# Scoring Health Reform in Congress (UPDATED 1/11/10): Children and Families Need Action, Affordability and Accountability

**By Elisabeth Wright Burak, Health Policy Director**

Health reform continues to progress through the House and Senate. On Saturday, November 7, the House of Representatives passed the *Affordable Health Care for America Act of 2009* bill by 220 votes. On the Senate side, lawmakers approved the *Patient Protection and Affordable Care Act*, early on December 24, 2009 by 60 votes. AACF thanks Senator Blanche Lincoln and Senator David Pryor for their historic Christmas Eve votes, and again thank Representatives Marion Berry and Vic Snyder for their support in the House.

Senate and House lawmakers are working now to merge the House and Senate bills, with the goal of passing both chambers and sending to President Obama's desk in late January or early February.

Our latest analysis updates our side-by-side with the final versions of the bills that passed the House and Senate. The bills differ in important ways described below, but both would mean significant improvements in the lives of Arkansas children and families. Many steps remain, but advocates should keep in mind that health reform has never come this close to passage, and encourage lawmakers to continue moving forward and finish the job for Arkansans.

Watch AACF's e-newsletters and web site for updates on any changes as the reform debate continues.

## Common Elements of Both Bills

The bills both seek to ensure that more Americans have access to affordable coverage and services, regardless of pre-existing conditions, income, changes in their job, or the state they live in. In terms of overall structure, this bill and other proposals would:

- Require all individuals and their children to have health insurance coverage or pay a penalty, with exceptions related to low income, financial hardship, and others.

- Require employers, with exceptions for smaller firms, to offer affordable coverage to employees or pay a fee.

- Significantly increase Medicaid income eligibility levels for low-income individuals under age 65 (children, parents and childless adults). The House bill expands eligibility to 150% of the federal poverty level, or $27,000 for a family of three. In the Senate, the Medicaid floor would increase to 133%, or $24,000 for a family of three.

- Create a Health Insurance Exchange ("Exchange"), or marketplace for families to compare and purchase insurance, which would offer a choice of plans to those who cannot otherwise access insurance through employers or are not eligible for Medicaid or Medicare. Individuals could choose among multiple plans, which would have minimum benefits and cost-sharing requirements. Subsidies would be available to individuals and families to help pay for Exchange coverage. In the Senate, the Exchanges would be state-based; the House bill creates a national Exchange.

Beyond these basic elements, the details differ on their specific impact on children and families. The scorecard below summarizes major elements of each bill related to children and families below. In May, AACF outlined *Five Questions Child Advocates Should Ask of Health Reform*. As with our previous scorecards, the questions frame the scorecard.

Neither bill is by any means perfect. The Senate bill, especially, has room for improvement in two areas: improving affordability for near-poor families in the subsidy structure and 2) protecting comprehensive coverage that children currently receive under the Children's Health Insurance Program (CHIP). (For more information, see AACF's 1/6/10 statement on our web site). Even more questions around implementation remain. Improvements could be addressed through a potential conference committee bill or through future tweaks to the bill after passage. **Overall, however, both proposals would be a significant step forward for the health of children and families in Arkansas.** Arkansas families continue to lose affordable coverage, worry about costs of a medical emergency, be buried in medical bills to the point of bankruptcy, and struggle to get themselves and their children the care they need. We cannot continue to sacrifice families' financial health for their physical health. Arkansas's working families need progress on meaningful reform now.

## For more information…

This overview does not offer every aspect of the bill affecting children and families. It draws heavily from the sources below as well as the bill texts. For more analysis and detail, including other areas of importance like prevention and wellness, quality improvement, or workforce enhancements, see:

- *Key Medicaid, CHIP, and Low-Income Provisions in the Senate Health Reform Bill – Patient Protection and Affordable Care Act* and *Key Medicaid, CHIP, and Low-Income Provisions in H.R. 3962: The Affordable Health Care for America Act of 2009* by Georgetown Center for Children and Families;
- Multiple analyses by the Center on Budget and Policy Priorities;
- Voices for America's Children's health reform resource center; and
- Bill comparison tools by the Henry J. Kaiser Family Foundation.

## AACF Analysis and Rating

| Five Questions Child Advocates Should Ask of Health Reform | House Bill (HB3962 passed 11/7/09) *Affordable Health Care for America Act of 2009* | Senate Bill (H.R. 3590 passed 12/24/09) *Patient Protection and Affordable Care Act* |
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| **1. Does the proposal recognize and support the unique developmental needs of kids?** |  <br>*Sets benefit benchmarks for private insurance coverage.* Health plans must provide a *minimum* benefits package that covers comprehensive services, including hospitalization, inpatient/outpatient services, physician and other health professional services, equipment and supplies, prescription drugs, rehabilitative services, mental health and substance abuse services, preventive services, immunizations, and maternity care. *Children's coverage must also include well baby and well child care, oral health, vision and hearing services, equipment and supplies through age 21*. No cost sharing (co-pays) would be allowed for preventive services in any benefit plan.<br><br>*Removes the ARKids First B waiting period for some children.* Arkansas, as well as other states, requires that families seeking ARKids First B (CHIP)[1] for their children demonstrate that the child has been without health insurance coverage for the previous six months.[2] This bill would require states to remove this waiting period for the following children: 1) under age two; 2) whose families lost employer-sponsored health insurance; or 3) who don't have access to affordable coverage, defined as coverage that costs less than 10% of family income.<br><br>*Transfers many low-income children to Medicaid, which offers more comprehensive benefits, including EPSDT.* In 2013, many low-income children would be moved to traditional Medicaid with the increase to 150% of the federal poverty level, or $27,000 for a family of three. In Arkansas, this means children between 100 and 150% of the federal poverty level would become eligible for ARKids First A rather than ARKids First B, which provides fewer benefits. Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) requires states to ensure children in Medicaid receive any service deemed medically necessary for their healthy development. Children that would be newly eligible for ARKids First A/Medicaid would gain access to this EPSDT benefit, providing all the care they require to grow into healthy adults. |  <br>*Sets benefit benchmarks for private insurance coverage* Health plans must provide a *minimum* benefits package that covers comprehensive services. For children, plans must cover the preventive care and screenings identified in Bright Futures, the "gold standard" guidelines for preventive care and screenings from the American Academy of Pediatrics (AAP) adopted by many states. No cost sharing (co-pays) would be allowed for preventive services in any benefit plan.<br><br>*Transfers many low-income children to Medicaid, which offers more comprehensive benefits, including EPSDT.* In 2014, over 70,000[5] low-income children would be moved to traditional Medicaid with the increase to 133% of the federal poverty level, or $24,000 for a family of three. In Arkansas, this means children between ages 6 through 18 between 100 and 133% of the federal poverty level would become eligible for ARKids First A rather than ARKids First B, which provides fewer benefits. (Children under age 6 in this income bracket are already eligible for ARKids First A). Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) requires states to ensure children in Medicaid receive any service deemed medically necessary for their healthy development. Children that would be newly eligible for ARKids First A/Medicaid would gain access to this EPSDT benefit, providing all the care they require to grow into healthy adults.<br><br>*Funds states to develop maternal, infant and early childhood home visitation programs.* (See "Will vulnerable children and families be protected?" below) |

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| | *Automatically enrolls uninsured newborns in Medicaid for 60 days* while a determination of eligibility is made for Medicaid or the Exchange/subsidies.<br><br>  <br>*Ends the Children's Health Insurance Program (CHIP) with no assurances that alternatives include comparable coverage and cost-sharing protections.* Retire the Children's Health Insurance Program (CHIP) by the end of 2013 and move some children into the Exchange in 2014. States with CHIP-financed Medicaid expansions[3] would keep children in existing programs. While national experts and Arkansas officials are still interpreting the precise impact on Arkansas, it seems likely ARKids First would remain intact, but some ARKids First B children at higher incomes may be subject to transfer into the Exchange.[4] Previous versions of the House bill would not allow ARKids First B (CHIP) children to be transferred to Exchange plans *until* 1) Exchange options are deemed equitable to benefits and cost-sharing under ARKids First B; and 2) the transition will not interrupt coverage. Before the House floor vote, this provision was weakened to instead commission a study to examine the comparability between the plans. |  <br>*Maintains the Children's Health Insurance Program until 2019, but does not ensure funding beyond 2015.* The Senate recognized the important role CHIP plays in protecting the physical and financial health of millions of children and families, keeping the program in place through 2019. Several senators fought to keep the program intact so that children covered under CHIP are not subject to new Exchange coverage that may not be comparable. Originally funding was only available until 2013, but the amended bill ensure funding though 2015.<br><br>Each state's CHIP federal matching rate, or enhanced FMAP, will increase by 23 percentage points by October 1, 2015 to a maximum of 95%. Since Arkansas's enhanced CHIP is already over 80%, Arkansas's match will increase to a cap of 95%. The increased match, of course, depends on more federal funding becoming available. If funding does not materialize for the 2016 federal fiscal year, children currently funded in CHIP would move to the Exchange with family subsidies. The Secretary of the federal Department of Health and Human Services would be required to study whether Exchange plans offer comparable coverage.<br><br>  <br>*Missed opportunity to reach uninsured newborns.* The Senate bill does not include the House requirement to auto- enroll uninsured newborns in Medicaid for 60 days while a determination of eligibility is made for Medicaid or the Exchange/subsidies. |
| **2. Will vulnerable children and families be protected?** |  <br>*Extends Medicaid to all low-income uninsured under 65.* The bill would require Arkansas and other states, starting in 2013, to cover all adults up to 150% of the federal poverty level ($27,000 for a family of three) under Medicaid, which offers a comprehensive benefits package for low-income individuals and families with no other affordable insurance option.6 This would be especially positive for low-income families. Currently, a non-disabled parent in Arkansas is only eligible if his or her income is at or below 17% of the federal poverty level (just over $3000 a year for a family of three). It would also remove asset tests for parents and many childless adults, meaning vehicles and other assets would not count against their income for eligibility |  <br>*Extends Medicaid to all low-income uninsured under 65.* The bill would require Arkansas and other states, starting in 2014, to cover all adults up to 133% of the federal poverty level ($24,000 for a family of three) under Medicaid, which offers a comprehensive benefits package for low-income individuals and families with no other affordable insurance option.[8] This would be especially positive for low-income families. Currently, a non-disabled parent in Arkansas is only eligible if his or her income is at or below 17% of the federal poverty level (just over $3000 a year for a family of three). It would also remove asset tests for parents and many childless adults, meaning vehicles and other assets would not count against their income for eligibility |

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| | purposes.[7] Covering entire families makes a difference: children are more likely to access health services when their parents have coverage.<br><br>*States would be allowed to cover home visiting services and therapeutic foster care through Medicaid.* The bill reiterates that states can use Medicaid for services that can help ensure children can stay in their homes and communities whenever possible. On the prevention side, home visitation programs offer support for parents that leads to an overall improvement in child well-being. The bill authorizes $750 million over five years for these programs. Therapeutic foster care supports children outside the home with particular needs, providing a chance to stay with a supportive and trained family in their community before being placed in institutional care. | purposes.[9] Covering entire families makes a difference: children are more likely to access health services when their parents have coverage.<br><br>*Funds states to develop maternal, infant and early childhood home visitation programs.* With one of the highest infant mortality rates in the country, Arkansas would benefit significantly from new resources for these programs. (See "Will vulnerable children and families be protected?" below)<br><br>*Allows Medicaid coverage to be extended to former foster care youth up to age 25.* The bill would require states to extend Medicaid eligibility to youth up to age 25 who spent at least six months in the foster care system. |
| **3. Will coverage be affordable for all?** |  <br>*Provides subsidies to low- and moderate-income families to help purchase coverage through the Exchange.* Individuals and families who do not have access to employer-based insurance or Medicaid with incomes under 400% of the federal poverty level (approximately $73,000 for a family of three) would receive subsidies on a sliding scale to purchase Exchange coverage. The size of subsidies is based on family income and average premium costs in the geographic area. This subsidy structure is much more affordable for families than that in the Senate bill. If these subsidies are weakened or scaled back in the conference bill, it could mean many people would be mandated to purchase insurance they cannot afford.<br><br>*Limits out-of-pocket costs for individuals and families (deductibles, coinsurance, copayments).* This provision offers a level of financial protection for consumers. Insurers could no longer cap the cost of benefits provided annually or over a lifetime. Basic benefits packages in the Exchange would be prohibited from requiring co-payments for preventive services, and out-of-pocket costs would be limited to an annual maximum of $10,000 for families. Maximums for families below 350% of the federal poverty level would from $1,000 to $9,000 based on income.[10]<br><br>*Makes subsidies available for very small businesses.* Businesses with less than 25 employees and average wages below $40,000 could receive sliding-scale subsidies up to 50% of employer premium costs. As many as 58,700 small businesses in Arkansas could qualify for these credits.[11]<br><br>*Extends Medicaid to all low-income uninsured under 65.* The bill would require Arkansas and other states, |  <br>*Limits out-of-pocket costs for individuals and families (deductibles, coinsurance, copayments).* This provision offers a level of financial protection for consumers. Insurers could no longer cap the cost of benefits provided annually or over a lifetime. Basic benefits packages in the Exchange would be prohibited from requiring co-payments for preventive services, and out-of-pocket costs would be subject to an annual cap.<br><br>*Makes subsidies available for very small businesses.* Businesses with no more than 25 employees and average wages below $40,000 could receive sliding-scale subsidies up to 50% of employer premium costs.<br><br>*Extends Medicaid to all low-income uninsured under 65.* The bill would require Arkansas and other states, beginning in 2014, to cover everyone up to 133% of the federal poverty level under Medicaid, which offers a comprehensive and affordable benefits package for low-income individuals and families with no other affordable insurance option (see above).<br><br>  <br>*Provides subsidies to low- and moderate-income families to help purchase coverage through the Exchange, but still a heavy lift for some families.* Individuals and families who do not have access to employer-based insurance or Medicaid with incomes under 400% of the federal poverty level (approximately $73,000 for a family of three) would receive subsidies on a sliding scale to purchase Exchange coverage. Despite the support from subsidies, households at the low end of the subsidy scale, especially those between |

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| | beginning in 2013, to cover everyone up to 150% of the federal poverty level under Medicaid, which offers a comprehensive and affordable benefits package for low-income individuals and families with no other affordable insurance option (see above).<br><br>  <br>*Low-income immigrant families would have fewer options for coverage* (see "Will coverage and access to services be equitable?" below). | 134 and 200 % of the federal poverty line, would still face significant out-of-pocket costs, forcing many people would be mandated to purchase insurance they cannot afford [12]<br><br>  <br>*Low-income immigrant families would have fewer options for coverage* (see "Will coverage and access to services be equitable?" below). |
| **4. Will coverage and access to services be equitable?** |  <br>*Prohibits insurers to deny coverage based on pre-existing conditions.* Plans in the Exchange or the small group insurance market would no longer be able to deny coverage for pre-existing conditions.<br><br>*Coordinates enrollment and verification between Medicaid and the Exchange.* Individuals or families applying through the Exchange who are determined Medicaid-eligible would be transferred to the appropriate state Medicaid agency and state would not conduct another redetermination of eligibility. In turn, the Exchange may choose to contract with and reimburse state Medicaid agencies to determine whether an Exchange-eligible person is eligible for Exchange subsidies.<br><br>*Increases reimbursement rates for Medicaid primary care providers*. Medicaid reimbursement rates are currently lower than private insurance and Medicare. In 2008, Medicaid physician rates were 72% of Medicare rates.[13] Medicaid rates would increase over time to 100% of Medicare rates by 2012. This would help ensure more children and families have access to doctors and other health professionals.<br><br>*Funds school-based health centers*. Clinics would offer another health services point to provide comprehensive preventive and primary care services for children and their family. With the success of Coordinated School Health and newly-funded school wellness centers from the state's tobacco tax, Arkansas would be well-positioned to take advantage of this kind of funding opportunity.<br><br>*Expands funding for community health centers*, which often serve as the only available health care home for the most vulnerable Arkansans. |  <br>*Prohibits insurers to deny coverage based on pre-existing conditions.* Plans in the Exchange or the small group insurance market would no longer be able to deny coverage for pre-existing conditions. This would take effect immediately for children and in 2014 for adults.<br><br>*Creates a "no wrong door" enrollment system* between Exchange subsidies, Medicaid and CHIP. A single application process would guide children and families to the program for which they are eligible, regardless of where they start their application process.<br><br>*Increases and extends funding in CHIP for Medicaid and CHIP enrollment and renewal activities.* An additional $40 million would be available to states and communities to improve enrollment and renewal efforts, increasing the total outreach funding to $140 million through 2015.<br><br>*Allows states to provide CHIP coverage to children of state employees.* Currently CHIP law prohibits states from enrolling state employee children. The bill would allow states to enroll these children in CHIP if the employee's cost sharing exceeds 5% of the family's income.<br><br>*Funds school-based health centers*. Clinics would offer another health services point to provide comprehensive preventive and primary care services for children and their family. With the success of Coordinated School Health and newly-funded school wellness centers from the state's tobacco tax, Arkansas would be well-positioned to take advantage of this kind of funding opportunity.<br><br>*Expands funding for community health centers*, which |

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| | *Creates a medical home pilot program in Medicaid* to test new incentive models to treat high-need populations.<br><br>*Sets benchmarks for insurance coverage:* Health plans must provide a *minimum* benefits package, with additional requirements for children (see above).<br><br>*Expands Medicaid enrollment out-stationing:* All hospitals and expanded numbers of community-based locations could enroll families, to extend the reach beyond county offices.<br><br>*Increases federal Medicaid match rate for interpreter and translation services.* States would receive 75% federal match (or FMAP) for translation and interpretation services provided to Medicaid-eligible adults for whom English is not the primary language.<br><br>  <br>*Few or no options available to many low-income immigrants.* Coverage for low-income immigrants, regardless of legal status, is largely unaddressed in this bill. "Lawfully present" immigrants would be eligible for subsidies on the Exchange. However, the five-year coverage waiting period for non-pregnant, legally-residing adult immigrants would still be in place under Medicaid.[14] Undocumented immigrants would not be eligible for taxpayer-supported coverage or subsidies and would be exempt from the individual mandate for insurance coverage. | often serve as the only available health care home for the most vulnerable Arkansans.<br><br>*Creates and funds a medical home model* using community health teams.<br><br>*Sets benchmarks for insurance coverage:* Health plans must provide a *minimum* benefits package, with additional requirements for children based on the AAP's Bright Futures guidelines (see above).<br><br>  <br>*'Employer responsibility' provision creates disincentives for some firms to hire low-income workers in full-time positions.* The proposal rightfully holds employers accountable for providing coverage for their workers by requiring larger firms who do not offer affordable benefits to pay a fee that offsets the cost of subsidies. These employer fees are tied to the number of full-time workers receiving subsidies, called 'premium credits,' to purchase coverage on the Exchange. While the most recent Senate bill is an improvement from Senate Finance bill, it would still create incentives for some employers to convert full-time to part-time positions, contract work out, or seek higher income employees to avoid a fee, making it more difficult for low- and moderate income families to obtain full-time employment.[15] A simpler and more equitable solution would be to base the employer fee paid by firms not offering affordable coverage on a percentage of a firm's total payroll.<br><br>*Few or no options available to many low-income immigrants.* Coverage for low-income immigrants, regardless of legal status, is largely unaddressed in this bill. "Lawfully present" immigrants would be eligible for subsidies on the Exchange. However, the five-year coverage waiting period for non-pregnant, legally-residing adult immigrants would still be in place under Medicaid.[16] Undocumented immigrants would not be eligible for taxpayer-supported coverage or subsidies and would be exempt from the individual mandate for insurance coverage.<br><br>*Does not address reimbursement rates for Medicaid primary care providers*. Medicaid reimbursement rates are currently lower than private insurance and Medicare. In 2008, Medicaid physician rates were 72% of Medicare rates.[17] The Senate does not increase these rates to those of Medicare as in the House bill. |
| |  <br>*Reform will be fully paid for through improved efficiency and a tax on the wealthiest Americans*. This |  <br>*Reform will be fully paid for through improved efficiency and a tax on the highest cost health plans*. |

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| **5. How will we pay for the plan and contain health care costs?** | bill is reported to cost the federal government just under $894 billion over the next 10 years.[18] Under the legislation, reform would be paid for by 1) improving efficiency in Medicare; and 2) including a tax on households with incomes over $1,000,000 ($500,000 for single taxpayers).[19] A very small percentage of Arkansas taxpayers would pay the proposed surcharge. Low- and middle-income Arkansans would not be affected.<br><br>*Reduce budget deficits by $104 billion over the next decade.*[20] This bill will not damage the economic futures of the next generations by adding to the deficit. In fact, according to the Congressional Budget Office, it would actually reduce deficits for ten years and beyond 2019.<br><br>*Extends ARRA state Medicaid fiscal relief for six additional months.* Under the American Recovery and Reinvestment Act (ARRA)[21] passed earlier this year, states received a boost in the share of Medicaid paid by the federal government through 2010. The House bill would extend the increased matching rate through June 2011 to allow more time for state budgets to recover from the downturn. In Arkansas the federal share increased from 73% to 79% federal contribution.<br><br>*States would not be required to take on expanded Medicaid costs until 2015.* To make more Americans eligible for Medicaid, the federal government would pay for all new costs under the state-federal Medicaid program for 2013-2014, but states would be expected to pick up 9% of new Medicaid costs starting in 2015. For Arkansas, adding so many new adults to Medicaid would likely come with significant cost, even at 9 %--as much as $200 million annually.[22] However, the rate is much less than the typical 23% the state usually contributes under Medicaid. The increased match could bring as much as $2.3 billion in federal dollars to the state annually. Hopefully Arkansas would be in a better economic position to take new costs on by 2015. | This bill is reported to cost the federal government $848 billion over the next 10 years. These costs are financed through a combination of savings from improved efficiencies in Medicare, Medicaid, and other health programs; a 40% excise tax on the value of health plans over $8,500 for individuals and $23,000 for families; and an increase of 0.5% Medicare payroll tax for high-income employees in households over $250,000 for families and $200,000 for individuals.[23]<br><br>*Reduce budget deficits by $130 billion over the next decade.*[24] This bill will not damage the economic futures of the next generations by adding to the deficit. In fact, according to the Congressional Budget Office, it would actually reduce deficits for ten years and beyond 2019.<br><br>*States would not be required to take on expanded Medicaid costs until 2017.* To make more Americans eligible for Medicaid, the federal government would pay for all new costs under the state-federal Medicaid program for federal fiscal years 2014-2016, and states would be begin to contribute d costs starting in 2017. Arkansas would take on 5% of the cost for new Medicaid recipients, much less than the typical 23% the state usually contributes under Medicaid. Over time the additional state cost is estimated to be approximately $100 million annually.[25] The 95% federal match would bring roughly $2 billion additional federal dollars into Arkansas annually.<br><br>  <br>*Does not extend the ARRA state Medicaid fiscal relief.* Under the American Recovery and Reinvestment Act (ARRA)[26] passed earlier this year, states received a boost in the share of Medicaid paid by the federal government through 2010. The Senate bill does not extend the fiscal relief under ARRA to aid state budgets. |

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[1] Families between 100 and 200% of the federal poverty level; Families eligible for ARKids First A/Medicaid are not subject to this waiting period.

[2] Note: This waiting period does not apply to ARKids First A (Medicaid), which currently covers children under six up to 133% of the federal poverty line and children 6 – 19 up to 100% of the poverty line.

[3] Many states, including Arkansas, originally expanded income eligibility for children through a Title XIX Medicaid waiver before CHIP was available. Federal CHIP funds then funded the Medicaid waiver rather than creation of a separate CHIP program at the state level. However, ARKids First B children may be subject to this transfer.
[4] AACF continues to research the exact impact of CHIP expiration. There is some question whether some of the current or newly-eligible ARKids First B children would be subject to be transferred to the Exchange, but overall the number of children would likely be small relative to the ARKids First population overall.
[5] State-level estimates by the Lewin Group for the National Governors Association on the Senate Finance bill.
[6] Note: the transfer of children between 100- 150% of the federal poverty level would not occur until 2014.
[7] Children are already not subject to asset tests in Arkansas for ARKids First A/Medicaid or ARKids First B.
[8] Note: the transfer of children between 100- 150% of the federal poverty level would not occur until 2014.
[9] Children are already not subject to asset tests in Arkansas for ARKids First A/Medicaid or ARKids First B.
[10] Estimates by Georgetown Center for Children and Families (2009). *Children in Health Reform: Where Things Stand*, p. 3.
[11] U.S. House of Representatives (2009). "Benefits of America's Affordable Health Choices Act." Figures taken for all four Congressional Districts. Information on benefits by Congressional District may be accessed at http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1717:hr-3200-americas-affordable-health-choices-act-of-2009-markup-district-by-district&catid=156:reports&Itemid=55
[12] For more detail on the Senate subsidy structure, see the analysis by January Angeles and Judith Solomon of the Center on Budget and Policy Priorities.
[13] Zuckerman, S., Williams, A.F., Stockley, K. (2009). "*Trends In Medicaid Physician Fees, 2003–2008*. "*Health Affairs*, 28, no. 3 (2009): w510-w519 (Published online 28 April 2009)
[14] Under the Children's Health Insurance Reauthorization Act (CHIPRA), passed earlier this year, states now have the option to remove the five-year waiting period for legally residing children in Medicaid and CHIP.
[15] For more information on the employer responsibility provisions and their effect on low- and moderate-income workers, see Greenstein R. and Van de Water P. (2009). "Senate Health Bill Improves Employer Responsibility Provision," Center on Budget and Policy Priorities. Available at http://www.cbpp.org/cms/index.cfm?fa=view&id=3003
[16] Under the Children's Health Insurance Reauthorization Act (CHIPRA), passed earlier this year, states got the option to remove the five-year waiting period for legally residing children in Medicaid and CHIP.
[17] Zuckerman, S., Williams, A.F., Stockley, K. (2009). "Trends In Medicaid Physician Fees, 2003–2008." *Health Affairs*, 28, no. 3 (2009): w510-w519 (Published online 28 April 2009)
[18] See the Congressional Budget Office analysis at http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/health%20reform/cbo%20-%20hr3962%2010-29.pdf
[19] For more information, see the Center on Budget and Policy Priorities 10/31 report at http://www.cbpp.org/cms/index.cfm?fa=view&id=2973
[20] For more information, see the Center on Budget and Policy Priorities 10/31 report at http://www.cbpp.org/cms/index.cfm?fa=view&id=2973
[21] See AACF overview *ARRA: What's in it for Arkansas Children and Families?* at http://aradvocates.org/_images/pdfs/45--ARRA%20distribution%20in%20Ark.%20June%2009.pdf
[22] Estimates by Arkansas Department of Human Services
[23] For more information, see the Center on Budget and Policy Priorities 11/19 report at http://www.cbpp.org/cms/index.cfm?fa=view&id=3005
[24] For more information, see the Center on Budget and Policy Priorities 11/19 report at http://www.cbpp.org/cms/index.cfm?fa=view&id=3005
[25] Estimates by Arkansas Dept of Human Services, phone conversation 1/8/10
[26] See AACF overview *ARRA: What's in it for Arkansas Children and Families?* at http://aradvocates.org/_images/pdfs/45--ARRA%20distribution%20in%20Ark.%20June%2009.pdf