"Family Opportunity Act of 2003"
Chairman's Mark

TITLE I. OPPORTUNITY TO PURCHASE MEDICAID COVERAGE FOR CERTAIN DISABLED CHILDREN

Section 101. Opportunity for Families of Disabled Children to Purchase Medicaid Coverage for Such Children

State Option to Allow Families of Disabled Children to Purchase Medicaid Coverage

Current Law

Federal law establishes the categories or groups of individuals that can be covered under Medicaid and, in many cases, defines specific eligibility rules for these categories. Some groups must be covered under Medicaid (called mandatory groups), while others may be covered at state option. In general, Medicaid is available to low-income persons who are aged, blind or disabled, members of families with dependent children, and certain other pregnant women and children. Applicants' income and resources must be within certain limits, most of which are determined by states, again within federal statutory parameters. States have considerable flexibility in defining countable income and assets for determining eligibility.

For disabled children, there are several potentially applicable Medicaid eligibility groups, some mandatory but most optional. Some of these children could qualify for Medicaid through more than one pathway in any given state. There are four primary coverage groups for which disability status or medical need is directly related to eligibility.

First, subject to one important exception, states are required to cover all children receiving Supplemental Security Income (SSI). Because SSI is a federal program, income and resource standards do not vary by state. In determining financial eligibility, parents' income is deemed available to noninstitutionalized children (but the need of household members is taken into account). If family income is higher than the SSI threshold, the child will not qualify for SSI or Medicaid.

The major exception to the required coverage under Medicaid of SSI recipients occurs in so called "209(b)" states. Such states can apply more restrictive income and resources standards and/or methodologies in determining Medicaid eligibility than the standards applicable under SSI. States that offer State Supplemental Payments (SSP) may also offer Medicaid coverage to SSP recipients who would be eligible for SSI, except that their income is too high.

Second, states may offer medically needy coverage under Medicaid. The medically needy are persons who fall into one of the other categories of eligibility (e.g., is a dependent child) but whose income exceeds applicable financial standards. Income standards for the medically needy can be no higher than 133⅓ percent of the state's former Aid to Families with Dependent Children (AFDC) payment standard in effect on July 16, 1996. Individuals can meet these financial criteria by having income that falls below the medically needy standard, or by incurring medical expenses

that when subtracted from income, result in an amount that is lower than the medically needy income standard. Resource standards correspond to those applicable under SSI. Older children or those with very large medical expenses may qualify for medically needy coverage. (Other eligibility pathways for younger children are described below.)

Third, states may extend Medicaid to certain disabled children under 18 who are living at home and who would be eligible for Medicaid via the SSI pathway if they were in a hospital, nursing facility, or intermediate care facility for the mentally retarded, as long as the cost of care at home is no more than institutional care. (This group is also called the Katie Beckett category.) The law allows states to consider only the child's income and resources when determining eligibility for this group. That is, states may ignore parents' income.

Fourth, states have an option to cover persons needing home and community based services, if these persons would otherwise require institutional care covered by Medicaid. These services are provided under waiver programs authorized by Section 1915(c) of Title XIX of the Social Security Act. Unlike the Katie Beckett option, which requires all disabled children within a state to be covered, such programs may be limited to specific geographic areas, and/or may target specific disabled groups and/or specific individuals within a group. States may apply institutional deeming rules which allow them to ignore parents' income in determining a child's eligibility for waiver services.

Disabled children can also qualify for Medicaid via other eligibility pathways for which disability status and medical need are irrelevant. These additional pathways cover children at higher income levels than those applicable to most of the disability-related eligibility categories described above. For example, states are required to provide Medicaid coverage to children under age 6 (and pregnant women) in families with incomes below 133 percent of the federal poverty level (FPL), and in FY2002, for children between ages 6 and 18 in families with income below 100 percent of FPL. States may cover infants under age one (and pregnant women) in families with income between 133 and 185 percent of FPL. Similarly, under the State Children's Health Insurance Program (SCHIP), states may extend Medicaid (or provide other health insurance) to certain children under age 19 who are not otherwise eligible for Medicaid in families with income that is above the applicable Medicaid standard but less than 200 percent of FPL, or in states that already exceed the 200 percent of FPL level for Medicaid children, within 50 percentage points over that existing level.

Chairman's Mark

Effective October 1, 2005, the Chairman's mark would add a new optional eligibility group for disabled children to Medicaid. The new group includes children under 18 years of age who meet the disability definition for children under the Supplemental Security Income (SSI) program and whose family income is above the financial standards for SSI but not more than 250 percent of FPL. States may exceed 250 percent of FPL, but federal financial participation is not available for coverage of disabled children in families with income above that level.

Interaction with Employer-Sponsored Family Coverage

Current Law

States may require Medicaid eligibles to apply for coverage in certain employer-sponsored group health plans (for which such persons are eligible) when it is cost-effective to do so. This requirement may be imposed as a condition of continuing Medicaid eligibility, except that failure of a parent to enroll a child must not affect the child's continuing eligibility for Medicaid.

If all members of the family are not eligible for Medicaid, and the group health plan requires enrollment of the entire family, Medicaid will pay associated premiums for full family coverage if doing so is cost-effective. However, Medicaid will not pay deductibles, coinsurance or other cost-sharing for family members ineligible for Medicaid. Third party liability rules apply to coverage in a group health plan. That is, such plans, not Medicaid, must pay for all covered services under the plan.

Under current law, cost-effectiveness means that the reduction in Medicaid expenditures for Medicaid beneficiaries enrolled in a group health plan is likely to be greater than the additional costs for premiums and cost-sharing required under the group health plan. Group health plan means a plan of (or contributed to by) an employer or employee organization to provide health care (directly or otherwise) for employees and their families.

In sum, when it is cost-effective, Medicaid pays the premiums and other cost-sharing under certain group health plans for Medicaid eligibles, as well as for Medicaid services not covered under the group health plan. This includes payment of any premium and cost sharing amounts that exceed limits placed on such payments in Medicaid law.

Chairman's Mark

The Chairman's mark would allow states to require parents of disabled children who are eligible for the newly defined coverage group to enroll in employer-sponsored family coverage under certain circumstances. Specifically, when the employer of a parent of a disabled child offers family coverage under a group health plan, the parent is eligible for such coverage, and the employer contributes at least 50 percent of the annual premium costs, states may require participation in such employer-sponsored family coverage plan as a condition of continuing Medicaid eligibility for the targeted child under the proposed optional eligibility category. In addition, if such coverage is obtained, states may elect to have families pay an amount that reasonably reflects the premium contribution made by the parent for this coverage on behalf of the disabled child. States may pay any portion of a required premium for family coverage under an employer-sponsored plan; for families with income that does not exceed 250 percent of FPL, the federal government will share in the cost of these payments.

In addition, states that use employer-sponsored family coverage for the new optional eligibility group must insure that these plans, not Medicaid, pay for all covered services under the plan, as is the case with all other third party liability situations.

State Option to Impose Income-Related Premiums

Current Law

Generally, for certain eligibility categories, states may not impose enrollment fees, premiums or similar charges. Further, states are specifically prohibited from requiring payment of deductions, cost-sharing or similar charges for services furnished to persons under 18 years of age (up to age 21, or any reasonable subcategory of such persons between 18 and 21 years of age, at state option).

In certain circumstances, states may impose monthly premiums for enrollment in Medicaid. For example, states may require certain qualified severely impaired persons ages 16 and above who but for earnings would be eligible for SSI to pay premiums and other cost-sharing charges set on a sliding scale based on income. Further, states may require such persons with income between 250 to 450 percent of FPL to pay the full premium. However, the sum of such payments may not exceed 7.5 percent of income.

For other groups, states may not require prepayment of premiums and may not terminate eligibility due to failure to pay premiums, unless such failure continues for at least 60 days. States can also waive premiums when such payments would cause undue hardship.

Chairman's Mark

The Chairman's mark adds a new section to Medicaid law governing premiums applicable to the new optional eligibility group. It would allow states to require families with disabled children eligible for Medicaid under the new optional eligibility group to pay monthly premiums for enrollment in Medicaid on a sliding scale based on family income. Aggregate payments for premiums paid by families for employer-sponsored family coverage may not exceed 5 percent of income.

States may not require prepayment of premiums, nor are states allowed to terminate eligibility of a targeted child for failure to pay premiums unless lack of payment continues for a minimum of 60 days beyond the payment due date. States may waive payment of premiums when such payment would cause undue hardship.

The mark does not change current law with respect to other cost-sharing by beneficiaries (e.g., deductibles, co-insurance, co-payments), which is not permitted for children under 18 years of age. Thus, Medicaid would pay such cost sharing obligations rather than the families of qualifying children under the new optional group.

Section 102. Treatment of Inpatient Psychiatric Hospital Services for Individuals Under 21 in Home or Community-Based Services Waivers

Current Law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of Title XIX of the Social Security Act give states the flexibility to develop and implement alternatives to placing Medicaid beneficiaries in hospitals, nursing facilities, or intermediate care

facilities for the mentally retarded (ICF-MRs). These waivers allow such individuals to be cared for in their homes and communities as long as the cost is no higher than that of institutional care.

Federal regulations permit HCBS programs to serve the elderly, persons with physical disabilities, developmental disabilities, mental retardation or mental illness. States may also target waiver programs to persons with specific illnesses or conditions, such as technology-dependent children or individuals with AIDS.

Services that may be provided under HCBS waiver programs include: case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. Other services needed by waiver participants to avoid institutionalization, such as non-medical transportation, in-home support services, special communication services, minor home modifications, and adult day care may also be provided, subject to approval by Centers for Medicare and Medicaid Services (CMS). The law further permits day treatment or other partial hospitalization services, psychosocial rehabilitation, and clinic services for persons with chronic mental illness. Room and board are excluded from coverage except under limited circumstances.

Under HCBS wavier programs, states may select the mix of services that best meets the needs of the targeted population to be served. Programs may be statewide or limited to a specific geographic area.

Chairman's Mark

The mark adds to the list of persons eligible for HCBS waiver programs individuals under 21 years of age requiring inpatient psychiatric hospital services, effective for medical assistance provided on or after January 1, 2004.

Section 103. Development and Support of Family-to-Family Health Information Centers.

Current Law

Title V of the Social Security Act authorizes the Maternal and Child Services Block Grant program, which provides grants to states for improving the health of mothers and children. The program has three components: (1) formula block grants to 59 states and territories; (2) Special Projects of Regional and National Significance (SPRANS); and (3) Community Integrated Service Systems (CISS) grants.

Activities supported under SPRANS include Maternal and Child Health (MCH) research, training, genetic services, hemophilia diagnostic and treatment centers and maternal and child health improvement projects that support a broad range of innovative strategies.

By law, 15 percent of the amount appropriated for the Maternal and Child Health Block Grant Program up to $600 million, is awarded to public and private not-for-profit organizations for SPRANS. SPRANS also receive 15 percent of funds remaining above $600 million after CISS funds are set aside. The CISS programs are initiated when the MCH appropriation exceeds $600 million. Of any amount appropriated over $600 million, 12.75 percent must be for CISS. The remaining amounts are allocated to the block grant program and to SPRANS.

Chairman's Mark

The Chairman's mark would increase funding for SPRANS for the development and support of new family-to-family health information centers. The mark would appropriate to the Secretary out of any money in the Treasury not otherwise appropriated, for this new purpose an additional $3 million for FY2004; $4 million for FY2005; and $5 million for FY2006. For each of fiscal years 2007 and 2008, the bill authorizes to be appropriated to the Secretary $5 million for this purpose. Funds would remain available until expended.

The family-to-family health information centers would: (1) assist families of children with disabilities or special health care needs to make informed choices about health care so as to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children; (2) provide information regarding the health care needs of, and resources available for children with disabilities or special health care needs; (3) identify successful health delivery models; (4) develop a model for collaboration between such children and health professionals; (5) provide training and guidance with regard to the care of such children; and (6) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals. The family-to-family health information centers would be staffed by families of children with disabilities or special health care needs who have expertise in federal and state public and private health care systems, and health professionals.

The Chairman's mark would require the Secretary to develop such centers in: (1) not less than 25 states in FY2004; (2) not less than 40 states in FY2005; and (3) not less than 50 states in FY2006. States would be defined as the 50 states and the District of Columbia.

Section 104. Restoration of Medicaid Eligibility for Certain SSI Beneficiaries.

Current Law

Except in the case of "209(b)"states, states are required to provide Medicaid benefits to all individuals who are receiving Supplemental Security Income (SSI). Persons eligible for SSI are low-income aged, blind, and disabled individuals. (Under the 209(b) provision, states may apply more restrictive income and resources standards and/or methodologies for determining Medicaid eligibility than the standards under SSI.) For disability purposes, two groups of disabled children exist: those under the age of 18 and those age 18 through 21 (if a full time student). Eligibility for SSI is effective on the later of: (1) the first day of the month following the date the application was filed, or (2) the first day of the month following the date that the individual became eligible.

Chairman's Mark

The Chairman's mark confers Medicaid eligibility to persons who are under age 21 and who are eligible for SSI, effective on the later of: (1) the date the application was filed, or (2) the date the individual became eligible for SSI.

The Committee's provision would apply to medical assistance for items and services furnished on or after the first day of the first calendar quarter that begins after the date of enactment of this Act.