

Description of Policy Options

**Expanding Health Care Coverage:
Proposals to Provide Affordable Coverage to All Americans**

Senate Finance Committee
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TABLE OF CONTENTS

SECTION I: Insurance Market Reforms	2
Non-Group and Micro-Group Market Reforms.....	2
Small Group Market Reforms.....	3
Health Insurance Exchange.....	4
Transition	7
Role of State Insurance Commissioners	7
SECTION II: Making Coverage Affordable	8
Benefit Options	8
Low-Income Tax Credits	10
Small Business Tax Credits	12
SECTION III: Public Health Insurance Option.....	13
SECTION IV: Role of Public Programs	14
Medicaid Coverage	14
Children’s Health Insurance Program (CHIP).....	19
Quality of Care in Medicaid and CHIP.....	22
Other Improvements to Medicaid	23
Medicaid Disproportionate Share (DSH) Hospital Payments	32
Dual Eligibles.....	34
Medicare Coverage	37
SECTION V: Shared Responsibility	39
Personal Responsibility Coverage Requirement.....	39
Employer Requirement	41
SECTION VI: Prevention and Wellness	43
Promotion of Prevention and Wellness in Medicare	43
Promotion of Prevention and Wellness in Medicaid	46
Options to Prevent Chronic Disease and Encourage Healthy Lifestyles.....	47
Employer Wellness Credits.....	48
SECTION VII: Long Term Care Services and Supports	49
SECTION VIII: Options to Address Health Disparities	56

Senate Finance Committee

Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans

The U.S. is the only developed country that does not guarantee health coverage for all its citizens, with 46 million uninsured and another 25 million underinsured. Today, the cost of caring for the uninsured is largely borne by those with insurance; providers charge higher prices to patients with private coverage to make up for uncompensated care, and these costs are passed on to consumers in the form of increased premiums. A high-performing health system would guarantee all Americans affordable, quality coverage regardless of age, health status, or medical history. This document outlines policy options for providing affordable health care coverage for all Americans.

Proposals included in this document would ensure that the insurance market functions effectively. Reforms proposed for the individual and small group markets would ensure a competitive insurance market in which plans compete on price and quality rather than on their ability to segment risk and discriminate against individuals with pre-existing health conditions. Proposals contemplated in this document would also make purchasing health insurance coverage easier and more understandable by establishing a gateway or marketplace where American consumers could easily compare and purchase the coverage that best fits their needs.

To ensure that coverage is affordable, this document outlines a proposal for targeted tax credits for low-income individuals and small businesses. And for the most vulnerable populations, policy options described here would improve public programs by covering those at the lowest end of the income scale who are least likely to have private coverage through an employer.

Once affordable, high-quality, and meaningful health insurance options are available to all Americans through their employer or the new gateway, individuals would have a personal responsibility to have health coverage. This step is necessary for insurance market reforms to function properly and to end the cost shifting that occurs within the system. It is expected that the vast majority of American employers would continue to provide coverage as a competitive benefit to attract employees.

Finally, this document outlines proposals to promote prevention and wellness services in public programs. By encouraging healthy behaviors, these policy options make a first step in moving our health system away from a focus on treating disease toward one focused on preventing disease.

This document and the options described in it are intended to spur discussion regarding proposed options for policies that the committee is scheduled to act on in June. While these proposed options are jointly offered for discussion, not all the options in this document have the support of Chairman Baucus or Ranking Member Grassley.

SECTION I: Individual Market Reforms

Non-Group and Micro-Group Market Reforms

Current Law

There are no federal rating rules for the non-group market. However, some states currently impose rating rules on insurance carriers in the non-group market. Existing state rating rules restrict an insurer's ability to price insurance policies according to the risk of the person or group seeking coverage, and vary from state to state. Such restrictions may specify the case characteristics (or risk factors) that may or may not be considered when setting a premium, such as gender. The spectrum of existing state rating limitations ranges from pure community rating, to adjusted (or modified) community rating, to rate bands, to no restrictions. Pure community rating means that premiums cannot vary based on any individual characteristic. Adjusted community rating means that premiums cannot vary based on health, but may vary based on other risk factors, such as age.

Rate bands allow premium variation based on health or other factors, but such variation is limited according to a range specified by the state. Rate bands are typically expressed as a percentage above and below the index (or average rate). For example, if a state establishes a rate band of +/- 25%, then insurance carriers can vary premiums up to 25 percent above and 25 percent below the average rate. Both adjusted community rating and rate bands allow premium variation based on any other permitted case characteristic, such as gender. And for each characteristic, the state typically specifies the amount of allowable variation, as a ratio. For example, a 5:1 ratio for age would allow insurers to charge an individual no more than 5 times the premium charged to any other individual, based on age differences. As of December 2008, two states have pure community rating rules, five have adjusted community rating rules, and eleven have rate bands in the non-group market.

HIPAA established federal rules regarding guaranteed issue, guaranteed renewability, and coverage for pre-existing health conditions in the non-group market for certain persons eligible for HIPAA protections. HIPAA guarantees that each issuer in the non-group market make at least two policies available to all "HIPAA eligible" individuals, and renewal of non-group coverage is at the option of such individuals, with some exceptions. HIPAA also prohibits non-group issuers from excluding coverage for pre-existing health conditions for HIPAA eligibles. In addition, a number of states have enacted their own guaranteed issue and pre-existing condition exclusion rules. As of December 2008, 14 states require issuers to offer some or all of their non-group insurance products on a guaranteed issue basis, and 42 states reduce the period of time when coverage for pre-existing health conditions may be excluded.

Proposed Options

Federal Rating Rules. This proposed policy would impose federal rating, issue, and other rules for the non-group and micro-group (2-10 employees) market. Guaranteed issue and guaranteed renewal rules would be imposed (using the same rate adjustment factors used at issue) on all coverage offered in the non-group and micro-group market, and exclusion of coverage for pre-

existing health conditions would be prohibited. Rates in this market would vary based only on the following characteristics: tobacco use, age, and family composition. More specifically, premiums could vary by a certain ratio for each characteristic, as follows:

- Tobacco use not to exceed 1.5:1
- Age not to exceed 5:1
- Family composition
 - single 1:1
 - adult with child 1.8:1
 - family 3:1
 - two adults 2:1

Premiums could also vary among rating areas to reflect geography. Taking all permissible factors together, premiums could not vary by more than a 7.5:1 ratio.

Effective Date. The effective date for these changes could be January 1, 2013 (or sooner if possible), which would provide states sufficient time to enact legislation by June 1, 2011. This schedule anticipates that plans could develop offerings by June 2012 and then begin marketing.

Risk-Adjustment. The Secretary would be required to implement a system for risk adjustment comparable to that used for adjusting Medicare payments to private plans. (In general, Medicare payments to Medicare Advantage plans are risk adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals.)

Under this option, both new market plans and grandfathered plans (described below) would be subject to a collective system of risk adjustment for a combined pool. The Secretary could either administer the risk adjustment system or require the states to do so. The Secretary and states may choose to collaborate with insurers in developing and administering the risk adjustment system.

Small Group Market Reforms

Current Law

There are no federal rating rules for the small group market. Similar to the non-group market, some states currently impose rating rules on insurance carriers in the small group market. As of December 2008, one state has pure community rating rules, eleven have adjusted community rating rules, and 35 have rate bands in the small group market.

HIPAA established federal rules regarding guaranteed issue, guaranteed renewability, and coverage for pre-existing health conditions for certain persons and groups. HIPAA requires that coverage sold to firms with 2-50 employees must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. HIPAA also guarantees

renewal of both small and large group coverage at the option of the plan sponsor (e.g., employer), with some exceptions. And HIPAA limits the duration that coverage for pre-existing health conditions may be excluded for “HIPAA eligible” individuals with group coverage. In addition, a number of states have enacted their own guaranteed issue and pre-existing condition exclusion rules, sometimes exceeding federal rules. All states require issuers to offer policies to firms with 2-50 workers on a guaranteed issue basis and reduce the period of time when coverage for pre-existing health conditions may be excluded, in compliance with HIPAA. As of December 2008, 13 states also require issuers to offer policies on a guaranteed issue basis to self-employed “groups of one,” and 21 states had pre-existing condition exclusion rules that provided consumer protection above the federal standard.

As part of its comprehensive health reform plan, Massachusetts merged its small and non-group markets. The practical effect is that insurance risk is now spread across the larger combined pool, upon which premiums are determined.

Proposed Options

Federal Rating Rules. The same federal rating rules that apply to the non-group and micro-group markets would also apply to the remainder of the small group market (as defined by the state).

State Option to Merge Individual and Small Group Markets. At their option, states would merge the pooling and rating rules for the non-group and small group markets. (Generally, “pooling” refers to the spreading of insurance risk across a pool of people to determine the applicable premium.)

Health Insurance Exchange

Current Law

No specific provision in federal law. However, the Health Insurance Exchange concept is similar in some ways to the Massachusetts Connector, as described below for illustrative purposes.

In 2006, in tandem with substantial private health insurance market reforms, Massachusetts created the Health Insurance Connector Authority, governed by a Board of Directors, to serve as an intermediary that assists individuals in acquiring health insurance. In this role, the Health Connector manages two programs; the first is Commonwealth Care, which offers a government-subsidized plan at three benefit levels from a handful of health insurers to individuals up to 300 percent of the federal poverty level (FPL) who are not otherwise eligible for traditional Medicaid or other coverage (e.g., Medicare, employer-based coverage). The second is Commonwealth Choice, which offers an unsubsidized selection of four benefit tiers (gold, silver, bronze, and young adult) from six insurers to individuals and small groups. Under state law, the Board of Directors has numerous responsibilities, including: determining eligibility for and administering tax credits through the Commonwealth Care program, awarding a seal of approval to qualified

health plans offered through the Connector’s Commonwealth Choice program, developing regulations defining what constitutes “creditable coverage,” constructing an affordability schedule to determine if residents have access to “affordable” coverage and may therefore be subject to tax penalties if they are uninsured, and developing a system for processing appeals related to eligibility decisions for the Commonwealth Care program and the individual responsibility.

Proposed Options

Plan Participation. All state-licensed private insurers in the non-group and small group markets, and the public health insurance option if applicable, operating nationally, regionally, statewide, or locally would be required to participate in the Health Insurance Exchange. Private insurers would also be permitted to sell these policies directly to purchasers.

Small Employer Participation in the Health Insurance Exchange. Micro-groups (2-10 employees) could purchase insurance through the Health Insurance Exchange immediately. The remainder of small employers can purchase through the Health Insurance Exchange once the federal rating rules are fully phased in by their state, but they would have to pick only one of the four benefit levels (lowest, low, medium or high) for their contribution level.

The tax exclusion for employer-provided health insurance allowed under current law would continue to apply in a case where the small business opts to purchase through the Exchange. The small group health insurance policy would be deemed a “group health plan.”

Establishment of Exchange. The Secretary would establish an Exchange that enables an individual to receive state-specific information. The Secretary could contract with a private entity to operate the Exchange.

Functions Performed by Secretary. The Secretary of Health and Human Services would be responsible for the following:

- After consultation with state insurance commissioners, develop a standard enrollment application for eligible individuals and small businesses seeking health insurance through the Exchange (both an electronic and paper version);
- Provide a standardized format for presenting insurance options, including benefits, premiums, and provider networks (allowing for customized information so that individuals could sort by factors such as ZIP code or providers);
- Develop standardized marketing requirements modeled after Medicare Advantage (CMS regulates the marketing activities of Medicare Advantage plans in order to protect beneficiaries from unscrupulous marketing practices). For example, marketing rules prohibit most unsolicited door-to-door and outbound sales calls to beneficiaries;
- Maintain call center support for customer service that includes multilingual assistance -- the center would have the ability to mail relevant information to residents based on their inquiry and ZIP code;

- Enable consumers to enroll in health care plans in local hospitals, schools, Departments of Motor Vehicles, local Social Security offices, emergency rooms, and any other offices designated by the state;
- Establish rate schedules for broker commissions (also currently done by CMS for Medicare Advantage plans);
- Establish a Web portal that directs individuals and small businesses to available insurance options in their state, provides a tax credit calculator so individuals and small businesses can determine their true cost of coverage, informs individuals of eligibility for public programs, and presents standardized information related to insurance options, including quality ratings;
- Establish a plan for publicizing the existence of the Exchange; and
- Establish procedures (which could be done through SSA, IRS or state Medicaid offices) for enabling:
 - enrollment of individuals and small businesses;
 - eligibility determinations for low-income tax credits;
 - appeals of eligibility decisions for tax credits;
 - appeals procedures for enforcement actions taken by the Department of the Treasury under the individual responsibility; and
 - annual certification upon request of a resident who has sought health insurance coverage through the Exchange, attesting that, for the purposes of enforcing the individual coverage requirement, no health benefit plan which meets the definition of creditable coverage was deemed affordable by the Exchange for that individual—and maintain a list of individuals for whom certificates have been granted

Exchange Related Functions Performed by State Insurance Commissioners. State Insurance Commissioners would establish procedures for review of plans to be offered through the Exchange and would develop criteria for determining that certain health benefit plans no longer be made available¹. They would also develop a plan to decertify and remove the seal of approval from certain health benefit plans.

Establishment of Multiple Exchanges. Another option would be to establish multiple, competing exchanges. The Secretary would still establish a national Exchange that enables the review of state-specific information and could contract with a private entity to operate the Exchange. Additionally, the Secretary would be required to accept and approve applications from private entities that demonstrate to the satisfaction of the Secretary that they have the capacity and expertise to carry out the required functions of an exchange and have submitted a proposal to the Secretary in such form and manner as the Secretary specifies. Multiple

¹ Under the proposed option, exchanges would be required to provide information on and facilitate enrollment in all plans offered by any issuer in an area. Individuals and small businesses may choose to either purchase plans through the exchange or go directly to an insurer or agent to purchase a plan, but all plans regardless of the point of sale must meet new rating and benefit requirements and individual tax credits will only be available to those purchasing through the Exchange. Insurance Commissioners would review all plans available by any issuer in an area to ensure they meet the new benefit and rating requirements.

exchanges may be permitted to operate in the same geographic area. Insurance carriers could not operate as exchanges or selectively participate in one of the multiple exchanges. The Secretary could limit the number of approved exchanges to three in an area (in addition to the one national Exchange) for the first five years, if the Secretary determines appropriate.

Funding for Operation of the Exchange. The Exchange would receive initial federal funding but then would be self-sustaining through premium assessments.

Transition

Current Law

No specified provision in federal law

Proposed Option

Grandfathered Plans. Individuals who currently have coverage and small employers who currently provide coverage to their employees could maintain such coverage (grandfathered plans). Issuers could continue to provide coverage under a grandfathered plan only to those individuals who are either currently enrolled in such a policy or to new employees hired by an employer offering such coverage. Once the small employer changes their contract for coverage, they must purchase a plan meeting the new federal benefit requirements. No low-income tax credits would be provided to those enrolled in grandfathered plans.

Transition Rules for Rating Requirements. Federal rating rules for non-group and micro-group markets (other than for grandfathered plans) will take effect on January 1, 2013 (or sooner if possible). Federal rating rules for the remainder of the small group market (as defined by the state) would be phased in over a three-to-ten year period, as determined by each state with approval from the Secretary.

Role of State Insurance Commissioners

Current Law

State insurance commissioners are responsible for protecting the interests of insurance consumers by performing functions such as antifraud efforts, addressing consumer complaints, market analysis, producer licensing, and regulatory interventions. They are responsible for enforcing the general rules governing insurance, which include licensing insurers and rules for brokers and agents activities.

HIPAA guarantees the availability of a plan and prohibits pre-existing condition exclusions for certain eligible individuals who are moving from group health insurance to insurance in the individual market. States have the choice of either enforcing the HIPAA individual market guarantees, referred to as the “federal fallback,” or they may establish an “acceptable alternative

state mechanism.” In states using the federal fallback approach, HIPAA requires all health insurance issuers operating in the individual health insurance market to offer coverage to all eligible individuals and prohibits them from placing any limitations on the coverage of any preexisting medical condition. Insurers have options for complying, such as offering the two most popular products and they can refuse to cover individuals seeking portability from the group market if financial or provider capacity would be impaired.

There are no federally-established rating areas in the private health insurance market. However, some states have enacted rating rules in the non-group and small group markets that include geography as a characteristic on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define these areas.

Proposed Option

Roles and Responsibilities. State insurance commissioners would continue to provide oversight of plans with regard to consumer protections (e.g., grievance procedures, external review, oversight of agent practices and training, market conduct), rate reviews, solvency, reserve requirements, and premium taxes. They would provide oversight of plans with regards to federal rating rules and any additional state rating rules and facilitate risk-adjustment within service areas.

Federal Fallback. In a manner similar to HIPAA there would be a federal fallback, so that if states did not adopt federal rating rules (through licensing requirements or legislation), the Secretary could enforce the rules. The Secretary would periodically review state enforcement of rating rules.

Rating Areas. Rating areas would be defined by State Insurance Commissioners and reviewed by the Secretary for adequacy. Rating areas (1) would allow for exceptions, (2) would be required to allow for pooling of similar cost people, and (3) would be risk adjusted across the areas.

SECTION II: Making Coverage Affordable

Benefit Options

Current Law

Generally, federal law only has certain requirements regarding actuarially equivalent benefit options in the context of private plan offerings through federal health insurance programs (e.g., Medicare Parts C and D, the Children’s Health Insurance Program). There is no federal law regarding actuarially equivalent benefit options in group and non-group private health insurance. However, states may have such standards. For example, Massachusetts defines a standard Gold benefit package for private health insurance available in its Connector. A plan with a different design can be qualified as Gold if it has an actuarial value that is within 5% of the standard Gold’s value. The state permits two other benefit packages available to all individuals in the

Connector: Silver is 80% of Gold (plus or minus 7.5%), and Bronze is 60% of Gold (plus or minus 2%). An additional option is available to young adults in Massachusetts that permits plans to exclude prescription drugs and to limit annual plan benefit payments.

Federal law does not define “minimum creditable coverage” benefit package for purposes of individual (non-group), small group (employers with 2-50 workers, 1-50 or up to 99 workers in some states), and other group private health insurance. States have the primary responsibility of regulating the business of insurance and may define what qualifies as minimum creditable coverage. However, federal law requires that private health insurance include certain benefits and protections. HIPAA and subsequent amendments require, for example, that group health plans and insurers cover minimum hospital stays for maternity care, provide parity in annual and lifetime mental health benefits, and offer reconstructive breast surgery if the plan covers mastectomies.

Proposed Options

All health insurance plans in the non-group and small group market would be required, at a minimum, to provide a broad range of medical benefits, including but not limited to, preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, including x-rays, maternity and newborn care, medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services, which at least meet minimum standards set by federal and state laws. In addition, plans could not include lifetime limits on coverage or annual limits on any benefits and cannot charge cost-sharing (e.g., deductibles, copayments) for preventive care services. Another option would be to allow plans to charge nominal cost-sharing for prevention services.

All insurers would be required to offer all four of the following benefit options:

- High option would have an actuarial value (defined as the percentage of health care expenses paid by the plan) of 93 percent;
- Medium option would have an actuarial value of 87 percent;²
- Low option would have an actuarial value of 82 percent.
- Lowest option would have an actuarial value of 76 percent.

Each plan design would be required to apply parity for cost-sharing for treatment of conditions within each of the following categories of benefits: (1) inpatient hospital, (2) outpatient hospital, (3) physician services, and (4) other items and services, including mental health services. Each plan design would also be required to meet the class and category of drug coverage requirements specified in Medicare Part D. Generally, Part D plans must offer two drugs in each class or category. The Secretary could allow some flexibility in plan design to encourage widely agreed

² This is approximately equal to the Federal Employees Health Benefit Program (FEHBP) Blue Cross Blue Shield Standard Option as estimated by the Congressional Research Service. Chris Peterson, “Setting and Valuing Health Insurance Benefits,” *Congressional Research Service*, R40491, (2009): 4.

upon cost and quality effective services but could discourage plan designs that could lead to adverse selection.

Participating insurers in the Exchange would be required to charge the same price for the same products in the entire service area as defined by the state regardless of how an individual purchases the policy (i.e., whether the policy is purchased from the exchange, from a broker or directly from the insurance carrier).

Low-Income Tax Credits

Current Law

Health Coverage Tax Credit. Certain individuals are eligible for the health coverage tax credit (“HCTC”). The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they have not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The credit is available for “qualified health insurance,” which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market.

The credit is available on an advance basis through a program established and administered by the Treasury Department. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury. The Treasury pays the full premium (the individual's portion and the amount of the refundable tax credit) to the insurer. Alternatively, eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.

Individuals entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized plans, or with certain other specified coverage, are not eligible for the credit.

COBRA Continuation Coverage Premium Reduction. The Consolidated Omnibus Reconciliation Act of 1985 (“COBRA”) requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the “applicable premium” for such period and the premium must be payable, at the election of the payor, in monthly installments.

Section 3001 of the American Recovery and Reinvestment Act of 2009 provides that, for a period not exceeding nine months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the

premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct). In addition, the qualifying event must occur during the period beginning September 1, 2008 and ending with December 31, 2009.

The premium subsidy also applies to temporary continuation coverage elected under the Federal Employees Health Benefits Program (FEHBP) and to continuation health coverage under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the premium subsidy. To the extent that the aggregate amount of subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on the entitlement to the premium reduction and subsidy, and it is conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed at the end of the year on an individual tax return.

Proposed Options

The proposal would provide a tax credit for low income taxpayers³ who purchase health insurance through the Exchange. The tax credit would be refundable and paid in advance. The tax credit would be in the form of a "premium subsidy" that would help offset the cost of purchasing health insurance. The tax credit would be available for individuals (single or joint filers) with modified adjusted gross income ("MAGI") between 100 and 400 percent of the federal poverty level (FPL).

The level of coverage subsidized would depend on the individual's MAGI. The individual would be required to pay a premium capped at a specified percentage of MAGI that increases as the individual's MAGI increases. The tax credit is available to individuals between 100 and 400 percent of FPL. The subsidized coverage would be divided into three levels: high benefit option for individuals with MAGI between 100 and 200 percent of the FPL; medium benefit option for individuals with MAGI between 200 and 300 percent of the FPL, and low benefit option for

³ Because the premium subsidy is a tax credit, reference is made to individuals, but the coverage generally would be for the individuals in a family group that includes the taxpayer (including a married couple filing jointly), such as single, one adult with children, two adults with no children, or two adults with children.

individuals with MAGI between 300 and 400 percent of the FPL.⁴ The subsidized coverage would be tied to the premium for the second lowest cost option in the individual's area for the level of coverage subsidized. Individuals would be able to buy a higher level of coverage but they would pay the full difference in the premium. As an individual's MAGI increases, the tax credit phases out on a linear scale.

Another option might be that the premium credit would be an amount calculated based on the enrollment-weighted average premium of the qualified low coverage option offered in the service area to be determined by the Secretary of Health and Human Services. In addition, there would be cost sharing assistance to limit the amount of cost-sharing an individual is required to pay up to the valuation of the high coverage option for those between 100 and 200 percent of FPL and the medium coverage policy for those between 200 and 300 percent of poverty.

The tax credit would be effective for months of coverage beginning on or after January 1, 2013 (or sooner if possible).

Small Business Tax Credits

Current law

The Code does not currently provide a tax credit for employers that provide health coverage for their employees. The cost to an employer of providing health coverage for its employees is generally deductible under section 162 as an ordinary and necessary business expense for employee compensation. In addition, the value of employer provided health insurance is not subject to employer paid Federal Insurance Contributions Act (FICA) tax.

Proposed Option

The proposal would provide a tax credit to certain small employers for the purchase of employer provided health insurance. The credit would be provided for each full time employee covered and would be equal to 50 percent of the average total premium cost paid by the employer for employer sponsored coverage in the employer's State. For this purpose, full time employee means an employee who generally works 30 hours a week. The credit would vary based on the type of coverage (i.e., single, adult with child, family or two adults) provided to the employee. The full amount of the credit would be available to an employer with 10 or fewer full time employees, and whose employees have average annual wages from the employer of less than \$20,000. The credit would phase out for employers with more than 10 employees but not more than 25 full time employees. Simultaneously, the credit would phase out for an employer for whom the average annual wages per employee is between \$20,000 and \$40,000.

The credit would only be available to offset actual tax liability and would be claimed on the employer's tax return. The credit would not be payable in advance to the taxpayer or refundable.

⁴ High, medium, and low benefit options are described in "Benefit Options."

SECTION III: Public Health Insurance Option

Current Law

There is currently no federal public health insurance option for non-disabled individuals under 65 years of age. Medicare, however, is an example of a federal public health insurance option for the aged and certain disabled individuals. Under Medicare, Congress and the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services (HHS) determine many parameters of the program including eligibility rules, financing (including determination of payroll taxes, and premiums), required benefits, payments to health care providers, and cost sharing amounts. Despite the public nature of this program, CMS subcontracts with private companies to carry out much of the administration of the program.

Proposed Option A

There are several major issues that must be resolved in detailing a public health insurance option. The first issue is how providers will be reimbursed for services they provide to enrollees of the public option. The second is whether or not the public option will be required to establish provider networks or can it compel providers to participate. The third is whether the public option will be required to have reserve funds to cover their incurred but not reported claims. The fourth is whether or not the premiums collected by the public option will be required to cover costs or can shortfalls will be subsidized by the federal treasury. Finally, there is the issue of administration of the public option and whether it will be done by a federal agency or by a third party.

Three separate options for a public health insurance plan are described below.

Approach 1: Medicare-Like Plan

This proposal would establish a “Medicare-like” public health insurance option to be offered through the Exchange. The public option would be administered by a new agency within the Department of Health and Human Services (HHS). Eligibility rules, markets, and income-related tax credits for the public option would mirror those for all other plans offered through the Exchange. Medicare providers would be required to participate in the public option, and would be paid Medicare rates plus 0-10%. Rating rules would apply to the public option in the same way that they apply to plans offered through the Exchange in the non-group and small group markets. (Rating rules restrict the variation in price of insurance policies according to the risk of the person or group seeking coverage and are explained in the section on non-group market rating rules and risk adjustment.)

Risk adjustment would apply to the public option in the same way that it applies to plans offered through the Exchange in the non-group and small group markets. (Risk adjustment is an adjustment in the payment for an insurance policy which reflects the expected variation in expenditures of sicker or healthier individuals. See the section on non-group market rating rules and risk adjustment.) The public option would incorporate any medical delivery system reforms adopted from the overall reform effort. The public option would not have solvency

requirements. The public option would start and accept enrollees on the same date that the Exchange begins.

Approach 2: Third Party Administrator

Proposal 2 would be similar to Proposal 1 with the following differences. First, instead of being operated by HHS, the public option would be administered through multiple regional third-party administrators (TPAs) who would be required to report to the Secretary. This governance structure will be separate from the agency overseeing competition among other private plan options. Second, the TPAs would be required to establish networks of participating medical providers. Payments for participating providers would be negotiated by the TPAs. Lastly, the public health insurance option would be required to have reserve funds.

Approach 3: State-Run Public Option

Proposal 3 envisions a State-run public option. This option could either be mandatory or optional for States but the details of its administration will be left to the States. One possible option for the States might be to allow individuals to purchase coverage through the State-employee plans.

Proposed Option B

Option B does not include a public health insurance option and instead relies on private options in a reformed and well regulated private market.

SECTION IV: Role of Public Programs

Medicaid Coverage

Eligibility Standards and Methodologies

Current Law

Eligibility for Medicaid is determined not only based on financial criteria, but also on categorical requirements – that is, to be eligible for traditional Medicaid, one must be a member of a covered group, such as children, pregnant women, the aged, or the disabled. For example, “childless adults” (nonelderly adults who are not disabled, not pregnant and not parents of dependent children) are generally not eligible for Medicaid, regardless of their income. Parents are eligible for Medicaid if they would have been eligible for the former federal cash welfare program Aid to Families with Dependent Children (AFDC) as of July 1, 1996. The upper-income threshold for AFDC eligibility in 1996 ranged across states from 11 percent to 68 percent of the federal poverty level (FPL), although states have the flexibility to raise eligibility to higher levels (in some states, parents are eligible for Medicaid up to 200 percent FPL). States are required to make pregnant women and children five and under eligible for Medicaid up to at least 133 percent FPL, and six to 18 year-olds up to 100 percent FPL, but can go higher.

For some Medicaid eligibility groups, states are required to disregard certain amounts and/or types of income (and sometimes expenses, such as child care or health care costs). For some Medicaid eligibility groups, states have the flexibility to disregard additional amounts or types of income and expenses, effectively expanding eligibility to higher-income individuals. Because states must share in the costs of Medicaid, income eligibility expansions may be dependent on the availability of such financing.

Proposed Option

Effective soon after enactment, all state Medicaid programs would be required to raise income eligibility for pregnant women, children, and parents. For example, make parents, pregnant women, and all children eligible up to 150 percent FPL. In addition, states would be required to maintain income eligibility for all previously eligible populations upon enactment, and this maintenance of effort would expire when the Secretary of HHS determines that the Exchange is fully operational. The Secretary would be directed to identify obsolete eligibility categories in light of these eligibility expansions.

No income disregards would be permitted for any Medicaid eligible population. Income would be measured based on modified adjusted gross income (MAGI), the same definition used by the Exchange to determine eligibility for the tax credit. This would ensure alignment between eligibility for Medicaid and eligibility for credits to purchase coverage through the Exchange.

Medicaid Program Payments

Current Law

The federal share for most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa). FMAPs have a statutory minimum of 50 percent and maximum of 83 percent.

The federal share for Medicaid administrative costs does not vary by state and is generally 50 percent. Certain administrative functions have a higher federal matching rate (*e.g.*, 75 percent for survey and certification of nursing facilities, and 90 percent for the startup expenses associated with establishing Medicaid Management Information Systems for claims and information processing).

States have broad authority to establish provider payment rates under Medicaid. Federal law requires that these rates be consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that covered benefits will be available to Medicaid beneficiaries at least to the same extent they are available to the general population in the same geographic area.

Proposed Option

Through 2015, the federal government would fully finance all expenditures for benefits provided to individuals newly eligible for Medicaid as a result of increases in income eligibility. The state share of these costs would be phased in over the next five-year period. Thus, in each year of this period, states would become responsible for an additional 20 percent of the otherwise applicable state share of benefit costs. After this phase-in period, the state share of these costs would be equal to the applicable proportion established under the FMAP formula. Alternatively, the federal government could pay an increased share for benefits provided to all populations for a certain duration.

For services provided to existing eligibility groups, and under existing waivers authorized in section 1115 of the Social Security Act, both the federal and state governments would share in the costs, as established under the FMAP formula. For administrative services, the current law rules for determining the federal and state share of costs would apply.

Finally, this option could require that payments to all providers not fall below a given percent (*e.g.*, 80) of Medicare reimbursement rates for the same or similar services.

Options for Medicaid Coverage

Current Law

There is no provision in federal law for Medicaid enrollees' purchase of public or private health insurance through an Exchange.

Massachusetts currently uses capped Medicaid funding (under a section 1115 demonstration waiver) for subsidies toward the purchase of private health insurance through the Massachusetts Connector. These subsidies are available to individuals up to 300 percent FPL who are not otherwise eligible for traditional Medicaid or other coverage (*e.g.*, Medicare, job-based coverage).

Proposed Options

Approach 1: Increased Coverage through the Current Medicaid Structure

Individuals eligible for Medicaid would be deemed ineligible for tax credits in the Exchange. For people eligible for Medicaid coverage but receiving coverage through employer-sponsored insurance (ESI), a state Medicaid program could provide premium assistance for ESI. A variation on this option would be to require a state Medicaid program to provide premium assistance to Medicaid-eligible individuals with ESI. Requiring the state to provide premium assistance could mitigate the likelihood of Medicaid-eligible individuals dropping ESI.

Approach 2: Increased Coverage through the Exchange

The Medicaid legal entitlement to coverage and services continues to exist under this option for all populations eligible for Medicaid. The disabled, dual eligibles and other special needs populations would continue to receive coverage through the existing state Medicaid program structure. The state Medicaid program would be required to provide coverage for children, pregnant women, parents, and childless adults through insurance plans in the Exchange. A state could also provide premium assistance for employer-sponsored insurance but would not be required to do so.

The state Medicaid program would provide eligible Medicaid enrollees with a choice of Exchange Low Option plans. Premiums for Medicaid-eligible populations in the Exchange would be fully subsidized consistent with the process for providing the low-income subsidy under sections 1860D-14 and 1935. The state Medicaid program would reimburse insurers for the cost of filling in cost-sharing and premiums and seek payment from the federal government consistent with the existing FMAP arrangement.

As part of the ongoing Medicaid entitlement to benefits, the state Medicaid program would arrange to provide coverage for health services of an amount, type, duration, and scope that exceeds or falls outside the limits of Exchange coverage to populations entitled to the coverage – for example, education setting services, transportation, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). This is similar to the legal arrangements states make with Medicaid managed care organizations under current law.

Products sold to Medicaid eligible individuals and families must meet requirements imposed on managed care organizations within title XIX. Plans must submit a contract to the state agreeing to provide services to Medicaid beneficiaries. Products are subject to all rules and regulations applied to all plans in the Exchange.

Variations for this option include, but are not limited to: increasing the reimbursement for states under the FMAP formula, providing eligible populations with a choice of High Option plans, allowing states to choose between this option and existing Medicaid, allowing a state to limit the populations that would be required to receive coverage through the Health Insurance Exchange to non-pregnant, childless adults, allowing states to create or act as a Health Insurance Exchange plan, and allowing states to create Medicaid-only plans to participate in the Health Insurance Exchange.

Approach 3: Increased Coverage through Both the Current Medicaid Structure and the Health Insurance Exchange

This option would expand coverage for children, pregnant women, and parents – mandatory populations – like the first two options. Children, parents, and pregnant women would continue to receive Medicaid in its current structure. However, under this option, childless adults would not become eligible for Medicaid. Instead, childless adults below 115 percent FPL would be eligible for federal tax credits to purchase coverage. There are two choices for purchasing

coverage – private coverage through the Health Insurance Exchange (including the public health insurance option if applicable), and public coverage through the state’s Medicaid program.

The public coverage alternative would be achieved by treating the tax credit administered by the Health Insurance Exchange as a “voucher” that the recipient could use to buy into the state’s Medicaid program. States would be required to accept this “voucher” if a recipient requests to buy into Medicaid. Recipients would get all of the same benefits and protections, including cost-sharing, that Medicaid offers to parents enrolled in the program. In the event that a low-income, childless adult buys into Medicaid and uses services to such a degree that the cost exceeds the value of the “voucher,” the Health Insurance Exchange will reimburse the state in full for all such services at the rate of 100 percent of the amount those services would cost if provided to a parent enrolled in Medicaid.

The private coverage alternative would be achieved by subsidizing the full amount of the premium of a qualified Health Insurance Exchange plan. Because the lowest-income individuals tend to be more vulnerable, additional protections would be attached to their Health Insurance Exchange coverage, including applying Medicaid limits on cost-sharing and requiring plans to include safety net providers (like public hospitals and community health centers) in their networks.

Variations for this option include, but are not limited to, making a subset of childless adults (*e.g.*, those below 50 percent FPL) Medicaid eligible, giving states the option to accept “vouchers” for buying into Medicaid, and making Medicaid accessible to the mandatory populations through the Health Insurance Exchange (similar to Approach 2).

Treatment of Territories

Current Law

Five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands) operate their Medicaid programs under rules that differ from those applicable to the 50 states and the District of Columbia (hereafter referred to as the states). The territories are not required to cover the same eligibility groups, and they use different financial standards (income and asset tests) in determining eligibility. For example, states must cover certain mandatory groups such as low-income pregnant women and children and qualified Medicare beneficiaries. For the territories, these groups are optional.

In the states, Medicaid is an individual entitlement. In addition, there are no limits on federal payments for Medicaid provided that the state contributes its share of the matching funds. In contrast, Medicaid programs in the territories are subject to annual federal spending caps. All five territories typically exhaust their caps prior to the end of the fiscal year. Once the cap is reached, the territories assume the full costs of Medicaid services, or in some instances may suspend services or cease payments to providers until the next fiscal year.

The federal share for most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which is based on a formula that provides higher reimbursement to states

with lower per capita incomes relative to the national average (and vice versa). FMAPs have a statutory minimum of 50 percent and maximum of 83 percent. Apart from recent, temporary increases in the federal share of Medicaid costs in the states and territories, the FMAP is typically set at 50 percent in the territories.

Proposed Options

Medicaid eligibility categories would be the same for the territories as for the states. The existing funding caps for the territories would be removed. With respect to federal matching dollars, the territories would receive FMAP as determined by the FMAP formula upon enactment, subject to existing statutory minimum and maximum percentages. This option could be effective immediately or phased-in over time.

An alternative to this option is to maintain the current structure of Medicaid in the territories, but increase the caps.

The Children's Health Insurance Program

Current Law

In general, the Children's Health Insurance Program (CHIP) allows states to cover targeted low-income children under age 19 with no health insurance in families with income above Medicaid eligibility levels. States can set the upper income level up to 200 percent of the federal poverty level (FPL), or 50 percentage points above the applicable pre-CHIP Medicaid income level. However, states are able to effectively expand eligibility for CHIP to higher income levels through income disregards. Generally, within broad federal guidelines, states have flexibility to determine what types and amount of income they will consider in determining whether an applicant's effective income is at or below the applicable income eligibility standard.

For states seeking federal approval to expand eligibility, the recent Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3) reduces federal CHIP payments for certain higher-income CHIP children. Specifically, the regular Medicaid match rate, which is lower than the CHIP enhanced matching rate (described in more detail below), will be used for CHIP enrollees whose effective family income exceeds 300 percent FPL using the state's policy of excluding "a block of income that is not determined by type of expense or type of income," with an exception for states that already had a federal approval plan or that had enacted a state law to submit such a plan for federal approval.

Under CHIP, states may enroll targeted low-income children in a CHIP-financed expansion of Medicaid, create a new separate state CHIP program, or a combination of both approaches. States choosing the Medicaid expansion option must provide all Medicaid mandatory benefits and all optional benefits covered under the state plan. As an alternative, states may opt for the combination approach and enroll Medicaid/CHIP children in benchmark and benchmark-equivalent plans that are nearly identical to the benefit packages offered through separate CHIP programs described below. For any child under age 21 in one of the major mandatory and

optional Medicaid eligibility groups, including targeted low-income children, the benefits available through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program must be provided, whether through a benchmark plan or otherwise (CHIPRA; P.L. 111-3). Under EPSDT, children receive well-child care, immunizations, and other screening services, as well as medical care necessary to correct or ameliorate identified defects, illnesses, or conditions, including optional services states may not otherwise cover in their Medicaid programs.

States that choose to create separate CHIP programs may elect any of three benefit options: (1) a benchmark package, (2) benchmark-equivalent coverage, or (3) any other health benefits plan that the Secretary of HHS determines will provide appropriate coverage to the targeted population. A benchmark plan is one of the following three options: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage that is offered and generally available to state employees in the same state, and (3) the health coverage that is offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved. Benchmark-equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages, and it must meet certain coverage requirements.

Dental services are also a required benefit under separate CHIP programs (CHIPRA; P.L. 111-3) and include services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. States may provide dental services through benchmark dental benefit packages modeled after the benchmark plans for medical services described above (*e.g.*, dental benefit plans under FEHBP, state employee programs, and commercial HMO options).

Like Medicaid, for each dollar of state spending, the federal government makes a matching payment drawn from federal CHIP allotments. A state's share of program spending for Medicaid is equal to 100 percent minus the federal medical assistance percentage (FMAP). The enhanced FMAP (E-FMAP) for CHIP means a state's share of expenditures is 30 percent lower than under the regular Medicaid FMAP. The temporary Medicaid FMAP increases specified in the recent American Recovery and Reinvestment Act (ARRA; P.L. 111-5) are not considered in calculating the E-FMAP. In FY2009, prior to this temporary increase, the Medicaid FMAP ranged from 50 percent to 75.84 percent across states, and the enhanced FMAP for CHIP ranged from 65 percent to 83.09 percent.

Five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the Virgin Islands) also receive federal matching funds to provide health insurance to low-income children under CHIP. Between FY1999 and FY2008, earmarked CHIP funds were distributed among the territories based on statutorily set proportions. For FY2009, territories' federal CHIP allotments were based on the largest of their federal CHIP expenditures from FY1999 to FY2008. For FY2010 to FY2013, the territories' allotments will be determined in the same ways as those of the states. The federal CHIP matching rate is 65 percent. All the territories use their CHIP funds to expand their Medicaid programs. These Medicaid programs operate under a

federal funding cap. In general, once this cap is exhausted, the territories provide coverage to eligible children with territory-only funds.

There is no provision in federal law for CHIP enrollees' purchase of private health insurance through a Health Insurance Exchange.

Proposed Option

Once the Health Insurance Exchange is up and running, there will be more coverage options for children of low-to-moderate income levels than exist today. As access to private insurance increases, the need for CHIP as it is currently structured will diminish. Furthermore, if individuals are required to have health insurance, CHIP can play a different role in helping to provide coverage.

Under this option, there would be no federal changes to the structure of CHIP prior to the end of the current reauthorization period (September 30, 2013) or prior to when the Health Insurance Exchange is fully operational, whichever occurs later. Upon enactment, states would be prohibited from decreasing income eligibility for currently eligible child populations until the end of the current authorization period or when the Health Insurance Exchange is fully operational, whichever is later.

After that point, the CHIP income eligibility would be increased to 275 percent FPL. In addition, CHIP programs would no longer be able to use income disregards, and income would be measured based on modified adjusted gross income (MAGI) as defined under the Health Insurance Exchange and Medicaid proposals.

Federal financial participation for CHIP will continue. With respect to benefits, as of the end of the current authorization period or when the Health Insurance Exchange is fully operational, whichever is later, CHIP coverage would include the Medicaid EPSDT benefit. Rules for the territories would be harmonized with the states as in Medicaid.

Once the Health Insurance Exchange is fully operational, CHIP enrollees would obtain their primary coverage through the Health Insurance Exchange. CHIP would serve as a secondary payer, with states arranging coverage for health services of an amount, type and scope that exceeds or falls outside the limits of Health Insurance Exchange coverage (*e.g.*, EPSDT).

Health Insurance Exchange plans would have to contract with the state to provide services to CHIP beneficiaries, while also being subject to all rules and regulations applied to all plans within the Health Insurance Exchange.

The cost-sharing for CHIP children would be limited to Medicaid's cost-sharing rules. For children in family plans in the Health Insurance Exchange, the portion of the premium that goes toward coverage of the CHIP-eligible child would be fully subsidized.

Variations for this option include, but are not limited to: allowing states to create or act as an Health Insurance Exchange plan, allowing states to create Medicaid-only plans to participate in

the Health Insurance Exchange, and limiting premium reimbursement to those services covered by Medicaid (e.g., EPSDT) that are not in the Health Insurance Exchange plan.

Quality of Care in Medicaid and CHIP

Current Law

The Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3) included several provisions designed to improve the quality of care under Medicaid and the Children's Health Insurance Program (CHIP). The law directs the Secretary of HHS to develop child health quality measures, a standardized format for reporting information, and procedures to encourage states to voluntarily report on the quality of pediatric care in these two programs. Examples of these initiatives include: (1) grants and contracts to develop, test, update and disseminate evidence-based measures, (2) demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and CHIP, (3) a demonstration to develop a comprehensive and systematic model for reducing child obesity, and (4) a program to encourage the creation and dissemination of a model electronic health record format for children enrolled in these two programs. The federal share of the costs associated with developing or modifying existing state data systems to store and report child health measures is based on the matching rate applicable to benefits (FMAP) rather than one of the typically lower matching rates applied to different types of administrative expenses.

CHIPRA also established a new Medicaid and CHIP Payment and Access Commission (MACPAC). This commission will engage in a number of activities. MACPAC will review program policies under both Medicaid and CHIP affecting children's access to benefits, including: (1) payment policies such as the process for updating fees for different types of providers, payment methodologies, and the impact of these factors on access and quality of care, (2) the interaction of Medicaid and CHIP payment policies with health care delivery generally, and (3) other policies, including those relating to transportation and language barriers. The commission will make recommendations to Congress concerning such access policies. Commission reports are due annually, beginning in 2010.

Proposed Option

The proposal would apply similar quality measures established in CHIPRA to all Medicaid eligible populations.

The proposal would appropriate \$10 million for MACPAC, with \$8 million through Medicaid funds and \$2 million through CHIP funds.

Other Improvements to Medicaid

Enrollment and Retention Simplification

Current Law

States have considerable flexibility to simplify and expedite the Medicaid eligibility determination and enrollment process (*e.g.*, allowing applications to be submitted by mail or fax, eliminating face-to-face interviews or asset tests, extending the length of time between initial enrollment and redeterminations of eligibility).

The Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) included several provisions to remove barriers to enrollment and created a bonus payment structure to encourage states to do so. For states to be eligible for CHIP bonus payments, they must increase Medicaid child enrollment by certain amounts and implement at least five out of eight specific outreach and enrollment activities. CHIPRA also permitted states to rely on findings from specified "Express Lane" agencies (*e.g.*, those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and Food Stamps) and the Social Security Administration (SSA) to determine whether a child has met one or more of the eligibility requirements (*e.g.*, income, assets, citizenship, or other criteria) necessary to determine initial eligibility or redeterminations of eligibility for Medicaid or CHIP. Also as a part of the outreach-related provisions, CHIPRA requires the Secretary of HHS, in consultation with state Medicaid and CHIP directors and organizations representing program beneficiaries, to develop a model process for the coordination of enrollment, retention, and coverage of children who frequently change their residency due to migration of families, emergency evacuations, and educational needs, for example.

Proposed Options

The proposal would eliminate the state option to rely on face-to-face interviews when determining eligibility for Medicaid and the ability to apply an assets test when determining eligibility for acute care services. States would also be required to: (1) implement 12-month continuous eligibility beginning on the date of application (or last renewal); (2) establish a Medicaid enrollment website to promote seamless enrollment in Medicaid should a Medicaid-eligible person apply for tax credits through the Health Insurance Exchange website; (3) permit states to enroll and redetermine Medicaid eligibility for all Medicaid beneficiaries at Disproportionate Share Hospitals, Federally Qualified Health Centers (FQHCs) and State Departments of Motor Vehicles; and (4) extend administrative automatic renewal and Express Lane renewal to all Medicaid beneficiaries. States complying with these requirements and others listed in CHIPRA to achieve the five-of-eight standard would be deemed as meeting the CHIPRA bonus payment enrollment and retention requirements, making them eligible to receive such bonus payments. Finally, as under CHIPRA, the proposal would require the Secretary of HHS, in consultation with state Medicaid and CHIP directors and organizations representing program beneficiaries, to develop a model process for the coordination of enrollment, retention, and coverage of all Medicaid beneficiaries who frequently change their state residency.

Family Planning Services and Supplies

Current Law

“Family planning services and supplies” is a mandatory Medicaid benefit that must be available to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the state Medicaid plan and who desire such services and supplies.

Proposed Option

The proposal would add a new optional categorically needy eligibility group to Medicaid. This new group would be comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under the Medicaid or CHIP state plan, and (2) at state option, certain individuals eligible for existing section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies (as per section 1905(a)(4)(C)) and would also include related medical diagnosis and treatment services. The proposal would also allow states to make a “presumptive eligibility” determination for individuals eligible for such services through the new optional eligibility group. That is, states may enroll such individuals for a limited period of time before full Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility. Under current law, such presumptive eligibility determinations can be made for children, pregnant women, and certain women with breast or cervical cancer. In addition, states would not be allowed to provide Medicaid coverage through benchmark or benchmark-equivalent plans, which are permissible alternatives to traditional Medicaid benefits, unless such coverage includes family planning services and supplies.

Treatment of Selected Optional Benefits

Current Law

Some Medicaid benefits are mandatory for most Medicaid groups (*e.g.*, inpatient hospital services, physician services, family planning services and supplies, federally qualified health center services, nursing facility services for persons age 21 or older), others are optional. Examples of optional benefits for most Medicaid groups that are offered by many states include prescription drugs (covered by all states), other licensed practitioners (*e.g.*, optometrists, podiatrists, psychologists), and nursing facility services for individuals under age 21.

While there is statutory authority to pay for services rendered by nurse midwives, there is no statutory authority to provide for direct payment to birthing centers for facility services.

Proposed Option

Podiatrists, optometrists, and free-standing birth centers would be given provider status.

Interstate Coordination Requirements for Child Medicaid Beneficiaries

Current Law

The Medicaid statute authorizes the Secretary to prescribe state plan requirements for furnishing Medicaid to state residents who are absent from the state. Federal regulations prescribe further details related to this statutory authority. A state must pay for services furnished in another state to the same extent that it would pay for services furnished within its boundaries if the services are provided to a Medicaid beneficiary who is a resident of the state and if any of the following four conditions are met: (1) medical services are needed because of a medical emergency, (2) medical services are needed and the recipient's health would be endangered if he/she were required to travel to the state of residence, (3) the state determines, on the basis of medical advice, that the needed medical services and supplementary resources are more readily available in the other state, and (4) it is general practice for beneficiaries in a particular locality to use medical resources in another state. Home states may require out-of-state providers to enroll in their programs, or otherwise enter into a service agreement as a condition of receiving payments.

For non-institutionalized individuals under age 21 whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the individual is living. For other non-institutionalized individuals under age 21, the state of residence is based on the rules governing residence under the former AFDC program. Generally, in such cases, the individual is a resident of the state in which he or she is living other than on a temporary basis.

In general, states must establish procedures to facilitate the furnishing of medical services to individuals who are present in the state and are eligible for Medicaid under another state's plan. States cannot deny Medicaid eligibility because an individual has not resided in the state for a specified period of time. Also states may not terminate a resident's eligibility because of that person's temporary absence from the state, if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined that the person is a resident there for Medicaid purposes. Finally, a state may (but is not required to) have a written agreement with another state setting forth rules and procedures for resolving cases of disputed residency. When two or more states cannot resolve which state is the state of residence, the state where the individual is physically located is the state of residence.

Proposed Option

The proposal would require interstate coordination to ensure that the child's home-state Medicaid program will cover the child when he or she is out of the state.

Mandatory Coverage for Prescription Drugs

Current Law

With a number of exceptions, Medicaid is available only to children, parents, pregnant women, and to aged, blind, or disabled people. People who do not fall into these categories—such as childless, single adults and couples—generally do not qualify for Medicaid regardless of their

income level. Historically, Medicaid eligibility has been divided into two basic classes, the “categorically needy” and the “medically needy.” The two terms once distinguished between welfare-related (categorically needy) beneficiaries and those qualifying under special Medicaid rules which allow states to cover people whose incomes are too high to qualify for cash welfare support, but who nevertheless need help with medical bills (medically needy).

However, non-welfare groups have been added to the “categorically needy” list over the years. As a result, the terms categorically and medically needy are no longer especially meaningful in sorting out the various populations for whom mandatory or optional Medicaid coverage has been made available. However, the distinction remains important when considering certain benefits. Some benefits are considered mandatory for categorically needy individuals; that is, states must cover those benefits for the categorically needy, but they are optional for medically needy individuals. Other benefits are optional for both groups of beneficiaries. Some states provide those optional benefits only to categorically needy individuals, while some states provide those benefits to both groups, and still other states provide optional benefits to selected subcategories of the medically needy as well as to all categorically needy beneficiaries.

Under Medicaid law, outpatient prescription drug coverage is an optional benefit, but all states have added prescription drug coverage to their Medicaid state plan benefits. Thus, prescription drug coverage is one of the few optional Medicaid services provided by all states. When states add prescription drug coverage as a state plan benefit, however, they must cover all categorically eligible beneficiaries, but they also may cover other optional eligibility groups, such as the medically needy. In 2005, 33 states covered prescription drugs for medically needy individuals, in addition to categorically eligible beneficiaries.

States have increased coverage of prescription drugs over the years, in part because it has been seen as representing a good value. While overall prescription drug spending has increased substantially, drugs remain relatively less expensive than many other clinical and therapeutic treatments. Appropriate use of prescription drugs is believed to help avoid larger and potentially more costly medical interventions such as emergency room visits and hospital admissions.

Proposed Options

This option would make prescription drugs a mandatory benefit for the categorically and medically needy.

Change the Status of Some Excludable Drugs

Current Law

Federal Medicaid law excludes 11 drug classes, including barbiturates and benzodiazepines. States still may cover these and other excluded drugs, but they do not receive federal financial participation (FFP) when they do. When Medicare Part D was implemented in January 2006, Medicare began covering prescription drugs for dual eligible individuals. Barbiturates and benzodiazepines were excluded from Part D as well as Medicaid. However, under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-271), Medicare

prescription drug plans and Medicare Advantage plans will be required to include barbiturates or benzodiazepines in their formularies for prescriptions dispensed on or after January 1, 2013. Barbiturates will also be required to be included in formularies for the indications of epilepsy, cancer, or chronic mental health disorder.

Proposed Option

Under this proposal, Medicaid law would be changed to eliminate smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excluded drug list.

Changes to Medicaid Payment for Prescription Drugs

Current Law

Medicaid law requires the Secretary of HHS to establish upper limits on the federal share of payments for prescription drug acquisition costs. These limits are intended to encourage substitution of lower-cost generic equivalents for more costly brand-name drugs. When applied to multiple source drugs, those limits are referred to as federal upper payment limits (FULs). FULs apply to aggregate state expenditures for each drug. CMS calculates FULs and periodically publishes these prices. Under the Deficit Reduction Act of 2005 (DRA; P.L. 109-171), new FULs issued after January 2007 were to equal 250 percent of the average manufacturer price (AMP) of the least costly therapeutic equivalent (excluding prompt pay discounts). AMP is defined in statute to be the average price paid to the manufacturer by wholesalers for drugs distributed to the retail pharmacy class of trade. Manufacturers are required to report AMP to CMS.

Proposed Option

Under this proposal, Medicaid law would be changed to increase the FUL percentage from 250 percent to 300 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. This proposal also would clarify what discounts and other price adjustments were included in the definition of AMP. Other technical modifications to Medicaid prescription drug law would include a revision to the definition of a multiple source drug, changing it from at least one other drug product to two or more drug products. A new prior authorization requirement would prevent more expensive drugs from being dispensed when generic equivalents are available absent medical necessity justifications.

Transparency in Medicaid and CHIP Section 1115 Waivers

Section 1115 Demonstration Waivers

Current Law

Section 1115 of the Social Security Act authorizes the Secretary to waive certain statutory requirements for conducting research and demonstration projects that further the goals of title

XIX (Medicaid) and title XXI (CHIP). States submit proposals outlining the terms and conditions of the demonstration program to CMS for approval prior to implementation.

In 1994, CMS issued program guidance that impacts the waiver approval process and includes the procedures states are expected to follow for public involvement in the development of a demonstration project. States were required to provide HHS a written description of their process for public involvement at the time their proposal was submitted.

In the 1990s, CMS emphasized the importance of public involvement in requests for project extensions. For demonstration extensions granted under the Balanced Budget Act of 1997, HHS required states to hold public hearings during which interested parties were allowed to present oral or written testimony. States were required to respond to questions that surfaced over the course of the hearings and to provide CMS with a summary of the proceedings.

Public involvement requirements for the waiver approval process continued through the early 2000s. In a letter to state Medicaid directors issued May 3, 2002, CMS listed examples of ways a state may meet requirements for public involvement (*e.g.*, public forums, legislative hearings, a website with information and a link for public comment).

Proposed Options

The proposal would impose statutory requirements regarding transparency in the development, implementation, and evaluation of Medicaid and CHIP section 1115 demonstration programs that impact eligibility, enrollment, benefits, cost-sharing, or financing. Options for new requirements on states include: (1) providing notice of the state's intent to develop and/or renew a section 1115 waiver and convene at least one meeting of the state's medical advisory board to discuss the impacts of the proposed changes; (2) publishing for written comment a notice of the proposal that provides information on how the public can submit comments to the state and includes state projections and assumptions regarding the likely impact of the waiver; (3) posting the waiver proposal on the state's Medicaid or CHIP website; and (4) convening open meetings over the course of the development of the proposal to discuss proposed changes. States could also be required to include information regarding the actions taken to meet the above-listed public notice requirements as a part of their waiver submission to CMS.

The proposal could also impose additional transparency-related statutory requirements on the Secretary of HHS. Options for new requirements on the Secretary include: (1) publishing a *Federal Register* notice identifying monthly waiver submissions, approvals, denials, and information regarding methods by which comments on the waiver will be received from the public; (2) publishing a copy of the proposed waiver to the CMS website; (3) allowing for, responding to, and making available public comments received about the proposal after it has been posted to the CMS website. Once approved, the Secretary must post waiver terms and conditions and related waiver approval documents, quarterly state-reported data and three-year evaluations to the CMS website. The Secretary could also be required to publish a *Federal Register* notice identifying monthly waiver approvals, denials, and returns to the state without action.

Medicaid State Plan Amendments (SPA) and Covered Benefits

Current Law

States are required to submit a state plan describing the nature and scope of a state's Medicaid program to the Secretary of Health and Human Services (HHS) for approval. The state plan must provide assurances that the program conforms to the requirements of title XIX and to any other official program issuances (*e.g.*, rules, regulations, program guidance, etc.). After approval of the original state plan by the Secretary of HHS, any subsequent changes (*e.g.*, those required by new federal or state statutes, rules, regulations, policy interpretations, guidance, court decisions, changes in the state's operation of the Medicaid program, etc.) must be submitted by the state to the Centers for Medicare and Medicaid Services (CMS) in the form of a state plan amendment (SPA) so that the Secretary of HHS may determine whether the Medicaid state plan continues to meet federal requirements. Federal regulations dictate the SPA approval process including requirements for Governor's review, CMS regional office review, disapproval of a SPA, and Judicial Review (*i.e.*, after a state's failure to conform to federal requirements). Federal law dictates time frames associated with the SPA review process, and requirements that the Administrator must meet when notifying a state that CMS intends to withhold federal matching payments for portions of the state plan that are out of compliance.

Proposed Option

The proposal would add transparency-related statutory requirements associated with the SPA approval process for proposals that limit benefits. States could: (1) provide notice of the state's intent to develop a SPA and convene at least one meeting of the state's medical advisory board to discuss the impacts of the changes requested in the proposed SPA; (2) publish a notice of the proposal that provides information on how the public can submit comments to the state and includes state projections and assumptions regarding the likely impact of the SPA; (3) post the SPA proposal on the state's Medicaid or CHIP website; and (4) convene at least one open meeting to discuss the proposed SPA. States could also be required to include information regarding the actions taken to meet the above-listed public notice requirements as a part of their SPA submission to CMS.

The proposal could also impose additional transparency-related statutory requirements on the Secretary of HHS. The Secretary could be required to: (1) publish a *Federal Register* notice identifying monthly SPA submissions and information regarding methods by which comments on each SPA will be received from the public; (2) publish a copy of the proposed SPA to the CMS website; and (3) publish a *Federal Register* notice identifying monthly SPA approvals, denials, and returns to the state without action.

Changes to the FMAP Formula

Current Law

Under Medicaid law, the FMAP formula compares each state's per capita income relative to U.S. per capita income, and provides higher reimbursement to states with lower incomes (with a

statutory maximum of 83 percent) and lower reimbursement to states with higher incomes (with a statutory minimum of 50 percent).

The formula for a given state is:

$$FMAP_{State} = 1 - 0.45 \left(\frac{(Per\ Capita\ Inc_{State})}{(Per\ Capita\ Inc_{U.S.})} \right)^2$$

The use of the 0.45 factor in the formula is designed to ensure that a state with per capita income equal to the U.S. average receives an FMAP of 55 percent (*i.e.*, state share of 45 percent). In addition, the formula's squaring of income provides higher FMAPs to states with below-average incomes than they would otherwise receive (and vice versa) without the squaring.

The Department of Health and Human Services (HHS) usually publishes FMAPs for an upcoming fiscal year in the *Federal Register* in the preceding November. Thus, FMAPs for FY2008 (the federal fiscal year that began on October 1, 2007) were calculated and published in 2006, and FMAPs for FY2009 were calculated and published in 2007. The FMAP calculation uses a three year average of state per capita income. The three-year average is used to ensure stability in the matching rates over time.

Proposed Option

This proposal would change the FMAP formula. The proposed FMAP change could be budget neutral. The formula would be changed so that it not only relies on a state's per capita income measure, it would also incorporate data on the state's poverty level. Two-thirds of the formula would be based on a state's relative per capita income compared to the national average. For the per capita income data used, the formula would be based on a two-year average rather than the current three-year average. One-third of the formula would be based on the state's poverty rate relative to the national poverty rate. The formula would remove the squaring factor. Under the revised FMAP formula, year-to-year FMAP fluctuations for states would be capped at +/- two percentage points. A state with a per capita income equal to the national per capita income and a poverty rate equal to the national poverty rate would have an FMAP equal to 55 percentage points. The new formula would be as follows:

$$FMAP_{State} = \left(1 - \left(\frac{2}{3} \left(\frac{(Per\ Capita\ Inc_{State})}{(Per\ Capita\ Inc_{U.S.})} \right) * 0.45 \right) + \left(\frac{1}{3} \left(\frac{(\% Pop_{State} < 100\% FPL)}{(\% Pop_{U.S.} < 100\% FPL)} \right) * 0.45 \right) \right)$$

Automatic Countercyclical Stabilizer

Current Law

The federal government's share of most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which varies by state and is determined by a formula set in statute. In addition to Medicaid, the FMAP is used in determining the federal share of certain other programs (*e.g.*, foster care and adoption assistance under title IV-E of the Social Security Act).

Periods of economic downturn can lead to an increase Medicaid enrollment at a time when state revenues are stagnant or falling. In the past, the Congress has enacted temporary FMAP increases as a part of fiscal relief packages to reduce the amount of state funding that is required to maintain a given level of Medicaid services. For example, the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA, P.L. 108-27) provided temporary fiscal relief for states and local governments through a combination of \$10 billion in FMAP increases and \$10 billion in direct grants.

Most recently, under the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5), all states and territories can receive a temporary FMAP (and/or federal spending cap) increase for a nine quarter period if specified requirements are met. In general, the law holds all states harmless from any decline in their regular FMAPs, provides all states with an across-the-board increase of 6.2 percentage points, and provides qualifying states with an unemployment-related increase. It allows each territory to choose between an FMAP increase of 6.2 percentage points along with a 15 percent increase in its spending cap, or its regular FMAP along with a 30 percent increase in its spending cap.

The unemployment-related FMAP increase is tiered based on a state's unemployment rate in the most recent three-month period for which data are available (except for the first two and last two quarters of the recession adjustment period, for which the three-month period is specified) compared to its lowest unemployment rate in any three-month period beginning on or after January 1, 2006.

Proposed Option

The option would provide an automatic increase in the Medicaid FMAP during periods of national economic downturn occurring after January 1, 2012. The national economic downturn assistance period would begin with the first fiscal quarter for which the Secretary of HHS determines that at least 23 states show a ten percent increase in their rolling average unemployment rate for that quarter (like from five percent to 5.5 percent), compared to the corresponding quarter two years prior.

States eligible for temporary increases in their Medicaid FMAP rates would include those for which the Secretary determines that the state rolling average unemployment rate (*i.e.*, the average of the six most recent months of seasonally adjusted unemployment data) for any quarter

during the national economic downturn assistance period has increased as compared to the corresponding quarter two years prior.

For qualifying states, the state-specific increase in FMAP would be based on the increased Medicaid cost attributable to the state's unemployment rate relative to the state's total Medicaid spending. The cost attributed to the increase in the state's unemployment rate is based on three factors: (a) the increase in the number of unemployed from the base period, (b) a national average amount of federal Medicaid spending attributable to the unemployed, and (c) adjusted by the state's relative Medicaid cost of nondisabled, nonelderly adults and children. The increase in the number of unemployed in the state would be based on a formula that takes into account state increases in the average number of unemployed individuals in a given quarter as compared to a base quarter. The national average amount of federal Medicaid spending per additional unemployed individual in a quarter would equal \$350.00 per person in 2012 (the amount for calendar quarters in succeeding fiscal years would be increased by the CPI-U). The state's adjustment for Medicaid spending is based on the state's relative annual per beneficiary spending on nondisabled, nonelderly adults and children in poverty as compared to the national annual average for such individuals.

The amount of the temporary FMAP increase would only apply to Medicaid benefit expenditures, and would exclude disproportionate share hospital payments, CHIP, and title IV-E. Territories would receive a commensurate increase.

The temporary FMAP increase would be phased-out in order to avoid a sudden drop in federal financial participation and to ensure that states that enter the recession late and are still showing increasing unemployment continue to receive support.

Medicaid Disproportionate Share (DSH) Hospital Payments

Current Law

States must pay DSH adjustments to hospitals serving a disproportionate share of Medicaid patients and patients with special needs.

For FY1998-FY2002, state-by-state DSH allotments were specified in federal statute. A number of changes to these allotments occurred after that time. Most recently, special allotments for 2004 and rates of growth for calculating DSH allotments for all states for the years immediately subsequent to 2004 were established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173). For years after 2004, if a state would have had a lower allotment by using the pre-MMA 2004 amounts, then their allotment for that year is equal to the 2004 MMA amount. Otherwise, the allotment is equal to the prior year's amount adjusted for inflation via the growth of the consumer price index for all urban consumers (CPI-U) for the previous year. State allotments are capped at 12 percent of total benefit payments for the prior year.

Recently the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) provided a temporary increase in DSH allotments. FY2009 state DSH allotments were increased by 2.5 percent above the otherwise applicable amounts. States DSH allotments for FY2010 will be equal to the FY2009 allotments, with the adjustment, increased by 2.5 percent. If states' annual DSH allotments grow at a greater rate than what they would have received without the 2.5 percent adjustment, then states will receive the higher DSH allotments without the recession adjustment. After FY2010, states' annual DSH allotments will return to 100 percent of the amounts as determined under current law.

Special rules apply to "low DSH states," comprised of states in which total DSH payments for FY2000 were less than three percent of the state's total Medicaid spending on benefits. DSH allotments for such states were raised for FY2004 through FY2008 to an amount that is 16 percent above the prior year's amount. For FY2009 forward, the allotment for low DSH states for each year will be equal to the prior year amount increased by the change in the CPI-U, as for all other states.

States cannot obtain federal matching payments for DSH that exceed the state's DSH allotment. Tennessee and Hawaii have special statutory arrangements relating to their state DSH allotments. As a condition of receiving federal Medicaid payments for FY2004 forward, states are required to submit to the Secretary of HHS a detailed annual report and an independent certified audit on their DSH payments to hospitals.

States have flexibility in establishing the designation of DSH hospitals, but must include at least all hospitals meeting either of two minimum criteria: (1) a Medicaid inpatient utilization rate in excess of one standard deviation above the mean rate for the state, or (2) a low-income patient utilization rate of 25 percent. States may not include hospitals with a Medicaid utilization rate below one percent.

States also have flexibility in calculating DSH payment amounts to hospitals, but must pay DSH hospitals at least (1) an amount calculated using the Medicare DSH payment methodology or (2) an amount calculated using a payment methodology that increases each hospital's adjustment as the hospital's Medicaid inpatient utilization rate exceeds the statewide average. DSH hospital payments cannot exceed a hospital-specific cap, set at 100 percent of the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid and uninsured patients for public hospitals (for all states except California, which is set at 175 percent of those amounts).

Proposed Option

The level of each individual state's current DSH allotment and the definition of a DSH hospital would remain as under current law. Under this proposal, state allotments would be designated as a pool for qualified hospitals within each state. Funds from this pool would be dispersed directly by the Secretary of HHS to qualifying hospitals.

In addition to Medicaid claims data already submitted by states to CMS, hospitals would submit claims data to CMS for uncompensated care. The Secretary, through regulation, must designate

specific services provided by hospitals that would be eligible for DSH payments. For those designated services, the Secretary would determine and pay the appropriate reimbursement rates for Medicaid services and uncompensated care. The payment must be made for services provided during the entire fiscal year, and would be remitted within one quarter after the end of the fiscal year.

The Secretary must report to Congress information relating to the type, variety and frequency of DSH-qualified services, and make a recommendation, based on trends in the level of services provided, for the future of state DSH allotments.

A variation on this option would be to also reallocate DSH funds amongst states.

Dual Eligibles

Under current Medicare and Medicaid rules, some elderly individuals qualify for health insurance under both programs. It was estimated that 8.8 million individuals were dually eligible in FY2005. These dually eligible individuals qualify for Medicare Part A and/or Part B (and Part D as well) and, because they are elderly and have limited income and assets, also are eligible for some type of Medicaid benefits. People qualify for Medicare when they or their spouse or in some cases a parent have worked and paid Medicare taxes, and they are either 65 and over; or are younger, but are blind or have a disability and are receiving cash assistance. People qualify for Medicaid because they have limited income and resources and meet other federal and state requirements such as age or disability.

There are two types of dual eligibles, full- and partial-benefit. In FY2005, there were approximately 7.1 million full-benefit beneficiaries (81 percent of all dual eligibles). Full-benefit duals receive Medicare and full Medicaid benefits. Medicaid fills in the gaps in Medicare coverage, pays Medicare premiums and cost sharing, covers additional services not covered by Medicare, such as long term care (LTC) services and supports, dental services, vision care, medical transportation, and until recently, outpatient prescription drugs. For partial-benefit duals, approximately 1.7 million beneficiaries (19 percent of all duals), Medicaid pays Medicare premiums, so partial-benefit duals have full Medicare coverage, but are not covered for Medicaid's other services. For dual eligibles, Medicaid is always the last payer (the payer of last resort). Thus, for benefits covered by both Medicare and Medicaid, Medicare is the primary payer, while Medicaid covers those costs in excess of Medicare coverage limits and services not covered by Medicare.

Waiver Authority for Dual Eligible Demonstrations

Current Law

States may apply to the Secretary of the Department of Health and Human Service (HHS) to waive Medicaid requirements or to use Medicaid funds to target otherwise ineligible populations, or to use innovative methods for delivering or paying for Medicaid services. Section 1115 of the Social Security Act allows for the waiver of any provision of Medicaid law for demonstrations

“likely to assist in promoting the objectives” of the program. Demonstration waivers have traditionally been granted for research purposes, like testing a program improvement (such as a new reimbursement methodology), and run for a limited period. Some demonstration waivers have been approved under both Medicaid and Medicare authorities. These Medicare and Medicaid demonstrations have mostly been statewide initiatives that have coordinated service delivery, benefit packages, and reimbursement for dual eligibles.

OMB reviews all section 1115 waivers, and since 1982 has required waivers to be budget neutral (there are no statutory requirements for determining budget neutrality). Section 1115 waivers do not have a set duration, but larger demonstrations might be extended to accommodate more start-up time and more thorough evaluation. These statewide reform projects would typically be approved for five years. In addition to demonstration waivers, Congress also has periodically instructed the Secretary of HHS to grant waivers for other initiatives.

Proposed Option

Under this proposal, Congress would establish a new Medicaid demonstration authority of five years for exploration of alternative approaches to coordinating care for dual eligibles.

Cost-Effectiveness Test

Current Law

Section 1915 of the Social Security Act (SSA) permits states to use several types of waivers. Under Medicaid law, section 1915(b), states are permitted to restrict beneficiaries’ choice of providers for obtaining covered services. States may request section 1915(b) waivers to operate programs that impact the delivery system for some or all Medicaid beneficiaries, such as:

- Mandatorily enrolling beneficiaries into managed care programs (although states have the option, through the Balanced Budget Act of 1997 to enroll certain beneficiaries into mandatory managed care via a State Plan Amendment), or
- Creating a “carveout” or selective contracting delivery system for specialty care, such as behavioral health care. Under carveouts or selective contracting, states may negotiate discounts with certain providers, such as hospitals, and then require beneficiaries to obtain covered services only from those providers (except in emergencies).

Section 1915(b), Freedom-of-Choice, waivers do not have to be operated statewide. In addition, they may not be used to expand eligibility to individuals who are not eligible under the approved Medicaid state plan. States also have the option to use savings achieved by using managed care to provide additional services to Medicaid beneficiaries not typically provided under the state plan.

In requesting a section 1915(b) waiver, states must demonstrate that their proposed program will be cost-effective, and must provide assurances that the restrictions established by the waiver will not impair beneficiaries’ access to medically necessary services of adequate quality. The maximum period for waivers is two years, but waivers may be renewed.

To implement these programs, the Secretary of HHS has authority to waive Medicaid requirements (statewide, comparability of services, and freedom of choice of provider.) There are four types of authorities under section 1915(b) that states may request:

- mandates Medicaid Enrollment into managed care;
- utilize a “central broker”;
- uses cost savings to provide additional services; and
- limits number of providers for services.

Proposed Option

Under this proposal, Medicaid 1915(b) waiver authority would be modified to permit states to use savings from coordinating care for dual eligibles between Medicare and Medicaid in their waiver applications. Because Medicare is the first payer and covers most acute care, saving achieved through coordinated care for dual eligibles would primarily be to Medicare in the form of reduced acute care utilization (fewer emergency room visits, less inpatient hospital admissions). Under current law savings to the Medicare program through better coordination of care for dual eligibles, would not count under a 1915(b) waiver application as reduced Medicaid expenditures. This proposal would allow Medicaid 1915(b) waivers to recognize Medicare savings in the 1915(b) cost effectiveness test. The changes in this proposal would give states the option of using 1915(b) waivers to increase contracting with managed care organizations, such as Medicare Advantage Special Needs Plans for dual eligibles, to help coordinate care for dual eligibles. All other 1915(b) authorities would remain unchanged.

Office of Coordination for Dually Eligible Beneficiaries

Current Law

There is no provision in current law for an Office of Coordination for Dually Eligible Beneficiaries within the Centers for Medicare and Medicaid Services (CMS).

Proposed Option

Although dual eligibles (referred to as duals) represent small percentages of Medicare and Medicaid beneficiaries, they are one of the most important beneficiary subgroups, because relative to their numbers, duals account for disproportionately large percentages of Medicare and Medicaid expenditures. In 2005, duals accounted for 46 percent of Medicaid expenditures and 25 percent of Medicare expenditures, yet they accounted for less than 20 percent of either program’s beneficiaries. The concentration of high health care utilization under both Medicare and Medicaid may present opportunities to reduce duals’ overall health care expenditures by better coordinating and integrating the two programs’ services. However, devising policy solutions to coordinate and fully integrate service delivery across Medicare and Medicaid is complex, in part because administration for each is separate, and program authority and policies differ and are sometimes contradictory.

Differing administrative authority and operations coupled with the size of Medicare and Medicaid can make it difficult to identify overlapping and sometimes conflicting policy, financing, and care delivery issues for duals, much less to implement program changes that cut across CMS. Better coordination within CMS between Medicare and Medicaid could help to integrate and improve the efficiency and clinical outcomes for dual eligibles. Although improved Medicare and Medicaid program coordination should occur at many levels, it needs to be initiated and led at CMS central office.

To ensure that coordination for duals occurs, this proposal would establish a new office within CMS, the Office of Coordination for Dually Eligible Beneficiaries (OCDEB). OCDEB would be responsible for identifying and leading agency efforts to align Medicare and Medicaid financing, administration, oversight rules, and policies for dual eligibles. OCDEB would need sufficient organizational stature to be effective, so it will be required to report directly to the CMS administrator. OCDEB also would be required to prepare annual reports which the Secretary of HHS would submit to Congress. OCDEB's annual report would document dual eligible spending with separate subtotals for Medicare and Medicaid and other health care categories, such as hospitals, physicians, home health, longer-term care services, waiver spending, and other expenditures. OCDEB also would develop outreach and training to improve coordination, propose policy changes, identify issues that might need legislative solutions, and develop strategies to ensure good outcomes for duals during care transitions, as well as develop procedures to assist "attainers" (Medicaid beneficiaries who are turning age 65) in navigating the transition from Medicaid only to Medicare and Medicaid.

Medicare Coverage

Reduce or Phase-Out the Medicare Disability Waiting Period

Current Law

Persons under the age of 65 are eligible for Medicare Part A benefits after a 24-month waiting period if they are also eligible for Social Security Disability Insurance (SSDI) benefits or other title II Social Security or Railroad Retirement benefits on the basis of disability. The 24-month Medicare disability waiting period begins when a person becomes eligible for SSDI, title II, or Railroad Retirement benefits.

There is no waiting period for persons with amyotrophic lateral sclerosis (Lou Gehrig's disease). Special waiting periods apply to persons with end stage renal disease (ESRD). A person with ESRD is eligible for Medicare beginning with the fourth month after the beginning of dialysis treatment or in the month of a kidney transplant.

While study results differ, it is estimated that between one-third and one-fifth of individuals in the waiting period do not have health insurance. Some may have health insurance through their spouse, a retiree plan, or continued coverage offered under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or other sources.

Proposed Options

There are four options for change in the Medicare disability waiting period.

Approach 1 would reduce the 24-month waiting period to 12 months beginning in October 2009. A waiting period would continue to exist.

Approach 2 would reduce the 24-month waiting period by one month every quarter beginning in October 2009 until the waiting period reaches zero months in July 2015.

Approach 3 would phase-out the waiting period based on the date of the individual's disability. It would phase-out the waiting period using the following schedule:

- maintain a waiting period of 24 months for persons disabled before October 1, 2009;
- reduce the waiting period to 18 months for persons disabled between October 1, 2009 and March 31, 2010;
- reduce the waiting period to 12 months for persons disabled between April 1, 2010 and September 30, 2010;
- reduce the waiting period to six months for persons disabled between October 1, 2010 and March 31, 2011; and
- eliminate the waiting period for persons disabled after April 1, 2011.

Approach 4 would retain the 24-month waiting period for persons with access to private health insurance coverage, not including COBRA, which meets or exceeds a specified actuarial standard. For others, the waiting period would be phased-out, according to one of the schedules described above.

Temporary Medicare Buy-In

Current Law

Like other adults, people between the ages of 55 and 64 who do not have employment-based or public health insurance coverage must rely on the individual market for private insurance. In the individual market, many people who have health problems are denied coverage or are offered policies that exclude coverage for preexisting conditions. Because older people are sicker, people ages 55 to 64 tend to have greater difficulty obtaining insurance in the individual market than their younger counterparts do. Additionally, many private employers face high legacy costs associated with providing health insurance to early retirees. However, these companies are forced to continue to provide retiree coverage as the non-group market is not a viable option.

There is no provision in current law for a Medicare buy-in or other type of public coverage for the near elderly.

Proposed Options

Approach 1: People ages 55 through 64 who do not have employer-sponsored insurance (ESI) or Medicaid coverage could voluntarily enroll in Medicare beginning January 1, 2011. After the initial enrollment period, enrollment would also be allowed for people of those ages who lose ESI and people who turn 55. The option would end once the Health Insurance Exchange is up and running, though people already enrolled could stay in Medicare.

Enrollees would pay a premium equal to the expected average cost of benefits for Medicare participants plus an administrative fee of five percent. If the actual costs incurred by Medicare exceed the premiums collected for a particular cohort of enrollees, individuals in that cohort would be required to pay an additional premium once they reach normal Medicare eligibility age and to continue doing so until they turn 85. Conversely, if the actual costs plus administrative fees were less than the premiums collected for a particular cohort, individuals in that cohort would receive a rebate on their Medicare premiums once they reach normal eligibility age.

Approach 2: The committee is seeking input from members on alternative ways to meet the needs of the near-elderly before insurance market reforms take effect.

SECTION V: Shared Responsibility

Personal Responsibility Coverage Requirement

Current Law

Federal law does not require individuals to have health insurance. Only Massachusetts, through its statewide program requires that individuals have health insurance. All adult residents of Massachusetts are required to have health insurance that meets “minimum creditable coverage” standards if it is deemed “affordable” at their income level under a schedule set by the board of the Massachusetts Connector. Individuals report their insurance status on state income tax forms. Individuals can file hardship exemptions from the requirement. Persons for whom there are no affordable insurance options available are not subject to the requirement for insurance coverage.

Beginning with tax year 2007, those without insurance and who are not exempt from the requirement lose their state income tax personal exemption. Beginning with tax year 2008, an additional penalty is levied for each month an individual is without insurance, equal to 50 percent of the lowest premium for which he or she would have qualified, to be collected through withholding of state income tax refunds. If no refund is due or the penalty exceeds the refund amount, the state notifies the taxpayer and may use existing state income tax enforcement and collection procedures to obtain the balance owed.

Proposed Options

Open Enrollment Periods in the New Market. All individuals would have a personal responsibility requirement to obtain health insurance coverage. The initial open enrollment

period for eligible individuals in the non-group market would last approximately three months. Special enrollment periods would be allowed for qualifying events, consistent with the special enrollment rights set forth under 9801 of the Internal Revenue Code, such as when an individual becomes a dependent through marriage or birth, or when an individual loses other health insurance coverage. There may be additional special enrollment periods allowed, consistent with those allowed under Medicare Part D (for example, special enrollment periods may be allowed for exceptional circumstances as determined by the Secretary of Health and Human Services). There would also be an annual open enrollment period when individuals could change plans. If an individual takes no action, they will maintain coverage in their current plan.

Another possible option is that during an initial 45-day open enrollment period, all coverage would be guaranteed issue, with no limits on pre-existing conditions. For those who did not enroll during their initial enrollment opportunity, carriers could exclude pre-existing conditions for up to 9 months and charge higher premiums.

Current enrollees could only change plans each year except for special changes allowed for job loss, divorce and other similar instances allowed under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272). A subsequent open enrollment period could also be provided, (presumably in addition to the initial open enrollment period) with guaranteed issue and no limitation on pre-existing conditions. Failure to enroll during the subsequent enrollment period could also result in up to 9-month pre-existing exclusions and increased premiums.

Coverage and Enforcement. All individuals would be required to purchase coverage through (1) the individual market, meeting requirements of at least a lowest cost option, (2) any grandfathered plan, or (3) in the group market, a plan that has an actuarial value equal to the lowest coverage option, with no annual or lifetime limits allowed. Exemptions from the coverage requirement would be allowed for religious objections that are consistent with those allowed under Medicare, and for undocumented aliens.

Consequences of Non-Coverage. In order to ensure compliance, taxpayers would be required to report the months for which they have the required minimum coverage for themselves and family members on their federal income tax returns. In addition, the insurer would be required to report months of qualified health coverage to the individual covered and to the Internal Revenue Service. A similar reporting requirement would apply to employers with respect to individuals enrolled in group health plans if the reporting is not provided by the insurer (for example in the case of self-insured plans).

The consequence for not being insured would be an excise tax equal to a percentage of the premium for the lowest cost option available through the Health Insurance Exchange for the area where the individual resides. The excise tax would be phased-in and would equal 25 percent of the premium for the first year that the requirement is in effect; 50 percent of the premium for the second year; and 75 percent of the premium for the third year and subsequent years. The penalty would apply for any period for which the individual is not covered by a health insurance plan with the minimum required benefit but would be prorated for partial years of noncompliance.

Individuals could apply for an exemption from the penalty in three circumstances: (1) where the lowest cost option available to an individual exceeds 10 percent of income; (2) where an individual is below 100 percent of poverty; and (3) hardship.

Effective Date. The individual requirement would be effective beginning January 1, 2013 (or sooner if possible).

Employer Requirement

Current Law

Currently, there is no federal requirement that employers offer health insurance coverage to employees or their families. However, as with other compensation, the cost of employer provided health coverage is a deductible business expense under section 162 of the Internal Revenue Code. In addition, employer-provided health insurance coverage is generally not included in an employee's gross income.

The Employee Retirement Income Security Act of 1974 ("ERISA") preempts State law relating to certain employee benefit plans, including employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law.

While ERISA does not require an employer to offer health benefits, it does require compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the Public Health Service Act and the Internal Revenue Code) in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), adding other federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

The Code imposes an excise tax on group health plans that fail to meet HIPAA and COBRA requirements. The excise tax generally is equal to \$100 per day per failure during the period of noncompliance and is imposed on the employer sponsoring the plan if the plan fails to meet the requirements.

Under Medicaid, states may establish "premium assistance" programs, which pay a Medicaid beneficiary's share of premiums for employer-sponsored health coverage. Besides being available to the beneficiary through his/her employer, the coverage must be comprehensive and

cost-effective for the state. An individual's enrollment in an employer plan is considered cost-effective if paying the premiums, deductibles, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the states' expected cost of directly providing Medicaid-covered services. States are also required to provide coverage for those Medicaid-covered services that are not included in the private plans. A 2007 analysis showed that 12 states had Medicaid premium assistance programs as authorized under current law.

Proposed Option A

Pay or Play. All employers with more than \$500,000 in total payroll for a taxable year will either offer their full-time (defined as 30 hours or more) employees health insurance coverage or pay an assessment. The coverage offered will have an actuarial value equal to the lowest coverage option and which also includes first dollar coverage for prevention services recommended by the U.S. Preventive Services Task Force. The employer will be required to contribute at least 50 percent of the premium for the employer-sponsored health insurance.

If an employee is offered coverage by their employer and takes it (either outside of the Health Insurance Exchange or with an employer who is offering coverage options to their workers through the Health Insurance Exchange), the worker will receive the tax exclusion for employer-provided health insurance (i.e., the employer's contribution is not treated as income) but they cannot receive the income-based tax credit. If an employee opts out of employer coverage (either by refusing a non-exchange plan offered by the employer or, if their employer is offering coverage through the Health Insurance Exchange, by refusing that option), the employee is potentially eligible for the income-based tax credit.

The worker pays into the Health Insurance Exchange in the same way as any other person seeking coverage in the Health Insurance Exchange, and is subsidized in the same way. The employer's normal contribution for a worker is then contributed to the Health Insurance Exchange to help finance tax credits in aggregate (it does not affect what the worker pays). Since the employer payment does not directly relate to the opting out worker's situation, the payment should not be treated as taxable income to the worker.

Employers that do not demonstrate that they have offered the required level of coverage to their employees would have to pay an assessment. The assessment would be an excise tax calculated as an amount per employee per month based on the employer's gross receipts for the taxable year.

For employers with total annual payroll between \$500,000 and \$1,000,000, the excise tax would be \$100 per employee per month. For employers with total annual payroll between \$1,000,000 and \$1,500,000, the excise would be \$250 per employee per month. For employers with total annual payroll greater than \$1,500,000, the excise tax would be \$500 per employee per month. Another option would be to require these employers to pay a tiered penalty based on total annual payroll, equal to: 2 percent of payroll between \$500,000 and \$1,000,000, 4 percent of payroll between \$1,000,000 and \$1,500,000, and 6 percent of payroll over \$1,500,000. A final option might be to require a larger penalty only on firms with total annual payroll of \$1,500,000 or more. Penalty amounts for each of these options would be indexed by Medical CPI.

Medicaid Interaction. States would be required to offer current-law Medicaid premium assistance to individuals eligible for Medicaid who are offered employer-sponsored coverage.

Proposed Option B

Requirements. Option B would not require employers to pay or play, but would still have a coverage requirement for individuals.

Medicaid Interaction. Option B would offer an alternative way to structure the Medicaid interaction. Medicaid eligible individuals offered employer-sponsored insurance could enroll in an individual policy using the premium and cost-sharing assistance provided through Medicaid and the general low-income tax credits offered under this legislation.

SECTION VI: Options to Improve Access to Preventive Services and Encourage Health Lifestyles

Promotion of Prevention and Wellness in Medicare

Personalized Prevention Plan and Routine Wellness Visit

Current Law

Under current law, Medicare covers a one-time initial preventive physical examination (IPPE) and certain preventive services enumerated in law. The goal of the “Welcome to Medicare” visit is “health promotion and disease detection and includes education, counseling, and referral with respect to [covered] screening and other preventive services....” The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) waived the deductible for the IPPE and extended eligibility for the visit from six months to within one year of Medicare Part B enrollment.

Proposed Option

This option would authorize a personalized prevention plan for all enrolled beneficiaries once every five years unless deemed inappropriate. Beneficiaries would first receive a comprehensive health risk assessment including at least a complete medical and family history, age-, gender, and risk appropriate measurements (including height, weight, body mass index, and blood pressure if not already part of the patient’s record). The assessment would also identify chronic diseases, modifiable risk factors, and emergency or urgent health needs. The assessment could be provided through an interactive telephonic or web-based program or during an encounter with a health professional as determined by the Secretary. The Secretary would design the assessment, in consultation with relevant groups and entities, as well as set standards for the electronic tools that could be used to deliver the assessment. No co-payment or deductible would apply.

Within six months of completing the comprehensive health risk assessment (HRA), the option would authorize Medicare payment for a visit to a qualified health professional to create a personalized prevention plan. The plan would include the following elements: review and update medical and family history; measure the patient's blood pressure, body mass index and any other measurements identified above not included the HRA; provide a schedule and referral for recommended, appropriate, covered preventive services and immunizations; provide a strategy to address identified conditions and risk factors; identify all medications currently prescribed and all providers regularly involved in the patient's care; and offer health advice and referral to Medicare-covered health education and preventive counseling or referral to community based interventions to address modifiable risk factors such as weight, physical activity, smoking, and nutrition. Optional elements, if appropriate, include referrals for diagnostic testing, or referrals to review treatment options for beneficiaries with chronic conditions; end of life care planning, and administration of appropriate Medicare covered immunizations and screening tests. No co-payment or deductible applies.

Incentives to Utilize Preventive Services and Engage in Healthy Behaviors

Current Law

All currently covered Medicare preventive services and any applicable cost-sharing requirements, as well as the reduction or elimination of such requirements, are established in statute. Co-payments, deductibles, or both have been reduced or eliminated for many of the clinical preventive services, including pneumococcal and influenza vaccines; cardiovascular disease screening, and diabetes screening tests among others. The Secretary does not have authority to modify cost-sharing requirements for preventive services. Evidence indicates that cost-sharing reduces Medicare beneficiaries' utilization of preventive services. For example, Medicare beneficiaries with supplemental insurance were substantially more likely to have had a mammogram screening than women without supplemental insurance. In addition, a National Bureau of Economic Research Working Paper concluded the elderly are "very price sensitive", finding that a \$10 co-payment increase led to an almost 20 percent decline in physician office visits.

In the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), Congress authorized the Secretary to add coverage for additional preventive services if, they were reasonable and necessary to prevent or detect an illness or disability early, appropriate for the individual entitled to benefits under Part A or enrolled under Part B and recommended by the United States Preventive Services Task Force (rated "A" or "B"). The U.S. Preventive Services Task Force (USPSTF), administered by the Agency for Healthcare Research and Quality (AHRQ), is an independent panel of private-sector experts in primary care and prevention which conducts rigorous, impartial assessments of scientific evidence for the effectiveness of a broad range of clinical preventive services, including, screening, counseling, and preventive medications. At this time no new services have been covered pursuant to this authority.

Proposed Option

This option would remove or limit beneficiary cost-sharing (co-payment, deductible or both) for preventive services covered under Medicare and rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF). The option would also encourage the Secretary to establish a mechanism to provide refunds or other incentives to Medicare beneficiaries who successfully complete certain behavior modification programs, such as smoking cessation or weight loss. Such programs must be comprehensive, evidence-based as determined by the Secretary, widely available and easily accessible. Finally, the option would explore ways to improve provider education and patient awareness of covered preventive services.

Coverage of Evidence-Based Preventive Services

Current Law

All currently covered Medicare preventive services were established in statute. In the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), Congress authorized the Secretary to add coverage for additional preventive services if, they were reasonable and necessary to prevent or detect an illness or disability early, appropriate for the individual entitled to benefits under Part A or enrolled under Part B and recommended by the United States Preventive Services Task Force (rated “A” or “B”).

Generally, all beneficiaries age 65 and older are entitled to covered clinical preventive services, regardless of age. In contrast, the United States Preventive Services Task Force (USPSTF) provides recommendations based on the scientific evidence for certain services based on age, gender and risk factors for disease. Consequently, recommendations may change across the age groups or based on gender within older populations. For example, the USPSTF recommends a one-time screening for an abdominal aortic aneurysm (AAA) by ultrasound for men, who have never smoked, until age 75. However, USPSTF recommends against a routine AAA screening for women. It rates this service “D” for women, meaning the evidence provided no net benefit or that the harm outweighed the benefit.

Proposed Option

This option would give the Secretary authority to withdraw Medicare coverage for preventive services that are rated “D” by the United States Preventive Task Force unless deemed medically necessary by a prescribing physician.

Promotion of Prevention and Wellness in Medicaid

Access to Preventive Services for Eligible Adults

Current Law

States are required, under Medicaid, to cover a package of “well-child” and preventive service benefits for the majority of eligible children under the age of 21, called the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. For eligible adults, states are required to cover family planning services and supplies, and certain pregnancy-associated services, including prenatal and postpartum care. Otherwise, state coverage of screening and preventive services for eligible adults is optional. Such services are defined in section 1905(a)(13) as “other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;....”

Proposed Option

The option would clarify the definition of “screening and preventive” services in Medicaid for adults as including services rated “A” or “B” by the United States Preventives Services Task Force (described in an earlier section) and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). This whole category of services is covered at the states’ option. If a state opts to provide Medicaid coverage for all approved preventive services and immunizations, the state would receive a 1% increase in the federal share of its Federal Medical Assistance Percentage (FMAP) for those services. At a minimum, states would be required to provide Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost-sharing for such services.

Incentives to Utilize Preventive Services and Encourage Healthy Behaviors

Current Law

Under traditional Medicaid, states may impose on beneficiaries certain costs, such as enrollment fees, premiums, deductions, and cost-sharing. Under specified conditions, states may be prohibited from imposing such costs for services provided to children, or to eligible adults who are in a hospital or other institutional facility, or who are receiving emergency services, family planning services, or hospice care. States are also prohibited from imposing deductions, cost-sharing, or other charges for Medicaid covered pregnancy-related services provided to pregnant women.

Proposed Option

The option would remove or limit cost-sharing for clinical preventive services rated “A” or “B” by the USPSTF. The option would permit states to design a proposal and apply for funds to

explore mechanism(s) to provide refunds or other incentives to Medicaid enrollees who successfully complete certain behavior modification programs, such as smoking cessation and weight loss. Such programs must be comprehensive and evidence-based, as determined by the Secretary, covered under the Medicaid program, as well as, widely available and easily accessible. The state’s application must include plans for educating providers and making patients aware of covered preventive services. Funding available will be capped.

Options to Prevent Chronic Disease and Encourage Healthy Lifestyles

“RightChoices” Grants

Current Law

No provision.

Proposed Option

The option contemplates annual, capped grants to states for three or five years – or until insurance options are available through the Health Insurance Exchange – whichever is sooner. These grants would provide access to certain evidence-based primary preventive services such as tobacco use screening, influenza immunization, counseling on daily aspirin use, hypertension screening, or obesity screening for uninsured adults and children.

Prevention and Wellness Innovation Grants

Current Law

None

Proposed Option

This option would establish a competitive grant program to promote health and human services program integration, improve care coordination and access to preventive services and treatments, and better integrate the delivery of health care services to improve health and wellness outcomes. The option identifies three approaches states may choose to implement while allowing flexibility to encourage innovation.

Additionally, the option would require the Department of Health and Human Services (HHS) to review and make improvements in the administration of its low income programs.

Promotion of Team-Based Care. States would submit an application to the Secretary to create locally integrated delivery systems including establishing multidisciplinary care teams.

Multidisciplinary community health teams would be required to provide: 1) comprehensive care management and patient and family support in conjunction with primary care providers; 2) care

coordination and health promotion activities including access to the range of services needed to maintain and improve health, such as behavioral services and nutritional counseling; and coordination with local public health offices; 3) social and economic support to facilitate patient and family assistance with social support services and referral to and coordination with community based programs; and 4) comprehensive transitional care from inpatient to institutional care settings or care provided in community-settings as well as assuring appropriate follow up.

Providing Individualized Plans. This option would allow states to implement service integration and delivery reform activities, including developing an individualized plan for health and human service needs of low-income beneficiaries.

Other Innovative Approaches. States would be allowed to submit a proposal that meets the goals and objectives of this grant. These proposals must include an evaluation component that assesses the impact of the proposed innovation on the health status of participating individuals.

Upon completion of the grants, the Department of Health and Human Services (HHS) would conduct a study of best practices to improve wellness outcomes for low-income families. Following the study, HHS would issue best practices for states on how to establish a well integrated model of care for health maintenance, reducing chronic disease, promoting patient care, and facilitating coordination between health and human service systems. Within two years after HHS issues recommended best practices, states would be required to submit a plan to better integrate services for low-income families, including a description of what programs already provide for individualized plans, and ways to facilitate integration of health and human services.

Employer Wellness Credits

Current law

The expense of an employer-provided wellness program for employees is deductible by the employer as a business expense under section 162.

Proposed Option

Under the option, a tax credit would be allowed for 50 percent of the costs paid by an employer for providing a “qualified wellness program” during a taxable year. The amount of the credit would be limited to an amount not exceeding \$200 for each employee not exceeding 200 employees, plus \$100 for each additional employee in excess of 200 employees. Only employees generally working more than 25 hours per week are taken into account. For purposes of this credit, any amount paid for food or health insurance could not be included as a cost of the wellness program. The credit would not be refundable and would not be paid in advance and would be available for a maximum of five years.

To claim the tax credit for eligible expenditures, an employer would be required to obtain a certification by the Secretary of HHS (in coordination with the Director of the CDC and the Secretary of the Treasury) that its program meets the definition of a qualified wellness program.

In order for a program to be a qualified wellness program under the proposal, all employees would be required to be eligible to participate in the program. Further, under the proposal, a qualified wellness program includes four components: health awareness (such as health education, preventive screenings and health risk assessment); employee engagement (such as mechanisms to encourage employee participation); behavioral change (elements proven to help alter unhealthy lifestyles such as counseling, seminars, on-line programs, self help materials); and a supportive environment (such as creating on-site polices encourage healthy lifestyles, eating, physical activity and mental health). For an employer with 500 or more employees, to be a qualified wellness program, a program would be required to include all four components. For an employer with less than 500 employees, to be qualified wellness program, a program would only required to include at least three of the four components.

In addition, to be a qualified wellness program under the proposal, the program would be required to be consistent with evidence-based research and best practices, as determine by the Secretary, such as research and practices described in the Guide to Community Preventive Services and Guide to Clinical Preventive Services and the National Registry for Effective Programs.

Finally, another option would apply all of the criteria described above as well as provide employers with 50 or fewer employees with a credit limited to \$400 per employee. The credit would not have a sunset requirement for those employers.

SECTION VII: Long Term Care Services and Supports

Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid HCBS State Plan Option

Current Law

Medicaid HCBS Waiver. Section 1915(c) authority under the Social Security Act gives states the option to extend a broad range of home and community based services (HCBS) to selected populations of individuals with level-of-care needs that would otherwise be offered in Medicaid-covered institutions, such as a nursing home, intermediate care facility for the mentally retarded (ICF/MR), or a hospital. Services that states may choose to offer under the section 1915(c) waiver include case management, homemaker/home health aide, personal care, adult day health, habilitation, respite care, rehabilitation, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not they are furnished in a facility) for individuals with chronic mental illness. States have flexibility to offer additional services if approved by the Secretary of HHS. Section 1915(c) waivers may not cover room and board.

Waivers have been used to cover persons aged 65 or older, individuals with mental retardation and developmental disabilities, persons under age 65 with physical and other disabilities, persons with HIV/AIDS, persons who are medically fragile or technologically dependent, and persons with mental illness. Individuals generally enroll in one HCBS waiver at a time. Average per capita expenditures for waiver participants may not exceed average per capita expenditures that states would have spent for these beneficiaries in institutions, including the costs of other state plan services for which beneficiaries may be eligible (*e.g.*, hospital services).

Medicaid HCBS State Plan Option. Under the Deficit Reduction Act of 2005 (DRA; P.L. 109-171), Congress gave states the option to extend HCBS to Medicaid beneficiaries under the HCBS State Plan Option (section 1915(i) of the Social Security Act) without requiring a section 1915(c) or section 1115 waiver. The section 1915(i) option allows states to select one or more services from the list of section 1915(c) services available, but does not give states the authority to seek approval from the Secretary to offer additional services. Also under 1915(i), states may amend their Medicaid plans without demonstrating budget neutrality as they do under 1915(c) waivers.

Proposed Option

The proposal would allow states to seek approval from the Secretary to offer additional services under section 1915(i), the Medicaid HCBS State Plan Option. It would also allow individuals to simultaneously enroll in more than one Medicaid waiver.

Eligibility for HCBS Services

Current Law

Medicaid HCBS Waiver. As mentioned above, to be eligible for section 1915(c) HCBS waivers, persons must require the level-of-care, as defined by a state's assessment, that would otherwise be offered in a Medicaid-covered nursing facility, intermediate care facility for the mentally retarded (ICF/MR), or a hospital. In addition, eligible persons must be among the waiver's targeted population groups (*e.g.*, persons aged 65 and over or persons with mental retardation, among others) and meet the state's financial standards for that waiver (established within federal parameters).

Persons who are already enrolled in Medicaid and who meet a state's eligibility criteria for a specific waiver may enroll if a slot is available. States may also use the optional eligibility pathway, known as the special income rule or "300 percent rule," to extend section 1915(c) waiver services and other Medicaid benefits to certain individuals with higher income. Thus, section 1915(c) may confer eligibility for persons whose income falls within the standards of the special income rule. Under the special income rule, such persons may have income up to a specified level established by the state, but no greater than 300 percent of the maximum Supplemental Security Income (SSI) payment applicable to a person living at home. A number of states also allow persons to place income in excess of the special income level in a trust, often referred to as a Miller Trust, and still qualify for Medicaid through the special income rule. Following the individual's death, the state becomes the beneficiary of amounts in this trust.

Medicaid HCBS State Plan Option. States that choose to implement the section 1915(i) HCBS state plan option must establish needs-based eligibility rules for services that are less stringent than the section 1915(c) waiver's institutional level-of-care criteria. The criteria established by the state requires an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform two or more activities of daily living (*i.e.*, eating, toileting, transferring, bathing, dressing and continence) or the need for significant assistance to perform such activities, and such other risk factors as the state determines to be appropriate.

Eligibility for services may be extended only to individuals already enrolled in Medicaid and whose income does not exceed 150 percent of the federal poverty level (FPL). Section 1915(i) does not confer eligibility for Medicaid for any populations.

Proposed Option

This proposal would eliminate the existing institutional level-of-care requirement for eligibility for section 1915(c) waivers and require states to replace it with less stringent criteria.

The proposal would also eliminate the prohibition against providing section 1915(i) services to persons with income above 150 percent FPL. In addition, states would have the option to confer eligibility for section 1915(i) HCBS services as well as full Medicaid benefits to individuals with income up to a specified level established by the state, but no greater than 300 percent of the maximum SSI payment, as long as these individuals would also meet the state-defined needs-based criteria. Persons with Miller Trusts would be able to qualify for section 1915(i) and other Medicaid benefits through the special income rule eligibility pathway.

Increase Access to Medicaid HCBS

Current Law

Both sections 1915(c) and 1915(i) allow states to cap enrollment to contain spending. Specifically, section 1915(c) allows states to place an enrollment cap on each of the state's HCBS waivers.

Under section 1915(i), states may limit participation to a projected number of enrollees. If enrollment exceeds state projections, states may modify their needs-based criteria without having to obtain prior approval from the Secretary if: (1) the state provides at least 60 days notice to the Secretary and the public of the proposed modification; (2) the state deems an individual receiving HCBS, on the basis of the most recent version of the criteria in effect prior to the effective date of the change, to be eligible for such services for at least 12 months beginning on the date the individual first received medical assistance for such services; and (3) after the effective date of the change, the state, at a minimum, does not make the criteria more stringent than the criteria used to determine whether an individual requires the level-of-care provided in a hospital, nursing facility, or an intermediate care facility for the mentally retarded. States may

use waiting lists to track those persons who would obtain services but for the cap. Waiting lists may also be used to limit the number of beneficiaries who access HCBS under the cap.

Proposed Options

Approach 1: This proposal would increase the number of persons under the cap that states would be required to enroll in either or both of these authorities.

Approach 2: This proposal would prohibit states from using waiting lists to prevent eligible beneficiaries from accessing HCBS.

Approach 3: The committee is seeking input from members on alternative ways to ensure that eligible beneficiaries are able to access HCBS.

Increase Federal Match for Medicaid HCBS

Current Law

The federal medical assistance percentage (FMAP) refers to the federal government's share of a state's expenditures for most Medicaid services, including the range of HCBS offered by states under waivers and the Medicaid state plan. The FMAP is determined annually and designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes). For FY2009, FMAPs range from 50.00 percent to 75.84 percent. In addition, the 111th Congress enacted a temporary FMAP increase for states in the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5).

Proposed Option

The proposal would increase the federal match for Medicaid HCBS by one percent.

Medicaid Spousal Impoverishment Rules

Current Law

Medicaid law includes spousal impoverishment provisions intended to prevent the impoverishment of a spouse whose husband or wife seeks Medicaid coverage for Long Term Care (LTC) services. The law requires that spousal impoverishment rules for eligibility and post-eligibility treatment of income be applied to non-institutionalized spouses (*i.e.*, community spouses) of persons residing in a medical institution or nursing facility for at least 30 consecutive days. It grants states the option to apply these rules to certain groups of individuals receiving HCBS waiver services under sections 1915(c), (d), and (e) of Medicaid law.

Although Medicaid law grants states the option to apply spousal impoverishment rules to the counting of income and assets for a couple during the eligibility determination for persons applying to section 1915(c) and (d) waivers, it does not allow states to apply these rules to the

eligibility determination for 1915(e) waivers. In addition, Medicaid law prohibits the application of spousal impoverishment rules for the post-eligibility treatment of income for purposes of 1915(c), (d), and (e) waivers for those who qualify for Medicaid through a state's medically needy eligibility pathway. The Secretary of HHS may grant authority for states to apply spousal impoverishment rules for eligibility and post-eligibility determination of income under section 1115 waivers which are sometimes used to offer HCBS instead of section 1915(c) waivers.

Proposed Option

The proposal would amend Medicaid law to require states to apply spousal impoverishment rules to applicants who would receive HCBS under sections 1915(c), (d), (e), (i), and (k), as well as under section 1115 of the Social Security Act. It would also apply to persons applying for HCBS through the medically needy eligibility pathway.

Medicaid Resources / Asset Test

Current Law

Within federal guidelines, states set asset (or resources) standards specifying the maximum amount of countable assets a person may have to qualify for Medicaid, including application for nursing facility services and Medicaid's section 1915(c) waivers. For the treatment of most types of assets, states generally follow SSI's program rules. Under SSI (and thus often under the Medicaid program), countable assets, such as funds in a savings account, stocks, or other equities, cannot exceed \$2,000 for an individual and \$3,000 for a couple. Most states use the more liberal standards for computing resources under section 1902(r)(2) of the Social Security Act to disregard certain types or amounts of assets, thereby extending Medicaid to individuals with higher levels of assets. Asset standards are often the same for all populations of aged and disabled groups applying to Medicaid.

States also check for asset transfers as part of the Medicaid asset test. The asset transfer test has two parts: (1) the transfer look-back and (2) the financial penalty. That is, financial penalties are imposed on people found to have made unauthorized asset transfers in the look-back period. The penalty is calculated by determining how much nursing home time the beneficiary could have paid for had the transfer not occurred. Once this calculation is done, the resulting number of months is then precluded from Medicaid coverage.

The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) increased the asset transfer look-back from 36 months to 60 months. The DRA also changed when the financial penalty can be imposed. Prior to the DRA, the penalty was triggered by the act of transfer, meaning that the number of months precluded from Medicaid coverage began with the month of transfer. The DRA changed the trigger to be the time of application for Medicaid.

Proposed Option

The proposal would allow states to treat those applying to Medicaid for HCBS differently by allowing them to retain higher levels of assets. For example, states could exclude from countable

assets up to six months of the average monthly cost to a private patient of nursing facility services in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. States would retain the authority to use section 1902(r)(2) to disregard additional assets for this population. The proposal would also reset the look-back period for asset transfers to 36 months. The time of imposition of the penalty would remain unchanged.

Long Term Care Grants Program

Current Law

There are a number of programs aimed at providing home and community based long term care services, many of which have been funded in part through grants.

Real Choice Systems Change Grant Initiative. In 2000, Congress enacted legislation that included appropriations for discretionary funding for the Real Choice Systems Change grant program under the Consolidated Appropriations Act, 2001 (P.L.106-554) authorized under section 1110 of the Social Security Act. These grants, awarded annually, are intended to help states expand community based LTC options. Since FY2001, CMS has awarded 338 grants totaling \$302.2 million to all 50 states, the District of Columbia, and two territories.

Aging and Disability Resource Centers (ADRC). A collaborative effort of the AoA and CMS, the ADRC initiative provides grants to support states' efforts to streamline information and access to LTC services through funding from CMS Real Choice Systems Change grants and AoA title IV research and demonstration authority. The OAA Amendments of 2006 (P.L. 109-365) allow for continued expansion by authorizing funds for ADRCs in all states. As of October 2008, approximately 175 ADRC pilot sites were operating in 42 states, the District of Columbia, and two territories. From FY2003 through FY2007, the AoA and CMS have awarded over \$42 million in discretionary grants to states.

Informal Caregivers. The National Family Caregiver Support Program (NFCSP) in title III, Part E of the Older Americans Act (OAA), provides direct support to informal caregivers primarily caring for the elderly through information and referral assistance, respite care, and training and support. FY2009 discretionary funding for the NFCSP is \$154.2 million. Under title XX of the Social Security Act (the Social Services Block Grant program) states have broad discretion to provide assistance to caregivers, primarily in the form of information and referral and respite care. Additional support to caregivers is authorized under the Lifespan Respite Care Act (P.L. 109-442), which provides respite care to informal caregivers caring for individuals of all ages. Finally, the Omnibus Appropriations Act of 2009 (P.L. 111-8) appropriates \$2.5 million in discretionary funding under the HHS Office of the Secretary for these activities (compared to \$0 in FY2007 and FY2008).

Prevention and Health Promotion. Prior to the 2006 reauthorization of the OAA, the Administration on Aging (AoA) provided grants to states and local communities to support the delivery of evidence-based disease prevention programs through community based aging service provider organizations (*e.g.*, senior centers, senior housing projects, faith-based organizations).

Since FY2003, AoA has funded discretionary grants totaling \$50 million to 27 states and local communities. Grantees are required to use interventions in one or more of the following subject areas: physical activity, fall prevention, nutrition and diet, and depression and/or substance abuse. The OAA Amendments of 2006 (P.L. 109-365) required the Assistant Secretary to establish criteria for and promote the implementation of these programs.

Green House Model. The Green House Model provides long term, skilled nursing care for frail elderly in a small group home for up to ten persons. Green Houses are designed to look like private homes with common living, dining and kitchen areas, a private room and bath for each resident, and an outside fenced yard and patio. Green Houses have direct care workers that are “universal workers” with core training as a Certified Nursing Assistants (CNAs). In addition to personal care, staffs perform a variety of tasks such as meal preparation, laundry, and housekeeping. There are currently 50 Green House homes operating in 17 long term care settings in 12 states. No federal funding has been used to support this model.

Proposed Option

The proposal would make grants available for the Secretary of HHS to award to eligible states. This additional discretionary funding could facilitate the delivery of HCBS by: (1) creating a Consumer Task Force to assist in the development of real choice systems change initiatives; (2) providing support for informal caregivers; (3) expanding prevention and health promotion education activities; (4) expanding the Green House Model; (5) implementing approved section 1915(i) Medicaid HCBS State Plan Option amendments; and (6) any other activity the Secretary approves to facilitate the use of HCBS. The proposal would also continue funding ADRCs.

Functional Assessment Tool for Post-Acute LTC

Current Law

As a guide to payment policy reform in the Medicare program, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) directed the Centers for Medicare and Medicaid Services (CMS) to develop a Continuity Assessment Record and Evaluation (CARE) tool to measure the health and functional status of Medicare acute care discharges and changes in severity and other outcomes for post acute care (PAC) Medicare patients. For the purposes of this tool, PAC providers include Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). This work is being conducted under contract by the Secretary of HHS with RTI International. According to RTI, the tool is expected to measure case mix severity differences in the discharge status of Medicare beneficiaries from acute care settings and take into account medical, functional, cognitive impairments, and social/environmental factors of beneficiaries.

Proposed Option

Based on consultation with CMS, the proposal would provide a timeframe for CMS to implement this assessment tool.

Money Follows the Person Rebalancing Demonstration

Current Law

Section 6071 of the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) established the Money Follows the Person Rebalancing Demonstration which authorizes the Secretary of Health and Human Services to award grants to states designed to increase the use of home and community based, rather than institutional long term care services; eliminate barriers that prevent or restrict the flexible use of Medicaid funds to enable Medicaid- eligible individuals to receive support for appropriate and necessary long term services in the setting of their choice; increase the ability of the state Medicaid program to assure continued provisions of home and community based long term care services to eligible individuals who choose to transition from an institutional to a community setting and ensure that procedures are in place to provide quality community based long term care services and to provide for continuous quality improvement in such services.

Funding is available through September 30, 2011.

Proposed Option

Extend the Money Follows the Person Rebalancing Demonstration through September 30, 2016.

SECTION VIII: Options to Address Health Disparities

Required Collection of Data

Current Law

The Medicare enrollment database (EDB) is the primary source for racial and ethnic data on Medicare beneficiaries. The EDB obtains this information from the Social Security Administration's (SSA) SS-5-FS form (commonly known as the "SS-5"), which is used to apply for a Social Security number. SS-5 data is transferred to CMS when a person enrolls in Medicare. The SS-5 form currently includes five racial categories: non-Hispanic white; non-Hispanic black; Hispanic; Asian, Asian-American or Pacific Islander. Primary language is not reported on the SS-5, though country of origin is reported. Several problems with the SS-5 exist: (1) before 1980 respondents were listed as either "White, Black, other, or unknown;" (2) the current five-item race/ethnicity question on the SS-5 is voluntary, or optional; and (3) a person other than a parent often fills out the SS-5 for a newborn, which may lead to misidentification of race or ethnicity or may increase the likelihood that the question goes unanswered.

The American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) included \$500 million to replace the SSA's National Computer Center and to cover the information technology costs associated with the new center. The current SSA National Computer Center is outdated and uses a programming system that makes upgrades and even the training of new information technology staff difficult. The SSA computer system also lacks the ability to properly interface with the Internet, other government systems, or health information technology networks.

Proposed Option

The proposal would require SSA to collect race, ethnicity, and language data on Medicare enrollees. The proposal would provide funding to upgrade SSA databases so that they can communicate with one another.

Data Collection Methods

Current Law

While federal data collection efforts collect a broad range of data for measuring disparities in the quality of and access to health care, there are no statutory requirements to ensure that the sample size is large enough to generate reliable, statistically significant estimates for various racial and ethnic groups. Some surveys oversample minorities (*e.g.*, the National Health Interview Survey, the National Health and Nutrition Examination Survey, the Medical Expenditure Panel Survey) in an effort to produce reliable data for blacks, Hispanics, and Asians. But no federal surveys have large enough samples to examine smaller groups like Puerto Ricans, Cubans, or Filipinos.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPAA; P.L. 110-275) instructed the Secretary to evaluate approaches for collecting disparities data on Medicare beneficiaries and provide a report to Congress, including recommendations for reporting nationally recognized quality measures, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, on the basis of race, ethnicity, and gender. MIPAA further instructed the Secretary to implement the approaches identified in the initial report and, subsequently, report back to Congress with recommendations for improving the identification of health care disparities among Medicare beneficiaries based on an analysis of those efforts.

The Institute of Medicine in its 2002 health disparities report, *Unequal Treatment*, recommended that “accreditation bodies, such as the Joint Commission and National Committee for Quality Assurance (NCQA), should require the inclusion of data on patient race, ethnicity and highest level of education ... in performance reports of public and private providers as part of healthcare performance measurement.” Current statutorily mandated quality reporting programs for Medicare hospitals and physicians do not require the inclusion of data on race, ethnicity or primary language.

By making patient demographic data easier to collect and analyze, health information technology (HIT) systems have the potential to benefit health disparities research. To that end, the recently enacted Health Information Technology for Economic and Clinical Health (HITECH) Act (ARRA; P.L. 111-5) instructed the new HIT Policy Committee to recommend standards ensuring that HIT systems collect patient demographic data, including at a minimum, race, ethnicity, primary language, and gender.

Proposed Option

The proposal would require that federally funded population surveys collect sufficient data on racial/ethnic subgroups to generate statistically reliable estimates in studies comparing health disparities populations. It would ensure that quality reporting requirements include proposals to collect data on patients by race, ethnicity, and primary language, and it would extend the MIPAA provisions regarding the collection of health disparities data to the Medicaid and CHIP populations.

Standardized Categories for Data

Current Law

The Office of Management and Budget (OMB) Directive 15 (Standards for the Classification of Federal Data on Race and Ethnicity) outlines standards for the collection of race and ethnicity data on federally-sponsored surveys, administrative forms, and other records (*e.g.*, school applications or mortgage lending applications). OMB Directive 15 does not mandate collection of such data. However, when race data are collected Directive 15 requires a minimum of five racial categories (White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander). When ethnicity information is gathered, a dichotomous identification question with the choices “Hispanic or Latino” or “not Hispanic or Latino” must be used. Data collection instruments may include additional categories such as Mexican-American, Chicano, Puerto Rican, Cuban, or Filipino, as long as these categories can be aggregated to the standard categories. When individuals are asked to self-identify (which is OMB’s “preferred method”), Directive 15 also requires that respondents be given the opportunity to report multiple races in response to a single question. Including “multiracial” as an option is not acceptable.

In addition, when self-identification is used, race and ethnicity should be determined by first asking about ethnicity (“Hispanic or Latino” vs. “not Hispanic or Latino”) and, second, asking individuals to choose one of the aforementioned five racial categories. When the data is not based on self-identification, a single item race/ethnicity question inviting people to choose “all that apply” is acceptable. Finally, persons who identify as Alaska Native should also be asked for their tribal affiliation.

Generally, all federal agencies and federally sponsored entities must use the Directive 15 categories when collecting race and ethnicity data; however, the requirements may be waived if an organization can demonstrate that it is either unreasonable to use the categories in a particular situation, or if it can be shown that race and ethnicity data are not critical to the administration of the program seeking this information. OMB standards do not apply to state and municipal public health departments or to Medicaid. While the standards do apply to the Children’s Health Insurance Program (CHIP), they are not binding on states which opt to use CHIP funding to finance a Medicaid expansion or which employ a combination approach.

While OMB Directive 15 does not address data on language, CMS requires that this information be reported for Medicaid beneficiaries. CMS does not require the collection of primary language data for CHIP enrollees and their parents. No one is required to collect data regarding disability.

Proposed Option

The proposal would establish uniform categories for collecting data on race and ethnicity, requiring the use of OMB Directive 15 standards and the OMB policy for aggregation and allocation of subgroups. Funding would be provided to states for technology upgrades needed to adopt OMB categories. The OMB standards would apply to Medicaid. CMS would be required to collect primary language data on CHIP enrollees and their parents.

Additionally, this proposal would require the collection of access and treatment data for people with disabilities. The Centers for Medicare and Medicaid Services (CMS) would be required to determine where people with disabilities access primary care and the number of providers with accessible facilities and equipment to meet the needs of the disabled. Access to intensive care units would also be evaluated. Quality reporting requirements would include provisions to collect data on patients with disabilities by type of disability.

Public Reporting, Transparency, and Education

Current Law

Medicare section 1886(b)(3)(B)(viii)(VII) requires the Secretary to establish procedures for making reported hospital quality data available to the public. Section 1886(b)(3)(B)(viii)(VIII) further requires the Secretary to post on the CMS website (1) quality measures of process, structure, outcome, and (2) patients' perspectives on care, efficiency, and costs of care that relate to inpatient care. Currently, individual hospital performance on specific quality measures and on certain conditions is available on the Hospital Compare website. However, this information is not stratified by race, ethnicity or gender.

The NCQA's online tool for comparing health plans, *Quality Compass*, does not stratify data from the Healthcare Effectiveness Data and Information Set (HEDIS) by race; NCQA only provides plan-level performance data on the HEDIS measures. The Joint Commission also reports quality data for its accredited entities at www.qualitycheck.org, but this information is also not stratified by race or ethnicity.

The Healthcare Research and Quality Act of 1999 (P.L. 106-129) instructed the Agency for Healthcare Research and Quality (AHRQ) to issue an annual National Healthcare Disparities Report. The annual report, which is based on an analysis of numerous existing data sources, tracks "prevailing disparities in health care delivery" as they relate to "racial factors and socioeconomic factors" in the United States.

Proposed Option

The proposal would require health care quality data to be published by race, ethnicity and gender.

Language Access

Current Law

Federal and state governments share in the cost of Medicaid based on a statutory formula defining the federal contribution (*i.e.*, federal medical assistance percentage, FMAP). The federal match for administrative expenditures does not vary by state and is generally 50 percent, but certain administrative functions have a higher federal matching rate. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA; P.L. 111-3) permits states to receive a 75 percent FMAP for translation or interpretation services in connection with the enrollment and retention of, and use of services under Medicaid by, children of families for whom English is not the primary language.

The HHS Office of Minority Health issued national standards for the delivery of culturally and linguistically appropriate health care services (CLAS). Federally funded health care programs must meet the Language Access Services standards established under CLAS. For example, staff must receive education and training in culturally and linguistically appropriate service delivery, and health care organizations must provide language assistance services.

Proposed Option

The proposal would extend the 75 percent matching rate for translation services to all Medicaid beneficiaries for whom English is not the primary language, and would establish CLAS standards for private insurers in the Health Insurance Exchange. The proposal would also establish grants for outreach and enrollment efforts to fund, for example, multi-lingual help lines and for data collection efforts.

Elimination of Five-year Waiting Period for Non-Pregnant Adults

Current Law

Under prior law, legal immigrants arriving in the United States after August 22, 1996, were ineligible for Medicaid or CHIP benefits for their first five years in the U.S. Coverage of such persons after the five-year bar was permitted at state option if they met other eligibility requirements for that program. For legal immigrants (but not refugees and asylees), the law requires that their sponsor's income and resources be taken into account in determining eligibility for those who have signed a legally binding affidavit of support. Generally speaking, for federal means-tested programs (*e.g.*, Medicaid, TANF), the affidavit of support required the sponsor to ensure that the new immigrant will not become a public charge and makes the sponsor financially responsible for the individual.

CHIPRA permits states that meet certain requirements to waive the five-year ban for Medicaid or CHIP coverage to pregnant women and children who are lawfully residing in the United States, and are otherwise eligible for such coverage. For states that elect to extend such coverage, the provision assures that the cost of care will not be deemed under an affidavit of support against an individual's sponsor. In addition, as a part of states' redetermination processes (*i.e.*, to redetermine eligibility at least every 12 months with respect to circumstances that may change and affect eligibility), individuals made eligible under this provision whose initial documentation showing legal residence is no longer valid will be required to show "further documentation or other evidence" that the individual continues to lawfully reside in the U.S.

Proposed Option

The proposal would add non-pregnant adults to the list of Medicaid beneficiaries for whom states would be permitted to waive the five-year bar to extend Medicaid coverage.

Reduction in Infant Mortality and Improved Maternal Well-Being

Current law

Title V of the Social Security Act is administered by the Maternal and Child Health Bureau, which is part of the Department of Health and Human Services' (HHS) Health Resources and Services Administration. Title V authorizes \$850 million each fiscal year in order to improve the health of children and mothers. These funds are authorized to increase access to services; coordinate services; provide prevention, diagnostic and treatment services for pregnant women, mothers, and children, including those with disabilities.

Proposed Option

Provide funding to states, tribes, and territories to develop and implement targeted approaches to reducing infant mortality. Grant funding would be authorized through the Title V – Maternal and Child Health Services Block Grant and may require coordination with other operating divisions of HHS. Awards will be based on the applicants' ability to demonstrate the capacity to engage in one or more types of evidence-based approaches to reduce infant mortality and its related causes, and consequences, such as preterm births, infant and child disability, reduced health status of women during their childbearing years, and maternal mortality. The Secretary would undertake and publish an evaluation of funded projects including a formal assessment of the funded projects for their potential, if scaled broadly, to improve health care practice, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.