and policies for dual eligibles (By March 1).
- Requires the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP (Regulations by September 19).
- Extends the 60 days that states have to repay the federal share of a Medicaid overpayment to one year or 30 days after an amount is determined through the judicial processes (March 23). Requires data reporting to MMIS to detect waste, fraud and abuse; mandates states' use of national correct coding initiative (January 1).
- Requires states to implement fraud, waste, and abuse programs by January 1, 2011 and increases funding for health care fraud and abuse control funding by \$10 million per year for fiscal year 2011 through 2020.

2011

- Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program) (Effective January 1, 2011 and payout of benefits starting 2016).
- Prohibits federal payments to states for Medicaid services related to health care acquired conditions (July 1).
- Creates a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion (January 1).
- Authorizes \$100 million in grant funding for states to establish programs for Medicaid beneficiaries to cease tobacco use, control weight, lower cholesterol, lower blood pressure and/or avoid or improve management of diabetes (Appropriates funds available January 1 available for 5 years).
- Creates the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services (October 1, 2011 through September 30, 2015).
- Establishes the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities (October 1).

2011 (continued)

- Establishes procedures for screening, oversight, and reporting requirements for providers and suppliers that participate in Medicaid, Medicare, and CHIP; imposes a fee on providers and suppliers for screening purposes; requires additional requires billing agents, clearinghouses and alternative payees to register under Medicaid (January 1).
- Increase spending caps for the territories (July 1, 2011 through September 30, 2019).

2012

- Establishes a bundled payment demonstration project for up to 8 states for acute and post-acute care (January 1, 2012 to December 31, 2016).
- Establishes demonstration projects in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (January 1, 2012 – December 31, 2016).

2013

- Extends authorization and funding for CHIP through 2015 (2 years beyond the current authorization which is until 2013).
- Extends and increases funding provided in CHIPRA for Medicaid and CHIP enrollment and renewal activities from \$100 million in 2013 to \$140 million in 2015.
- Increase Medicaid payments for primary care services provided by primary care doctors with 100% federal funding (For services provided from January 1, 2013 through December 31, 2014).
- Provides states with a 1 percentage point increase in the FMAP for preventive services recommended by the US Preventive Services Task Force with a grade of A or B and recommended immunization for adults if offered with no cost sharing (January 1).

2014

- Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) and provides enhanced federal matching for new eligibles (January 1).
- Establishes Medicaid coverage (with EPSDT benefits) for children under age 26 who were in foster care when they turned 18 (January 1).
- Eliminates smoking cessation drugs, barbiturates, and benzodiazepines from excluded drug list (January 1).
- Permits all hospitals participating in Medicaid (with state verification of capability) to make presumptive eligibility determinations and allows hospitals and other providers to make presumptive eligibility determinations for all Medicaid eligible populations (January 1).
- Requires states to: enable individuals to apply or renew Medicaid coverage through a website with electronic signature; establish procedures to enable individuals to apply for Medicaid, CHIP or the Exchange through a State-run website that must be in operation by January 1, 2014; conduct outreach to enroll vulnerable and underserved populations in Medicaid and CHIP. Enrollment website must be operational by January 1, 2014.
- Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments (Beginning in FY 2014).
- Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.

2015 and later

- Requires states to report annually beginning January 2015 on changes in Medicaid enrollment by population, outreach and enrollment processes and other data to monitor enrollment and retention of Medicaid eligible individuals. Then HHS would report findings to Congress beginning in April 2015 annually on a state-by-state basis.
- Requires that CHIP eligible children who cannot enroll in CHIP due to federal allotment caps must be screened to determine if they are eligible for Medicaid and if not would be eligible for tax credits in a plan that is certified by the Secretary by April 2015 to be comparable to CHIP in the exchange.
- Provides for a 23 percentage point increase in the CHIP match rate up to a cap of 100% beginning in October 1, 2015.

For additional information, see <http://www.kff.org/healthreform/8064.cfm>.

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CENTER FOR CHILDREN AND FAMILIES

Early Wins for Children and Families in Health Care Reform

If passage of health reform is used to help spur the families of uninsured children to enroll them in coverage, it may be one of the most powerful, early benefits of the legislation.

Now that the Patient Protection and Affordable Care Act (PPACA; Public Law 111-148) has been signed into law, families across the country are interested to know what the legislation means for them. While many of the sweeping changes to insurance industry practices and other major provisions do not go into effect until January 1, 2014, there are some important early wins in health reform for children and their families. This issue brief reviews those early wins in some detail.

The brief also explores the opportunity created by health reform to inform families about the chance to enroll their uninsured children in Medicaid and the Children's Health Insurance Program (CHIP). Even prior to passage of health reform, almost two-thirds of uninsured children were already eligible for these public programs.¹ If passage of health reform is used to help spur the families of these children to enroll them in coverage, it may be one of the most powerful, early benefits of the legislation.

1. Strengthening the Opportunity for Families to Enroll Their Uninsured Children in Medicaid and CHIP

With health reform "in the news," many families are seeking information about what the legislation means for them. This creates an important opportunity to raise awareness among eligible families that their children could secure coverage through Medicaid or CHIP. A similar dynamic occurred in 1997 after CHIP was enacted into law. The excitement in the media and among state leaders over the new program caused many families to come forward, seek more information, and apply. In many cases, it turned out that their children were eligible for the existing Medicaid program. This unintended boost to Medicaid enroll-

ment – or "welcome mat effect" – was one of the major reasons why the country succeeded in reducing the uninsured rate of low-income children by over a third in the past decade.²

"Holding Steady" on Medicaid and CHIP. Along with serving as a potentially powerful tool for raising awareness about Medicaid and CHIP, the health reform legislation includes some provisions that directly strengthen the programs. Most notably, as of the PPACA's March 23, 2010 enactment date, states are required to "hold steady" when it comes to Medicaid and CHIP coverage. Specifically, the PPACA requires that states maintain eligibility standards and enrollment procedures for children in Medicaid and CHIP until October 1, 2019, and for most adults – primarily parents – in Medicaid until January 1, 2014, when the new health exchanges are operational. This assures that Medicaid and CHIP will remain available to families as health reform is being implemented, and that states cannot impose new paperwork barriers to enrolling in and retaining coverage. In the absence of such a requirement, some states might have scaled back on Medicaid or CHIP coverage in light of their serious fiscal problems.³

New Coverage Portal. A complementary provision to reaching uninsured children eligible for Medicaid and CHIP is a new requirement that, by July 1, 2010, Health and Human Services (HHS) work in consultation with states to establish a website (and possibly other tools) that will provide state-level information about affordable health coverage options, including Medicaid, CHIP, and the new high risk pools (see item 5). While families still will need to apply for and enroll in Medicaid or CHIP through their states, the portal should help them to learn about and connect with these programs and other sources of coverage.

2. Covering Uninsured Young Adults on a Parent's Plan

For families with young adults up to age 26 who are in need of coverage, the health reform law includes an important new provision to cover them under a parent's insurance policy. Currently, most health plans that provide family-based coverage cover children only until age 19 or 20 (unless they are in college full-time or a state law requires coverage until an older age). As a result of the PPACA, young adults or "dependents" up to age 26 will qualify for coverage under a parent's policy that offers dependent coverage. The new policy goes into effect for health plan years that begin after September 23, 2010. It applies to all health insurance policies that provide dependent coverage, i.e., existing and new family coverage policies offered in the individual and group markets. (A group plan generally refers to one offered through an employer.) With young adults representing 28 percent of the uninsured population, this provision will provide an important new option for many families.⁴

HHS will issue regulations defining "dependents" for purposes of the new rule. The statutory language leaves open the possibility for a broad definition that includes, for example, a full-time student or a married adult child (although the law stipulates that plans are not obligated to cover any of the young adult's children). Before 2014, existing employer health plans are not required to cover a young adult who has access to coverage through his or her own job. This provision does not apply for plan years beginning after 2014.

The new coverage will not be free to families. Instead, they will need to select the family-coverage option from their employer plan (or when purchasing coverage in the individual market), which typically costs more than employee-only (or employee/spouse) coverage. Insurers may adjust their rates for family-based coverage upward across-the-board to reflect that they expect to cover more young adults, but any increases should be relatively modest, especially compared to the benefits of obtaining coverage for these uninsured young adults.

3. Providing Preventive Coverage and Screenings at No Cost

As part of the effort to encourage greater use of preventive care, the PPACA requires new insurance plans in the individual and group markets, issued after September 23, 2010, to provide specific preventive services without cost sharing. For children, this includes

KEY EARLY IMPROVEMENTS BENEFITING CHILDREN AND FAMILIES

March 23, 2010 (date of enactment)

- States must maintain Medicaid and CHIP eligibility and enrollment procedures for children until October 1, 2019. (This provision is effective for most adults until 2014.)
- States have the flexibility to expand eligibility further or to simplify enrollment in Medicaid and CHIP.
- States have the option to provide children of state employees with CHIP coverage under certain circumstances.
- Certain small employers can receive tax credits covering 35 percent (50 percent by 2014) of health care premiums.

By July 1, 2010

- Uninsured children and families with pre-existing conditions can seek coverage through newly established high-risk pools.

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

- Everyone signing up for a new health plan will receive preventive services at no cost.
- Insured children cannot be denied coverage for a pre-existing condition.
- Young adults up to age 26 can obtain coverage through a parent's plan.
- New health insurance reforms make it easier for everyone to use and keep their insurance coverage.

preventive care recommended by Bright Futures, an initiative by the American Academy of Pediatrics and the HHS Health Resources and Services Administration (HRSA). For example, families with new plans are expected to no longer face co-insurance or co-payment charges for well-child visits, vision and hearing tests, various health and behavioral assessments, and developmental screenings. Further guidance is required to clarify what constitutes a "new plan."

In addition to the Bright Futures' requirements, the PPACA requires that new health plans cover preventive services for children and adults recommended by the United States Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. New health plans must also cover, at no cost, preventive care for women, such as screenings for cervical cancer and mammograms, recommended by HRSA.

Health reform is designed to very quickly ensure that children with pre-existing conditions can secure coverage.

4. Covering Children with a Pre-Existing Condition

A major purpose of the PPACA is to transform the way the insurance industry operates, such as by making it easier for people with illnesses or chronic conditions to secure affordable coverage. While many of these broader changes will not be implemented until 2014, health reform is designed to very quickly ensure that children under age 19 with pre-existing conditions can secure coverage and to ban the insurance industry's use of other particularly egregious practices (see item 6 for other early improvements).

Currently, "pre-existing condition exclusions" can be applied to families with insurance in many situations, which means that they may be denied coverage for services related to a child's (or other family member's) particular health condition. Such exclusions can be applied on a time-limited (e.g., 12 months) or even permanent basis, depending on the type of health plan and a person's previous coverage history.⁵ Beginning with health plan years in effect after September 23, 2010, the PPACA bans the use of pre-existing condition exclusions for children's coverage. As a result, a child with asthma, for example, who is on a parent's employer plan no longer can be denied coverage for services related to his or her asthma.

Along with banning the use of pre-existing condition exclusions, HHS officials have said that they will issue regulations to ensure that the insurance industry no longer engages in the practice of simply not selling an insurance policy to families with a sick or disabled child.⁶ This would take the early insurance reform improvements for children one step further, providing much-needed relief for families with sick or disabled children who simply cannot secure any insurance for their children in the current individual insurance market.

While health reform provides immediate relief from pre-existing condition exclusions for children, it is not until January 1, 2014 that insurance companies are expected to face legal constraints on raising premiums for someone who is ill or has a chronic condition. As a result, it will be important to monitor whether insurers respect the law's intent to ensure that children with health care problems can immediately secure affordable coverage or if they will attempt to disregard it, such as by sharply raising premiums for those families with disabled or sick children.

5. Establishing Temporary High-Risk Pools for Uninsured People with Pre-Existing Conditions

Currently, 35 states operate some type of high-risk pool to provide coverage to those who are uninsurable, although many have sharply limited enrollment. In 2008, these pools provided coverage to about 200,000 enrollees.⁷ The PPACA establishes a new \$5 billion national high-risk pool program to help increase the number of people who can obtain coverage due to a pre-existing condition while broader health reform is being implemented. The pools are expected to operate in every state, and to be available from July 1, 2010 through January 1, 2014. States will have the option to set up a pool (alongside a current state high risk pool or through other existing coverage options) or leave implementation to HHS.⁸

Eligibility. To enroll in a pool, a person must be a citizen or lawfully present immigrant, have a pre-existing condition, and be uninsured for six months prior to applying for coverage.⁹ There are no age limits to the pools so children, their parents, and other adults presumably could be eligible for the program, although it is not clear whether family coverage will be available in the pools (meaning that children may need to obtain an individual coverage plan). With funding limited, HHS may need to establish guidelines on enrollment caps and waiting lists, and potentially consider setting enrollment priorities.¹⁰

Premiums and Benefits. Premiums in the pools will be based on the "standard rate for a standard population."¹¹ As a result, enrollees with pre-existing conditions will pay premiums that are comparable to what someone without their conditions would pay. Plans will be expected to cover at least 65 percent of health costs that an average family will incur¹² and to limit out-of-pocket costs (including co-payments and deductibles) based on the federal limits established for high-deductible plans (in 2010, \$5,950 for an individual or \$11,900 for a family). These cost protections will be a significant improvement for these families, however, without a subsidy to help families purchase the coverage, a "standard" premium for high-risk pool coverage could still remain too expensive for some families.

6. Implementing Other Early Reforms Important for Children and Families

Some additional "early wins" for children and families include:

Support for new Medicaid and CHIP expansions. Health care reform provides states with the flexibility to expand eligibility further or simplify enrollment in Medicaid and CHIP. This includes exercising the options made available to them under the Children's Health Insurance Program Reauthorization Act (CHIP-RA), which was signed into law by President Obama in February 2009. In addition, through the PPACA, states can phase in coverage for adults up to 133 percent of the federal poverty level prior to 2014. To implement this option, states will only need to submit a state plan amendment. Until 2014 (when states will receive an enhanced match rate in Medicaid for this "newly eligible" group), states will receive their regular Medicaid match rate for this population.

CHIP option for children of state employees. To date, children of state employees have been excluded from CHIP even when they meet the eligibility criteria, but now states can choose to enroll such children in CHIP. States can implement this option for its employees 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.

Tax credits for small businesses. To encourage small employers to offer health insurance coverage, the PPACA immediately provides tax credits to employers with less than 25 full-time employees. Eligible employers must pay an average salary of \$50,000 or less per year and cover at least 50 percent of their workers' health costs. From 2010 through 2013, these employers can receive a tax credit up to 35 percent for premiums paid to their workers. In 2014, the credit is available to fewer employers and is time-limited but the rate increases to 50 percent.

Insurance market reforms. There are a number of early reforms that will make it easier for families to keep and use their insurance coverage. Unless otherwise noted, each of these provisions goes into effect after September 23, 2010, when a new health plan year begins.

- All insurance plans, current and new, can no longer establish lifetime limits. In addition, new individual plans and all (existing and new) group plans cannot have "restrictive" annual limits (with no annual limits after 2014).
- No insurer can rescind coverage once a person is enrolled (for example, if a person is sick) except in cases of fraud and misrepresentation.
- New plans must establish internal and external processes through which people can appeal coverage determinations and claims.
- People enrolling in new plans will have greater flexibility in designating who they want as a primary care provider (such as an OB/GYN) and will no longer have to obtain prior authorization for emergency health care.
- Beginning in fiscal year 2010, states will receive grants (\$30 million in the first year) to develop consumer assistance programs to help families with enrolling in coverage, educating them on their rights with respect to insurance coverage, and helping them to file complaints and appeals.
- Starting in 2011, large group policies must spend at least 85 percent, and small group or individual policies at least 80 percent, of premium dollars on medical care and quality improvement. If insurers spend less than is required by these "medical loss ratio" standards, they must refund the difference to enrollees.
- The Secretary of HHS and states will establish, starting in the 2010 plan year, an annual review process to identify "unreasonable increases in premiums." States will receive grants until 2014 to support this process. After 2014 the Secretary of HHS will monitor the Exchange plans.

There are a number of early reforms that will make it easier for families to keep and use their insurance coverage.

Endnotes

1. G. Kenney, A. Cook, & L. Dubay, "Progress Enrolling Children in Medicaid/CHIP: Who is Left and What are the Prospects for Covering More Children," Urban Institute (December 2009).
2. Johns Hopkins University Bloomberg School of Public Health, analysis of the National Health Interview Survey for the Center for Children and Families (March 1, 2008).
3. For more information on state requirements for maintaining Medicaid and CHIP coverage, see Georgetown Center for Children and Families and Center on Budget and Policy Priorities, "Holding the Line on Medicaid and CHIP: Key Questions and Answers about Health Care Reform's Maintenance-of-Effort Requirements" (March 2010).
4. J. Holahan & G. Kenney, "Health Insurance Coverage of Young Adults: Issues and Broader Considerations," Urban Institute (June 2008).
5. See Public Health Service Act §1204, 42 U.S.C. §300gg(a). Currently, insurers in the employer group market are barred from applying pre-existing condition exclusions for more than 12 months after initial enrollment (18 months in the case of those not enrolling when initially eligible), although some plans may have a shorter time period or none at all. A person's prior health coverage can be used to offset the 12-month pre-existing condition exclusion, as long as there was no interruption in coverage of more than 63 days. Also, group plans cannot apply a pre-existing condition exclusion to pregnancy, genetic information, or newborns enrolled within 30 days of birth. Finally, a group plan can only look back 6 months for a health condition that was present (and for which a person received treatment) before the start of coverage. Under federal law, individual insurers face no restrictions on the use of pre-existing condition exclusions except that states are required to make sure that people who leave group plans with pre-existing conditions are subsequently able to get health insurance (which many states provide through high-risk pools). Note that state law may offer more generous protections.
6. Letter from Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services to Karen Ignagni, America's Health Insurance Plans (March 29, 2010).
7. K. Pollitz, "Issues for Structuring Interim High-Risk Pools," Kaiser Family Foundation (January 2010).
8. Office of the Secretary of the U.S. Department of Health and Human Services, "Sebelius Continues Work to Implement Health Reform, Announces First Steps to Establish Temporary High Risk Pool Program," (April 2, 2010).
9. An individual enrolled in most health coverage programs, including a state high-risk pool, will not be eligible unless they drop coverage and are uninsured for the six-month period.
10. HHS intends to allocate funding to states based on population and state costs. The funds can be used to pay administrative costs and claims in excess of premiums collected. A state opting to participate cannot displace current state high-risk pool expenditures.
11. Premiums also may not vary by more than 4 to 1 based on age.
12. The PPACA states that the plans must have an actuarial value of 65 percent. This is a measurement of the percentage of medical expenses paid by a health plan for a standard population.

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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