

Affordable Health Care for America Act (H.R. 3962)

Provisions Impacting Vulnerable Children, Youth, and Families

On Thursday, October 29, leaders in the U.S. House of Representatives introduced a comprehensive health reform bill, the Affordable Health Care for America Act, H.R. 3962. The legislation is expected to provide health coverage to nearly 96% of legal residents under the age of 65, at a net, fully offset cost of \$894 billion over ten years. The legislation makes significant insurance reforms, expands the Medicaid program to more needy individuals, provides assistance to individuals and small businesses, and creates a Health Insurance Exchange containing a public option wherein individuals, small businesses and eventually large businesses could purchase health coverage. The legislation contains many provisions that would impact the physical and mental health of vulnerable children, youth, and families—many of which are detailed below.

Immediate Reforms

High-Risk Individuals: Individuals who have been uninsured for several months or denied coverage due to a pre-existing condition could receive coverage through a new \$5 billion program. The program will end when funds are exhausted or when the Exchange is created (Section 101).

Young Adults: Uninsured young adults would have the option to stay on their parent's health insurance until age 26 (Section 105).

Pre-existing Conditions Limitation: Before the absolute prohibition on discriminating based on pre-existing conditions, starting January 1, 2010, plans could only look back for pre-existing conditions for 30 days (rather than the current 6 months) and could only exclude benefits for 3 months (as opposed to 12) (Section 106).

Lifetime Limits: Health insurers could no longer impose lifetime limits on benefits (Section 109).

Medicaid

Beginning in 2013, individuals under 65 (including children, pregnant women, parents, individuals with disabilities, and childless adults) would be eligible for Medicaid if their income level is below 150% of the federal poverty level (150% of FPL for 2009 is \$16,245 for an individual and \$27,465 for a family of three). The federal government would wholly pay for newly eligible individuals under this expansion for the first two years. Starting in 2015, the federal government would pick up 91% of the cost to cover the expansion populations, with the states contributing the remaining 9% (Section 1701).

Newborns who otherwise do not have coverage must be covered by Medicaid for the first 60 days of life. The federal government would wholly pay for this temporary coverage (Section 1701).

Reimbursement: Medicaid payments to primary care physicians and practitioners for primary care services would be increased to 80% of Medicare rates in 2010, 90% in 2011, and 100% in 2012 and beyond. Through 2015, the federal government would wholly pay; after 2015, states would have to contribute 10% (Section 1721).

Maintenance of Eligibility: States cannot restrict Medicaid eligibility, methodologies, and procedures more than as they existed on June 16, 2009 (Section 1703).

Family Planning Services: State Medicaid programs could provide family planning services to low-income women who are not pregnant without first obtaining a waiver. This coverage could occur during a presumptive eligibility period (Section 1714).

Medical Home Pilot Program: A five-year pilot program would be created to test the medical home concept with Medicaid beneficiaries, including medically fragile children and high-risk pregnant women (Section 1722). This would be significant, as the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351) requires more extensive planning and coordination around the health needs of children in care—including the possible use of medical homes.

Youths Released from Public Institutions: Medicaid coverage would be suspended, rather than terminated, for beneficiaries under age 19 during period of incarceration (Section 1729).

Transitional Medicaid Assistance (TMA): TMA would be extended through December 31, 2012 for families leaving cash assistance (Section 1732).

Extension of ARRA FMAP Increase

The temporary increase to state's Federal Medical Assistance Percentage (FMAP) contained in the American Recovery and Reinvestment Act (ARRA, P.L. 111-5) would be extended for two quarters—through June 30, 2011 (Section 1749). It is assumed this increase extension would apply to both state Medicaid and IV-E programs. The state's maintenance of effort requirement remains the same as contained in the ARRA—to receive the temporary FMAP increase, the state's eligibility standards, methodologies and procedures must be no more restrictive than those in place on July 1, 2008.

Home Visiting

State Medicaid programs would have the option of covering nurse home visitation, done by trained nurses to families with a first-ever pregnant woman or Medicaid-eligible child under age 2 (Section 1713).

New grants would also be available under IV-B of the Social Security Act to support voluntary, evidence-based home visitation programs for pregnant women and for families with pre-school age children (Section 1904).

Therapeutic Foster Care

Medicaid reimbursement for the treatment contained in therapeutic foster care would be protected (Section 1727).

School-based Health Clinics

A new program would support school-based health clinics, with \$50 million appropriated for FY 2011 and such sums as may be necessary for FY 2012-FY 2015. Medicaid would have to reimburse on the same basis as they reimburse federally-qualified health centers (Sections 1730B, 2511)

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program is currently set to expire in October 2013. H.R. 3962 would extend CHIP for one quarter beyond this. In 2014, when CHIP is no longer, children enrolled in CHIP would be able to receive coverage through either Medicaid or the newly created health exchange. A

previous version of the House health reform bill required the Secretary of Health and Human Services (HHS) to certify *before actually moving children from CHIP to the Exchange* that children's benefits would be as good or better in the Exchange. H.R. 3962 however merely requires the Secretary to submit a report comparing the benefits and cost sharing of CHIP versus the Exchange. This is a troubling difference that could potentially leave children in a worse position, receiving less comprehensive benefits.

Maintenance of Eligibility: States cannot restrict CHIP eligibility, methodologies, and procedures more than as they existed on June 16, 2009; this maintenance of effort remains in place until CHIP's expiration December 31, 2013 (Section 1703).

Continuous Eligibility: Children below 200% FPL in stand-alone CHIP programs would receive 12-month continuous eligibility (Section 1733).

Elimination of Waiting Periods for Certain Children: There could be no eligibility waiting periods for CHIP-eligible children: (1) under age 2; (2) in families losing insurance due to unemployment; and (3) in families spending over 10% of income for health coverage (Section 1734).

Medicaid and CHIP Payment and Access Commission

Funds would be provided for the Medicaid and CHIP Payment and Access Commission authorized under the recent CHIP reauthorization. The Commission will review Medicaid and CHIP policies as they relate to children's access to covered health services and make recommendations to Congress (Section 1784).

Medicaid and CHIP Outreach and Enrollment

The Secretary would be required to issue guidance regarding Medicaid and CHIP outreach and enrollment, with an emphasis on vulnerable populations such as homeless youth (Section 1785).

CMS Center for Medicare and Medicaid Innovation

A Center for Medicare and Medicaid Innovation would be created within CMS that would research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care (Section 1907). This could potentially offer opportunities to allow more flexible reimbursement approaches for residential and other forms of care.

Benefits

Guaranteed Benefits: Guaranteed, essential benefits would include: inpatient and outpatient hospital services, physician services and equipment and supplies provided afterward, preventive services, maternity services, prescription drugs, rehabilitative and habilitative services, and mental health and substance abuse services including behavioral health treatments. For children, guaranteed, essential benefits would include well baby and well child visits, as well as oral health, vision, and hearing services. An independent Committee will be established to update the core benefits package (Sections 221, 222).

There would be no cost-sharing for preventive services. Annual out-of-pocket spending related to essential benefits would be limited to \$5,000 for an individual and \$10,000 for a family.

Mental Health and Substance Abuse: Mental health and substance abuse services would be guaranteed, essential benefits that would have to be offered at parity (Section 214), continuing the good work the

Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008, contained in P.L. 110-343

Affordability

Financial assistance would be available to help individuals and families with incomes up to 400% of the federal poverty level purchase health insurance. Affordability credits would be available on a sliding scale, ranging from 1.5% of income to 12% for those at 400% FPL. Cost sharing would also be limited, ranging from 3% of plan costs to 30% for those between 350-400% FPL (Sections 341-347).

Workforce

Investments are made in several areas of the health care workforce, including:

- Increased loan repayment for those in the National Health Service Corps (Section 2201);
- Loan repayment for those serving in areas of moderate need (Section 2211);
- Training for general, pediatric and public health dentists and dental hygienists (Section 2215);
- Establishes a new training program for mental and behavioral health professionals (including those specializing in substance abuse counseling and addiction medicine) to promote interdisciplinary training and coordination of delivery (Section 2522);
- Establishes a new program to promote cultural and linguistic competence among health care professionals (Section 2251).

Teen Pregnancy Prevention

Would establish a new program whereby states can provide evidence-based education to reduce teen pregnancy and sexually transmitted infections. States could work with public or private nonprofit organizations, including schools and community- and faith-based organizations. \$50 million per year from FY 2011-2015 would be authorized (Section 2526).

Infant Mortality

A new program would be established to support pilot programs seeking to reduce infant mortality. \$10 million per year from FY 2011-2015 would be authorized (Section 2532).

Community-based Collaborative Care Networks

A new program would be established to support community-based collaborative networks, being a consortium of health care providers offering coordinated and integrated health care services for low-income populations or medically-underserved areas. Such sums as may be necessary from FY 2012-FY 2015 are authorized to carry out the program (Section 2534).

Disparities

A couple of provisions would begin to address racial, ethnic, and other significant health disparities, including:

- Workforce strengthening initiatives including scholarships, loan repayment, and fellowships to individuals from disadvantaged backgrounds (Section 2241), establishing a new program to promote cultural and linguistic competence among health professionals (Section 2251), and requiring the Secretary of Health and Human Services (HHS) to collect data on the supply, diversity, and geographic distribution of the Nation's health workforce (Section 2271);
- Community-level preventive health grants, with at least half of the funding targeted at addressing health disparities (Section 3151);

- Establishment of an Assistant Secretary for Health Information to coordinate and develop standards for the collection of health information, including information to measure, study, and reduce health care disparities (Section 2402);
- Increased \$12 billion additional for community health centers (Section 2101);
- Requires the Secretary of Health and Human Services (HHS) to identify health and health care disparities as part of the National Prevention and Wellness initiative (Section 3121); and
- Directs the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services to consider health disparities as they produce evidence-based recommendations on the use of preventive services (Sections 3131 and 3132).

Rural

H.R. 3962 contains provisions that would help individuals living in rural America access affordable, quality health coverage, including:

- Expansion of Medicaid to individuals below 150% of the federal poverty level (FPL) and subsidies to individuals to purchase coverage up to 400% FPL;
- Incentives to primary care doctors working in underserved areas and additional training for the workforce—for example, through expansion of the National Health Service Corps;
- Permits infant mortality pilot programs to be directed at at-risk mothers in rural areas (Section 2532);
- Directs the Institute of Medicine (IOM) to study geographic inequities in Medicare reimbursement rates and directs the Secretary to adjust rates accordingly (Section 1157).

Comparative Effectiveness Research

A new Center would be created at the Agency for Healthcare Research and Quality, with an independent stakeholder commission recommending the Center's research priorities, study methods, and means to disseminate research (Section 1401). This has possibilities for more research surrounding the health needs of children in care.

For more information about H.R. 3962, visit
<http://edlabor.house.gov/blog/2009/10/affordable-health-care.shtml>