Scoring Health Reform in the U.S. House of Representatives (UPDATED 11/10/09): A major step forward for children and families

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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. AACF thanks Arkansas Representatives Marion Berry and Vic Snyder for voting for the bill.

Our latest analysis offers a look at the House bill passed November 7th and the Senate bill currently under consideration. 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.

On the Senate side, lawmakers voted on Saturday, November 21 to begin debate on the *Patient Protection and Affordable Care Act*, which merges bills passed by the Senate Finance and Health, Education, Labor and Pensions Committees. Floor debate will begin the week after the Thanksgiving holiday. Watch AACF's e-newsletters and web site for updates on any changes as the reform debate continues.

The Basics of the Proposed Structure

The proposal aims to ensure that two-thirds of all Americans have access to affordable coverage and services, regardless of pre-existing conditions, income, changes in their job, or the state they live in. Most provisions would not go into effect until 2013. 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 some exceptions.

- Require larger employers[1] to offer affordable coverage to employees or pay a fee ranging from 2 to 8 % of payroll.

- Raise Medicaid eligibility for low-income individuals under age 65 (children, parents and childless adults), beginning in 2013, to a minimum of 150 percent of the federal poverty line (or $27,000 for a family of three).

- Create a Health Insurance Exchange ("Exchange"), or marketplace for comparing and buying 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. States have the option to set up their own Exchanges or similar structures. Subsidies would be available to individuals and families to help pay for Exchange coverage.

- 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[2] 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.[3] AACF will continue to monitor the exact impact of this provision on Arkansas children.

Within this structure, many of the details in the bill would impact children and families. In May, AACF outlined *Five Questions Child Advocates Should Ask of Health Reform*. Those questions frame the scorecard below.

Questions on the details of this proposal and implementation certainly remain as reform moves through Congress. **Yet on balance this bill 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 meaningful reform now.

For more information…

This overview does not detail every aspect of the bill affecting children and families. It draws heavily from the sources below as well as the bill text. For more detail, see:

- *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;
- Analysis by the Center on Budget and Policy Priorities;
- Voices for America's Children's health reform resource center; and
- Summary by the Henry J. Kaiser Family Foundation.

AACF Analysis and Rating

Five Questions Child Advocates Should Ask of Health Reform	Current House Proposal (HB3962 passed 11/7/09)
Does the proposal recognize and support the unique developmental needs of kids?	 *Sets benchmarks for 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. *Removes the ARKids First B waiting period for some children.* Arkansas, as well as other states, requires that families seeking ARKids First B (CHIP)[4] for their children demonstrate that the child has been without health insurance coverage for the previous six months.[5] 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. *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 all the care they require to grow into healthy adults. *Automatically enrolls uninsured newborns in Medicaid for 60 days* while a determination of eligibility is made for Medicaid or the Exchange/subsidies.

	 *No assurances that children being transferred to the Exchange would receive comparable benefits and cost-sharing protections.* The previous House bill, through amendment by Rep. DeGette, 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. In the latest negotiations, this provision was weakened to instead commission a study to examine the comparability between the plans. *EPSDT not extended to higher income children.* Earlier proposals considered extending EPSDT benefits, required under Medicaid, to families at higher income levels (e.g. 250 % of the federal poverty level). Under federal law, EPSDT says that children in Medicaid must receive any service deemed necessary for their healthy development. Setting a minimum benefits package accomplishes this to an extent, but does not go as far as the EPSDT benefit. The Senate Health Education, Labor and Pensions (HELP) committee proposal used the American Academy of Pediatrics (AAP) Bright Futures[6] guidelines as the standard for quality children's services, which would be a welcome benchmark moving forward for the minimum benefits standard discussed above.
Will vulnerable children and families be protected?	 *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 under Medicaid, which offers a comprehensive benefits package for low-income individuals and families with no other affordable insurance option.[7] 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 purposes.[8] Covering entire families makes a difference: children are more likely to access health services when their parents have coverage. *States would be allowed to cover home visiting services and therapeutic foster care through Medicaid.* The bill confirms Medicaid coverage 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.
Will coverage be affordable for all?	 *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 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 those emerging from the Senate. 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. *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. *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.[9] *Extends Medicaid to all low-income uninsured under 65.* The bill would require Arkansas and other states, 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).  *Low-income immigrant families would have fewer options for coverage* (see "Will coverage and access to services be equitable?" below).

Will coverage and access to services be equitable?	 *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. *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.[10] 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. *Authorizes federal funding for school-based health clinics*. 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. *Expands funding for community health centers*, which often serve as the only available health care home for the most vulnerable Arkansans. *Creates a medical home pilot program in Medicaid* to test new incentive models to treat high-need populations. *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. *Sets benchmarks for insurance coverage:* Health plans must provide a *minimum* benefits package, with additional requirements for children (see above). *Expands Medicaid enrollment out-stationing:* All hospitals and expanded numbers of community-based locations could enroll families, to extend the reach beyond county offices. *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.

	 *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.[11] Undocumented immigrants would not be eligible for taxpayer-supported coverage or subsidies and would be exempt from the individual mandate for insurance coverage.
How will we pay for the plan and contain health care costs?	 *Reform will be fully paid for through improved efficiency and a tax on the wealthiest Americans*. This bill is reported to cost the federal government just under $900 billion over the next 10 years.[12] 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).[13] **A very small percentage of Arkansas taxpayers would pay the proposed surcharge. Low- and middle-income Arkansans would not be affected.** *Reduce budget deficits by $104 billion over the next decade.*[14] 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. *Extends ARRA state Medicaid fiscal relief for six additional months.* Under the American Recovery and Reinvestment Act (ARRA)[15] 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. *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%. However, the rate is much less than the typical 23% the state usually contributes under Medicaid. Hopefully Arkansas would be in a better economic position to take new costs on by 2015.

	Questions about financing remain… More information on payment options under consideration should be available in the coming days, with the details and analysis of the merged Senate bill. Watch AACF's e-newsletters and web site for a similar analysis of the package coming out of the Senate.

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[1] Employers with payrolls under $500,000 would be exempt from this requirement.
[2] 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.
[3] AACF continues to research the exact impact of CHIP expiration. There is some question whether some of the curent ARKids First B children would be subject to be transferred onto the Exchange, but overall the number of children would likely be small relative to the ARKids First population overall.
[4] Families between 100 and 200% of the federal poverty level; Families eligible for ARKids First A/Medicaid are not subject to this waiting period.
[5] 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.
[6] For more information, see http://brightfutures.aap.org/
[7] Note: the transfer of children between 100- 150% of the federal poverty level would not occur until 2014.
[8] Children are already not subject to asset tests in Arkansas for ARKids First A/Medicaid or ARKids First B.
[9] 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
[10] 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)
[11] 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.
[12] 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
[13] 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
[14] 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
[15] 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