

Summary of Federal SCHIP Reauthorization, Economic Stimulus, and Health Care Reform Bills and Proposals

I. Children's Health Insurance Program (CHIP) Reauthorization Act of 2009

A. Funding for CHIP. The Act provides a four-and-a-half year reauthorization (through FY 2013) of the Children's Health Insurance Program to strengthen the program's financing, increase health insurance coverage for low-income children, and improve the quality of health care children receive.

B. Coverage of Low-Income Children. The legislation will provide health coverage to an additional 4 million low-income children who are currently uninsured and will ensure that the 7 million children currently covered by CHIP continue to receive health coverage.

C. Additional Benefits for Children (Dental Coverage/Mental Health Parity). Dental coverage will be provided to all children enrolled in CHIP. The Act also requires that if mental health services are provided they must be provided on the same terms as medical and surgical benefits covered under CHIP.

D. Other Eligibility Provisions.

- **Pregnant Women:** The Act adds a new state option to cover pregnant women. Existing options to cover pregnant women through a state waiver or regulation are preserved.
- **Parents:** No new waivers to cover parents in the CHIP program will be allowed. States that have received waivers to cover low-income parents under CHIP will be allowed to transition parents into a separate block grant. The federal match for services to parents covered through CHIP will be reduced.
- **Childless Adults:** The current prohibition on waivers for coverage of childless adults is retained. Childless adults who are currently covered will transition off of CHIP. For states that have received CHIP waivers to cover childless adults, those waivers will be terminated after a one-year period. Instead, states will receive temporary Medicaid

funding for already-enrolled adults and be allowed to apply for a Medicaid waiver for any further coverage.

- **Legal Immigrant Children and Pregnant Women:** The bill gives states the option to cover children and pregnant women lawfully residing in the U.S. and who otherwise meet state Medicaid or CHIP eligibility requirements without requiring those children and pregnant women to wait five years for needed health care.
- The bill does not allow federal funds to be used for benefits for individuals who are not lawfully residing in the U.S.

E. State Allotments. The legislation improves the CHIP financing structure, making it more stable and predictable. States will receive state-based allotments that are responsive to state demographic and national spending trends and that allow additional up-front funding for states' planning improvements. States that face a funding shortfall and meet enrollment goals will receive additional payments to ensure that no eligible child is denied coverage or placed on a waiting list. The formula also sets in place new overall caps on federal funding to ensure the program's expenditures do not exceed the amounts authorized. The bill provides incentive payments for states that lower the rate of uninsured children by enrolling eligible children in CHIP or Medicaid.

The new federal allotment will bring an estimated \$700 million per year in additional federal funding to California. This will provide sufficient federal funding to cover all currently eligible children and to expand coverage to children in families with incomes between 250 percent of the federal poverty level (FPL) and 300 percent of the FPL.

F. Outreach. The legislation provides \$100 million in grants for new outreach activities to states, local governments, schools, community-based organizations, safety-net providers and others.

G. Quality of Health Care for Low-Income Children. The legislation establishes a new quality initiative to develop and implement quality measures and improve state reporting of quality data.

H. Access to Private Coverage. The bill expands on current premium assistance options for states. It allows states to offer a premium assistance subsidy for qualified, cost-effective employer-sponsored coverage to children eligible for CHIP, who have access to such coverage. It also changes the federal rules governing employer-sponsored insurance to make it easier for states and employers to offer premium assistance programs.

I. Financing. The cost of the legislation is offset over the five- and ten-year budget window by raising the federal tax on tobacco products and savings from closing a loophole in federal law whereby physicians can refer patients to facilities they own for personal gain.

II. Health – Related Provisions of Federal Economic Stimulus Bill

1. Premium Subsidies for Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage for Unemployed Workers (\$24.7 billion)

- Subsidy for eligible workers is 65% of the premium for 9 months
- Administered by Treasury through mechanism that allows employers (or health plans if they administer COBRA benefits) to receive a credit against payroll taxes
- Eligible workers includes individuals with annual incomes below \$145,000 (single) or \$290,000 (couples), but phase-out of subsidy begins at \$125,000 (single) or \$250,000 (couples). Workers must have been involuntarily terminated between September 1, 2008, and December 31, 2010. The subsidy also applies to health care continuation coverage if required by states for small employers. Family coverage is also subsidized.

2. Medicaid Funding and Eligibility

A. Temporary Federal Medical Assistance Percentage (FMAP) increase (\$86.7 billion)

- Funding distributed for a 27-month period beginning 10/1/2008 through 12/31/2010
- Across-the-board increase to all states of (6.2%) and corresponding increase for territories
- Bonus structure (in addition to across-the-board increase) in the form of a decrease in the state's share based on the state's increase in the unemployment rate
- Maintenance of effort on eligibility

B. Temporary Increase in Disproportionate Share Hospitals (DSH) Payments (\$550 million)

- Increases states' FY 2009 annual DSH allotments by 2.5%
- Increases states' FY 2010 allotment by 2.5% above FY 2009 DSH allotment
- After FY 2010, states' annual DSH allotments would return to 100% of the annual DSH allotments as determined under current law

C. Extends Moratoria on Medicaid Regulations (\$100 million)

- Extends moratoria on Medicaid regulations for targeted case management, provider taxes, and school-based administration and transportation services through June 30, 2009
- Adds moratorium on Medicaid regulation for hospital outpatient services through June 30, 2009
- Expresses sense of Congress that the Secretary of Health and Human Services should not promulgate regulations concerning intergovernmental transfers, Graduate Medical Education, and rehabilitative services

D. Transitional Medical Assistance (TMA) (\$1.3 billion)

- Extends the TMA program through December 31, 2010 (current program expires June 30, 2009)

E. Qualified Individual (QI) Program (\$550 million)

- Extends the Qualified Individual (QI) program through December 31, 2010

F. Indian Health Provisions (\$100 million)

- Eliminates cost-sharing for American Indians and Alaska Natives in Medicaid.
- Provides protections for Indian Tribal property and protections for access to Indian facilities.

G. Prompt Payment Requirements for Nursing Facilities and Hospitals (\$680 million)

- Applies prompt pay requirements to nursing facilities and hospitals in Medicaid

3. Health Information Technology Provisions

A. Adoption and Use of Health Information Technology (HIT) [\$36 billion total outlays/\$19 billion net]

Provides an estimated \$36 billion in funding for health information technology – \$34 billion for Medicare and Medicaid incentive payments and \$2 billion for HIT grants. Net investment of \$17.2 billion in HIT over 10 years for Medicare/Medicaid incentives.

- Codifies the Office of the National Coordinator for Health Information Technology (ONCHIT) and establishes an open and transparent process led by the National Coordinator to develop standards by 2010 that allow for secure nationwide electronic exchange of health information.
- Provides \$2 billion in immediate discretionary funding under the National Coordinator to fund the development of the health information technology infrastructure, including telemedicine; state grants to promote health information technology; grants for the development of loan programs to facilitate the widespread adoption of certified EHR technology; and demonstration programs to integrate health information technology into clinical education and assistance to establish or expand medical health informatics education programs.
- Expands current federal privacy and security protections for health information, including extending the Health Information Portability and Accountability Act privacy rules to “business associates” of covered entities, requiring that an individual be notified if there is an unauthorized disclosure or use of their health information, and requiring a patient’s permission to use their personal health information for marketing purposes.
- Provides temporary bonus payments over 5 years of up to \$44,000 for Medicare physicians, and up to \$75,000 for Medicaid physician for meaningful use of electronic health records. Hospitals receive base funding of \$2 million, plus additional funds based on statutory formula, for meaningful use.

- Critical access hospitals, federally qualified health centers, rural health clinics, children's hospitals, and others qualify for incentive payments
- Phases-in Medicare payment penalties for those physicians and hospitals not using electronic health records starting in 2015.

III. Federal Health Care Reform Proposals (Partial Listing)

1. President Obama and Senator Baucus ("Call to Action") Proposals

A. Overall Approach: These proposals aim to achieve universal coverage through a mix of private and public group insurance with a shared responsibility for financing. Employers, with the exception of small employers, would be required to offer coverage or contribute to the cost of their employees' coverage. The proposals expand eligibility for Medicaid and SCHIP. The proposals also create an insurance exchange or connector, which would offer a choice of private plans and a public plan option, and provide premium subsidies for low- and moderate-income families as well as tax credits for small employers.

B. Individual Requirement for Coverage: Under President Obama's plan, only children would be required to have health insurance coverage. Under Senator Baucus' plan, all people would be required to have health insurance once it is determined that affordable coverage is available. The requirement under Sen. Baucus' plan would be enforced through the tax system or another point of contact between individuals and government.

C. Benefit Packages: Under President Obama's proposal, all plans offered through the insurance exchange would be required to offer benefits commensurate with those provided to federal employees. Under Senator Baucus plan, the exchange would include a public plan option similar to Medicare, and private plan options in the insurance exchange would include high, medium, and low benefit package options. Participating insurers would be required to charge the same amount for the same benefit packages inside and outside the exchange.

D. Premiums and Cost-Sharing: Under both proposals, the federal government would provide income-related premium assistance for people buying insurance through the connector. Under Senator Baucus' plan, refundable tax credits would be available to all individuals and families with incomes up to 400 percent of the FPL who purchase coverage through the exchange. Small businesses would also receive a tax credit to offset premium costs.

E. Health Insurance Regulation: Private insurers offering coverage both inside and outside the exchange would be required to offer the same coverage for all people, regardless of pre-existing conditions. The Baucus plan would establish an Independent

Health Coverage Council, with members appointed by the President, with advice and consent of the Senate, to ensure coverage is affordable, is clinically appropriate, provides access to necessary services, and protects enrollees from high out-of-pocket costs. It would also set standards for chronic care management and quality reporting.

F. Medicare: Senator Baucus' plan would temporarily expand Medicare to older adults, ages 55 to 64, until the insurance exchange is fully implemented. The two-year waiting period for Medicare coverage for disabled people would be phased out.

G. Medicaid and SCHIP: Both proposals would expand eligibility for Medicaid and SCHIP. The Baucus plan would expand Medicaid and SCHIP to adults up to 100 percent of poverty and children up to 250 percent of poverty, and increase federal matching rates during economic downturns.

H. Quality and Efficiency: Both proposals include health system reforms to promote prevention and wellness, better management of chronic conditions, patient-centered medical homes, coordinated care, health information technology, and comparative effectiveness research.

I. Reinsurance and Risk Adjustment: Under President Obama's plan, reinsurance would be provided to employer plans for catastrophic costs. Sen. Baucus' plan would give the exchange authority to ensure that plans enrolling sicker than average people would not be financially disadvantaged relative to plans that enroll healthy people.

2. Representative Stark's "AmeriCare Health Care Act" (Introduced as H.R. 193 in the 2009-10 Congress)

A. Overall Approach: Creates a new public health insurance program administered by the federal government to provide all residents with health coverage options. Employers would either offer their employees coverage or pay into a fund to cover them through a new public program.

B. Benefit Package: Enrollees in the new program would have two choices: 1) fee-for-service coverage under Medicare Parts A and B, enhanced with additional benefits such as pregnancy-related services, well-child care, and a drug benefit package similar to that in the most popular Federal Employees Health Benefits Program (FEHBP) plan; and 2) a choice of private plans that contract with the federal government and provide a standard benefit package.

C. Cost-Sharing: Under the Medicare fee-for-service option, cost-sharing would include: deductibles equal to \$350 for individuals and \$500 for families; 20 percent coinsurance; and an out-of-pocket cap of \$2,500 for individuals and \$4,000 for families. Premiums would be established by Department of Health and Human Services (HHS) based on cost of coverage and enrollment category (e.g. individual, couple, or family).

D. Affordability: There would be no cost-sharing for children and young adults under age 24, pregnant women, and people with incomes less than 200 percent of the FPL.

E. Financing: Establishes a new trust fund, modeled on the existing Medicare Trust Fund. Employers would either offer their employees coverage and pay 80 percent of their premiums, or pay 80 percent of the AmeriCare premium into the trust fund, with employees paying the remaining 20 percent, subject to premium subsidies and out-of-pocket cost caps. States would contribute to the new trust fund an amount equal to the amounts they would have contributed to Medicaid and SCHIP.

F. Automatic Enrollment: People would automatically be enrolled in AmeriCare at birth under the bills. People with employer coverage with equivalent benefits would be able to opt-out of the AmeriCare program.

G. Efficiency and Quality Improvement: HHS would be required to negotiate prescription drug prices with pharmaceutical manufacturers. HHS would also establish standards for uniform claims and electronic medical records and create an electronic claims database.

3. Senator Wyden’s and Representative Baird’s “Healthy Americans Act” (Introduced as S. 334 and H.R. 3163 in the 2007-08 Congress)

A. Overall Approach: Establishes a requirement for most non-elderly, non-disabled persons to purchase private insurance, called Healthy Americans Private Insurance (HAPI). Coverage policies would be available from “Health Help Agencies” (HHAs) created by each state or territory or, under the Senate bill, through an employer. The income tax exclusion for employer health benefits would be eliminated. After the first two years, employers would make shared responsibility payments into a trust fund, equal to a percent of the national average premium per full-time employee. People would purchase their own health insurance through an HHA.

B. Benefit Package: Each HAPI plan would be required to offer benefits equivalent to those offered to federal employees, plus certain preventive services and other benefits specified by HHS.

C. Premiums and Cost-Sharing: The full HAPI plan premium would be paid by the individual. Employed persons would pay premiums through payroll deductions. Employer contributions would be counted as income for purposes of income and payroll taxes. Subsidies would be provided to persons with modified adjusted gross income less than 400 percent of FPL. Individuals selecting more expensive plans would be responsible for the difference between the subsidy and the selected plan’s premium. No cost-sharing would be allowed for preventive items or services, early disease detection, or chronic care. Additionally, individuals with income below 100 percent of poverty would be eligible for a full cost-sharing subsidy, and those with income above 100 percent of poverty could be eligible for cost-sharing subsidies at the discretion of an HHA.

D. Financing: The exclusion of employer-paid health insurance premiums from employees' taxable incomes would be eliminated. Employers would be required to make payments to fund subsidies for low-income persons.

E. Medicaid and SCHIP: These bills would essentially terminate the Medicaid and SCHIP programs. However, to ensure that benefits are not decreased because of the bill, the legislation would allow the Medicaid and SCHIP programs to maintain supplemental coverage for children, and elderly and disabled persons who are enrolled in the programs as of an effective date. Additionally, the Medicaid program would continue to pay for cost-sharing and premium subsidies for low-income Medicare beneficiaries.

F. Medicare: The bills would add primary care and chronic care benefits to the Medicare program.

4. Senator Enzi's "Ten Steps to Transform Health Care in America Act" (Introduced as S. 1783 in the 2007-08 Congress)

A. Overall Approach: Promotes expanded health insurance coverage by modifying the tax treatment of health insurance, setting standards for state insurance regulations, allowing coverage to be offered through small business health plans, and providing Medicaid and SCHIP beneficiaries with the option of using the value of the benefits to purchase private health insurance. The bill also includes provisions related to health information technology, quality improvement, health professions education and the health care workforce, and tort reform.

B. Tax Treatment: The bill would eliminate the exclusion from income of employer-paid health insurance premiums for individual tax purposes. The bill would create a standard tax deduction for qualified health care insurance premiums equal to \$7,500 for individuals and \$15,000 for families. It would also create an income-based advanceable and refundable tax credit for qualified health insurance coverage for households earning less than 300 percent of the federal poverty level.

C. Insurance Regulation: The bill would require the creation of uniform national rules for the individual and group insurance markets, including requirements regarding benefit mandates, premium variation, and allowable cost-sharing. Insurers would be required to offer "qualified core plans" (QCPs), subject to certain benefit and premium requirements.

D. Automatic Enrollment: People who do not indicate on their tax forms that they have health insurance coverage, or who access a provider without health insurance, would be automatically enrolled in a QCP, or in Medicaid and SCHIP if eligible. State insurance commissioners would work with the federal government to develop notification procedures for people who indicate a lack of coverage on tax returns or when they access a provider.

E. Small Business Health Plans: Small businesses and other organizations would be able to offer health insurance through small business health plans. Small business health

plans would be allowed to operate across state lines, subject to oversight by a single state. The bill would require the plans to cover mandated benefits applicable under the law. Premiums would be based on the experience of the pool.

F. Other: The bill would also provide individuals the option of using the value of Medicaid and SCHIP program benefits to purchase private health insurance.