



## Key Medicaid, CHIP, and Low-Income Provisions in the Health Care Reform Package (As of March 24, 2010)

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590), which is designed (with its companion set of amendments in H.R. 4782) to provide coverage to 32 million 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 (95 percent if undocumented immigrants are excluded from the calculation). In that year, an additional 16 million individuals (mostly childless adults and parents) will obtain coverage through Medicaid and CHIP and 29 million will obtain coverage through new health insurance Exchanges.<sup>1</sup> The Senate is expected to adopt H.R. 4782 and to send it to the President for his signature.

Most of the provisions of the health reform package will go into effect January 1, 2014. (See box of more immediate changes.) The package will:

- Create 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 in later years, establish co-operatives, opt into a national Exchange, and/or seek waivers to utilize other reform mechanisms.
- Provide Medicaid to non-elderly individuals with income up to 133 percent of the federal poverty level (FPL) and preserve Medicaid and CHIP coverage for children above 133 percent of the FPL.

### 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 in place now.
- Small employers receive tax credits covering 35% (increasing to 50% by 2014) of health care premiums.

#### *By June 24, 2010*

- A high-risk pool established for qualified uninsured people with pre-existing conditions (until the Exchanges operational).

#### *After September 23, 2010 (as the 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.

<sup>1</sup> Congressional Budget Office, *Cost Estimate of H.R. 4872, Reconciliation Act of 2010*, March 20, 2010. CBO estimates that the health reform package will cover 32 million uninsured people. This accounts for those gaining coverage through the Exchange and Medicaid/CHIP coupled with a net change in those receiving employment-based and individual market coverage.

- Provide tax credits to help people with income up to 400 percent of the FPL purchase Exchange coverage and limit their out-of-pocket costs.
- Establish a new mandate that people with gross income above the federal tax-filing threshold obtain insurance or face a tax penalty (with some exceptions, including if the cost of coverage exceeds eight percent of income).
- Require employers (those with 50 or more workers) to pay penalties for employees who receive a premium subsidy through a state Exchange. Small businesses receive tax credits to purchase coverage for their employees.
- Adopt 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. A high-risk pool is established immediately to assist families denied coverage prior to the new rules going into effect (in 2014).
- Establish a number of health care delivery and access, quality, wellness, and prevention initiatives, make investments in community health centers, and address fraud and waste in Medicaid and Medicare. Also will implement Medicare reforms, including the addition of annual exams and other preventive services at no cost (beginning in 2011) and gradually closing the “doughnut hole” in drug coverage (rebates and discounts to seniors starting in 2010 until its full elimination by 2020).

The CBO estimates that the package 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 (higher thresholds for retirees and employees in high-risk professions).

The following provides an overview of some of the bills’ proposed changes to Medicaid and CHIP, as well as other provisions of particular importance to low-income families and children.

### 1. Medicaid and CHIP

Under the health reform bills, Medicaid and CHIP serve as key building blocks for coverage. Most uninsured individuals and families not eligible for Medicaid or CHIP will be able to purchase coverage through state-based Exchanges (see Section 2).

#### *Eligibility Changes for Adults*

- **Medicaid coverage for adults under age 65 with income up to 133 percent of the FPL.<sup>2</sup>** 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. Beginning in 2014, states will be required to cover them up to 133 percent of the FPL using a new gross income standard.<sup>3</sup> To promote coordination with tax credits, the gross income standard also will apply

<sup>2</sup> Excludes Medicare recipients under age 65 who also receive Medicaid. Newly eligible adults will be covered by a benchmark benefit plan, as discussed further below. States can cover adults up to 133 percent of the FPL prior to the 2014 implementation date (note that these states will be eligible for the increased FMAP starting in 2014 since these adults will be considered “newly-eligible”).

<sup>3</sup> The bill establishes a new Modified Adjusted Gross Income (MAGI) standard, consistent with tax policy, which will be utilized in Medicaid, CHIP, and in determining tax credits. MAGI is defined as 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.

to most existing Medicaid eligibility groups. A standard five-percent of income disregard will be built into the gross income test to compensate for the loss of other, existing Medicaid disregards.<sup>4</sup>

- **Federal financial assistance for newly-eligible beneficiaries.** For fiscal years (FY) 2014 through 2016, the federal government will pick up 100 percent of the cost of covering newly-eligible adults.<sup>5</sup> In subsequent years, the increased federal match rate (FMAP) will be: 95 percent in FY 2017, 94 percent in FY 2018, 93 percent in FY 2019, and 90 percent in FY 2020 and future years. (See Table 1.)
- **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 states<sup>6</sup> 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 FY 2014, 60 percent in FY 2015, 70 percent in FY 2016, 80 percent in FY 2017, 90 percent in FY 2018, and 100 percent in FY 2019 and future years. All states, including expansion states, will receive their regular FMAP for parents eligible for coverage under the rules in place on March 23, 2010. (See Table 1.)

**Table 1. Enhanced Match Rates for Parents and Childless Adults FY 2014 and Beyond**

Fiscal Year	Newly-Eligible Parents & Childless Adults (up to 133% FPL)	Childless Adults in Expansion States Only*	
		Transition Percentage used to Calculate Enhanced Match	Example: State with 60% Original FMAP <i>Regular FMAP + [(Newly-Eligible Enhanced Match Rate - Regular FMAP) x Transition Percentage]</i>
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%

\* The 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.

<sup>4</sup> The disregard will streamline the process states use for determining eligibility for coverage by effectively changing the eligibility level. For example, for the 133 percent of the FPL ceiling, instead of states applying deductions per applicant they will apply a uniform eligibility level of 138 percent of the FPL.

<sup>5</sup> Newly-eligible is defined as childless adults and parents up to 133 percent of the FPL who, as of December 1, 2009, were not already eligible for a comprehensive benefit package.

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

- **Temporary maintenance-of-effort on existing Medicaid coverage.** As a condition of receiving federal Medicaid funding, states will be required to maintain existing Medicaid eligibility levels for non-elderly adults, in effect on March 23, 2010, until 2014. However, beginning in 2011, states with budget deficits can seek an exemption from maintaining eligibility levels for adults above 133 percent of the FPL. States still have the flexibility to provide coverage to adults above 133 percent at any point in time.
- **Optional five-year waiting period for lawfully residing immigrants remains in effect.** The health reform package 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). Since this population will be required to obtain coverage under the bill, low-income legal immigrants not eligible for Medicaid or CHIP due only to this restriction can seek subsidized coverage through the Exchanges. Undocumented immigrants will remain ineligible for Medicaid and CHIP, and cannot obtain coverage through the Exchanges.

### *Eligibility Changes for Children*

- **Medicaid coverage for children with income up to 133 percent of the FPL.** States already must provide Medicaid to children under age six with family income up to 133 percent of the FPL and those ages six through 18 with family income up to 100 percent of the FPL. In addition, all states have chosen to provide coverage above these levels through a combination of Medicaid and CHIP. In 2014, states will provide all children with family income up to 133 percent of the FPL with Medicaid (including those currently covered through separate CHIP programs).<sup>7</sup> As with adults, a new gross income standard with a uniform five percent disregard will apply in order to simplify coordination with the tax credits provided through the Exchanges.<sup>8</sup>
- **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. As a condition of receiving federal Medicaid funding, states cannot scale back their income eligibility levels and enrollment procedures for children eligible for Medicaid and CHIP in place on March 23, 2010. States will receive their current federal match rate for these kids, with the exception of children in CHIP as described below. As with children below 133 percent of the FPL, a gross income standard with a five percent income disregard will 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 FY 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, 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 HHS will be required to review and certify which plans in the Exchanges provide CHIP-comparable benefits and cost sharing, however no mechanism is described in the bill for ensuring that these plans are available in the Exchanges.

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<sup>7</sup> The bills do not address the match rate for children in separate CHIP programs up to 133 percent of the FPL 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.

<sup>8</sup> *op. cit.* (3).

- **Increased federal financial assistance for CHIP.** 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, the health reform package will extend and increase funding provided in CHIPRA for Medicaid and CHIP enrollment and renewal activities. Under the bill, \$140 million (an increase of \$40 million) will be available through 2015.
- **Medicaid coverage for former foster care children.** Effective January 1, 2014, children up to age 25 who were formally in foster care (for more than 6 months) will be newly eligible for Medicaid and EPSDT benefits.
- **New state option to provide CHIP coverage to children of state employees.** Children of state employees eligible for family coverage can be enrolled in CHIP if the employee's premium and cost sharing contributions exceed five percent of the family's income. To implement this option, a state cannot have decreased its premium contribution for family coverage below 1997 levels (adjusted for inflation).

## 2. Exchange Coverage and Tax Credits

Families without health coverage who are not eligible for public programs will be able to shop and buy insurance through state-based Exchanges. Individuals and families with moderate incomes will be eligible for premium tax credits and cost sharing subsidies. The package also allows states to offer coverage to this population through other mechanisms, such as a waiver.

- **Premium 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.<sup>9</sup> 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 overall cost sharing, expressed as an increase in the plan's actuarial value.<sup>10</sup> In addition, all plans will limit out-of-pocket costs at a maximum of \$5,950 for an individual and \$11,900 for a family in 2010, with decreased levels for those with lower incomes. (See Table 2; next page.)
- **Income in prior tax year used to determine eligibility for the 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 be put in place for counting income of families with mixed immigration status.

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<sup>9</sup> The size of the credit for a person at any given income level will be tied to the premium for the second-lowest-cost basic plan in the silver benefit tier, which has an actuarial value of 70 percent. Enrollees can purchase additional coverage at their own expense.

<sup>10</sup> 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.

**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 <sup>11</sup>
Below 133% <sup>12</sup>	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

- 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 tax credits 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<sup>13</sup> can apply their employer contribution toward the purchase of Exchange coverage (but receive no tax credits). 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 options.** States can choose to receive federal funding<sup>14</sup> 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. 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 premium tax credits and coverage through the state-based Exchanges. In addition, in 2017, a state can apply for a waiver to establish its own health reform program that is comparable to that provided under the bill.

<sup>11</sup> 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. Note that the HSA limits are reduced by family income as follows: 101 to 200 percent FPL by two-thirds; 201 to 300 percent FPL by half; 301 to 400 percent FPL by one-third. It is not clear if the reduction applies to families with income at or below 100 percent FPL.

<sup>12</sup> Households with income below 133 percent of the FPL will generally be eligible for Medicaid. Lawfully residing immigrants who are not eligible for Medicaid will be eligible for subsidies. Those with income below 134 percent of the FPL will have a premium contribution level limited to 2 percent of income.

<sup>13</sup> The upper percentage amount will most likely be 9.5 percent to correspond to amendments made to the percentage limit for "affordable coverage."

<sup>14</sup> States will receive 95 percent of the funds that would have been paid as federal premium and cost sharing subsidies for individuals in the Exchange.

### 3. Coordination of Coverage between Medicaid and Exchanges

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

- **Screen and enroll procedures between Medicaid/CHIP and Exchanges.** Individuals seeking coverage through either an Exchange or Medicaid/CHIP will be screened for eligibility for all programs and referred to the appropriate program for enrollment, without submitting additional materials or undergoing multiple determinations.
- **Streamlined and uniform enrollment process.** To ensure the implementation of the “no wrong door” process described above, a single, streamlined application form will be created for persons applying to either Medicaid, CHIP or premium tax credits through the Exchanges.<sup>15</sup> The form can 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 an 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” (trade and professional organizations, unions, etc.) to assist with public education and enrollment. In addition, all hospitals that participate in Medicaid will be allowed to implement presumptive eligibility for all Medicaid populations.
- **State Medicaid agency may administer premium tax credits.** Exchanges can contract with a state Medicaid agency to determine whether an Exchange-eligible person is eligible for the premium credits.

### 4. Health Care Benefits and Access

The health reform bills define benefit packages that will be available through the Exchanges (and individual and group markets, with some exceptions) and creates a new Medicaid benefit requirement. In addition, the bill includes a number of provisions related to combating health care disparities and transforming the health care delivery system.

- **Four benefit packages available within Exchanges.** The four benefit categories (bronze, silver, gold, and platinum) 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.** The bill requires that new health plans that are effective after September 23, 2010 cover, at no cost, the preventive care and screenings identified in [Bright Futures](#) (the American Academy of Pediatrics' "gold standard" for preventive care). Child-only health plans will also be available through the Exchanges. In addition, after September 23, 2010, insurers will be prohibited from denying coverage to insured children for pre-existing conditions (the new regulations for adults will go into effect in 2014) and will be

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<sup>15</sup> A supplemental or alternative application form is allowed for those Medicaid beneficiaries whose eligibility is not determined by MAGI.

required to provide coverage to “dependent children” (definition of which to be defined) up to age 26 on their parents’ health plan.<sup>16</sup>

- **Higher Medicaid reimbursement rates for primary care.** As reform is being launched in 2013 and 2014, states will receive 100 percent federal funding for the cost of increasing their Medicaid reimbursement rates for specific primary care services up to Medicare levels. 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.
- **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 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.** The Senate bill also extends CHIPRA’s quality measures for children to adults in Medicaid, supports establishment of medical home models, expands state flexibility to provide family planning coverage, and provides grants to states to develop early childhood visitation programs. In addition, the bill will reduce Medicaid Disproportionate Share Hospital (DSH) payments to states, allocate \$10 billion over five years to expand community health centers and the National Health Service Corps, and provide extra Medicaid payments to states that provide in-home or community services.



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<sup>16</sup> The pre-existing condition provisions also apply to “grandfathered” group health plans and the dependent coverage provisions to all “grandfathered plans.” Grandfathered plans are those in which an individual was enrolled at time of the bill’s enactment. These plans are exempt from a number of requirements so that those who like their current coverage can keep it.