"Mothers and Newborns Health Insurance Act of 2002"
Chairman's Mark

SECTION 1 - SHORT TITLE

SECTION 2–STATE OPTION TO EXPAND OR ADD COVERAGE OF CERTAIN PREGNANT WOMEN UNDER MEDICAID AND SCHIP

State Option to Expand Coverage Under Medicaid

Current Law

States are required to provide Medicaid coverage to pregnant women with no other children who have family income up to 133 percent of the federal poverty level (FPL), and have the option to extend such coverage to pregnant women with no other children who have family income between 133 and 185 percent of FPL. Both of these eligibility categories are commonly referred to as "poverty-related pregnant women." These pregnant women are entitled only to pregnancy-related services (e.g., prenatal, delivery and postpartum care up to 60 days after delivery). States may increase the effective income level above these standards by modifying applicable income and resource methodologies. In addition, states may seek waivers of program rules to extend Medicaid to pregnant women at higher income levels.

The State Children's Health Insurance Program (SCHIP) allows states to cover uninsured children under age 19 in families with income above applicable Medicaid financial standards. States may choose from among three benefit options when designing their SCHIP programs. They may expand Medicaid, create a new separate state program that must meet minimum benefit requirements, or devise a combination of both approaches. Among the many services available under SCHIP are prenatal care and hospital services. Pregnant women ages 19 and above are eligible for SCHIP only through special waivers of program rules, or when employer-sponsored family coverage subsidized by SCHIP includes adults in families with eligible children.

The federal share of Medicaid costs is equal to the federal medical assistance percentage (FMAP) of those costs. The FMAP is determined annually according to a formula designed to pay a higher federal matching rate to states with lower per capita incomes relative to the national average. The law establishes a minimum FMAP of 50 percent and a maximum FMAP of 83 percent. Under SCHIP, an enhanced FMAP (E-FMAP) is available. The E-FMAP is defined as the FMAP under Medicaid increased by 30 percent of the number of percentage points by which the FMAP for the state is less than 100 percent. E-FMAP ranges from 65 to 85 percent (the statutory upper limit).

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below applicable Medicaid income standards, until a formal determination of eligibility is made. Payments made on behalf of Medicaid children

during periods of presumptive eligibility are matched at the regular Medicaid FMAP, but are paid out of state SCHIP allotments.

Federal funds for SCHIP were appropriated in the original enacting statute for FY1998 through FY2007. From each year's appropriation, a state is allotted an amount as determined by a formula set in law. Expenditures associated with presumptive eligibility for children under Medicaid are counted against a state's SCHIP allotment.

Chairman's Mark

Effective for items and services furnished on or after October 1, 2002, the Chairman's mark would allow states meeting two conditions to cover additional pregnant women under Medicaid. Women eligible for such coverage under this provision include those with no other children in families with income exceeding 185 percent of FPL up to a state's SCHIP income level for children in effect as of January 1, 2002. The two conditions that must be met include: (1) the state must cover under Medicaid and SCHIP such pregnant women in lower income families before or in addition to pregnant women in higher income families, and (2) the state must apply an income level to the new group of pregnant women that is no lower than the effective income level in place for pregnant women already covered under the state Medicaid plan as of January 1, 2002. This provision would apply to items and services furnished on or after October 1, 2002, regardless of whether implementing regulations have been issued.

For states expanding coverage to additional pregnant women with incomes *exceeding* 185 percent of FPL, the SCHIP enhanced FMAP would apply and all payments would be counted against the state's SCHIP allotment.

Finally, the Chairman's mark would eliminate the requirement that expenditures associated with presumptive eligibility for children under Medicaid be counted against a state's SCHIP allotment.

State Option to Expand Coverage Under SCHIP

Current Law

In general, SCHIP allows states to cover uninsured children under age 19 in families with incomes that are either: (1) above the state's Medicaid financial eligibility standard but less than 200 percent of FPL, or (2) in states with Medicaid income levels for children already at or above 200 percent of FPL, within 50 percentage points over the state's Medicaid income eligibility limit for children in effect on March 31, 1997.

Generally, states cover SCHIP-eligible kids by either enrolling them into Medicaid expansion programs, or into separate state health insurance plans that meet specific standards for benefits and cost-sharing, or through a combination of both.

States covering SCHIP-eligible children through Medicaid must provide the full range of mandatory Medicaid benefits, including maternity care, and all optional services specified in their state Medicaid plans. Coverage for pregnant women under Medicaid is limited to services

related to the pregnancy (e.g., prenatal, delivery, and postpartum care up to 60 days after delivery); complications of pregnancy; and family planning services.

Alternatively, states operating separate state insurance plans may choose any one of three other benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other health benefits plan that the Secretary determines will provide appropriate coverage for the targeted population of uninsured children. These three additional benefit options may include maternity care. However, apart from requiring coverage of inpatient and outpatient hospital services, and physicians' surgical and medical services, there is no specific language in the federal statute that requires provision of prenatal, delivery and postpartum services with these non-Medicaid benefit plan options.

The SCHIP program does not include pregnancy status among its eligibility criteria, and does not cover individuals over age 18. There are two circumstances under which uninsured pregnant women over 18 years would be eligible for SCHIP. First, SCHIP has a "family coverage option" that allows states to provide coverage under a group health plan that may include maternity care to adult females in eligible families. States may cover entire families including parents if the purchase of family coverage is cost effective when compared with the cost of covering only the targeted low-income children in the families involved, and would not substitute for other health insurance coverage. Alternatively, states may apply for waivers of program rules to extend coverage to adults such as parents and pregnant women.

Cost sharing refers to the out-of-pocket payments made by beneficiaries of a health insurance plan. States that chose to implement SCHIP as a Medicaid expansion must follow the nominal cost sharing rules of the Medicaid program. Under separate state programs, total annual aggregate cost-sharing (including premiums, enrollment fees, deductibles, copayments, coinsurance, and other similar charges) for any family may not exceed 5 percent of total income in a year. Preventive services are exempt from cost-sharing.

For each fiscal year, the states and the District of Columbia are allotted a proportion of the total amount of federal SCHIP dollars available. From that amount, federal matching funds are disbursed quarterly to each state by a formula set in statute. The original authorizing legislation for SCHIP requires that 0.25 percent of the program's total authorization be set-aside for five territories. This total is distributed among these territories based on specific percentages defined in statute.

Chairman's Mark

In addition to allowing states to expand Medicaid to cover pregnant women above 185 percent of poverty up to the income eligibility for SCHIP children, the Chairman's mark also allows states to cover additional pregnant women under SCHIP. The SCHIP expansion group includes pregnant women with family income above the state's Medicaid financial eligibility standard for pregnant women in effect on January 1, 2002, up to the income eligibility for SCHIP children in effect as of January 1, 2002. The mark would also require states to meet the following conditions before they are permitted to expand their eligibility. First, the state must have already expanded Medicaid eligibility for pregnant women up to at least185 percent of FPL. Second, the same two conditions required of states choosing to expand coverage to pregnant

women under Medicaid must also be met: (1) the state must cover under Medicaid and SCHIP pregnant women in lower income families before or in addition to pregnant women in higher income families, and (2) the state must apply an income level to the new group of pregnant women that is no lower than the effective income level in place for pregnant women covered under the state Medicaid plan as of January 1, 2002. Coverage for pregnant women would be limited to services related to the pregnancy (e.g., prenatal, delivery, and postpartum care up to 60 days after delivery); complications of pregnancy; and family planning services.

The Chairman's mark would prohibit: (1) excluding pregnancy-related services based on a preexisting condition; (2) imposing a waiting period for the purpose of minimizing substitution, and (3) cost sharing for pregnancy-related services.

Children born to women receiving pregnancy-related services under SCHIP Medicaid expansions or separate state plans would be automatically enrolled in such program at the time of birth and would remain eligible for such assistance until the child attains 1 year of age. Unless the state issues a separate eligibility number for the child, such child would retain the medical assistance eligibility identification number of the mother during this eligibility period.

For each of fiscal years 2003 through 2006, the Chairman's mark would add an additional appropriation, in the amount of $200 million, out of funds not otherwise appropriated from the Treasury. A total of 98.95 percent of such funds would be distributed among the states in the same manner as SCHIP funds are distributed under current law. The remaining funds would be distributed among the territories also in the same manner as defined in current law. Funds added to the SCHIP program could be used for child health assistance for targeted low-income children, as well as for pregnancy-related assistance for pregnant women. Funds would be available to states that expand coverage to pregnant woman under title XXI (SCHIP), or title XIX (Medicaid) beyond those covered as of January 1, 2002. Additional funds would not be available to the states before October 1, 2002.

Eligibility of a Newborn

Current Law

A child born to a woman eligible for and receiving medical assistance under a Medicaid state plan on the date of the child's birth, is deemed to have applied for, and to have been found eligible for such assistance. The child remains eligible for such assistance until that child attains 1 year of age as long as the child is a member of the woman's household, and the woman remains (or would remain if pregnant) eligible for Medicaid.

Chairman's Mark

For a child born to a woman eligible for and receiving medical assistance under a Medicaid state plan on the date of the child's birth, the Chairman's mark would remove current law requirements that the child remain a member of the woman's household; and the woman continue to be eligible (or would remain eligible if pregnant) for Medicaid.

Application of Qualified Entities to Presumptive Eligibility for Pregnant Women Under Medicaid

Current Law

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards, until a final formal determination of eligibility is made. Entities qualified to make presumptive eligibility determinations include Medicaid providers, agencies that determine eligibility for Head Start, subsidized child care, or the Special Supplemental Food Program for Women, Infants and Children (WIC).

The "Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000" (BIPA) added several entities to the list of those qualified to make Medicaid presumptive eligibility determinations. These include agencies that determine eligibility for Medicaid or the State Children's health Insurance Program (SCHIP); certain elementary and secondary schools; state or tribal child support enforcement agencies; certain organizations providing food and shelter to the homeless; entities involved in enrollment under Medicaid, TANF, SCHIP, or that determine eligibility for federally funded housing assistance; or any other entity deemed by a state, as approved by the Secretary of HHS.

Chairman's Mark

For purposes of presumptive eligibility determinations, the Chairman's mark would clarify that qualified providers be included under qualified entities as defined in current law. The Chairman's mark would further clarify that qualified entities would be permitted to make presumptive eligibility determinations for pregnant women in addition to children.

SECTION 3. REVIEW OF STATE AGENCY BLINDNESS AND DISABILITY DETERMINATIONS

Current Law

State agencies are required to conduct blindness and disability determinations to establish an individual's eligibility for: (1) Title II, (Federal Old-Age, Survivors, and Disability Insurance (OASDI) benefits); and (2) Title XVI (Supplemental Security Income, (SSI)). Disability determinations are made in accordance with disability criteria defined in statute as well as standards promulgated under regulations or other guidance.

The Commissioner of Social Security is required to review state agency Title II initial blindness and disability determinations in advance of awarding payment to individuals determined eligible under such requirements. This requirement for review is met when: (1) at least 50 percent of favorable determinations have been reviewed, or (2) other such determinations have been reviewed as necessary to ensure a high level of accuracy.

Chairman's Mark

The Chairman's mark would align the initial review requirements for Title XVI with those currently required under Title II. As under Title II, the Commissioner of Social Security would be required to review initial Title XVI SSI blindness and disability determinations made by state agencies in advance of awarding payments.

For FY2003, the SSI review would be required for 25 percent of all favorable state-determined allowances. In FY2004 and thereafter, review would be required for at least 50 percent of favorable state-determined allowances. To the extent feasible, the Chairman's mark would require that the Commissioner to select for review the determinations that are most likely to be incorrect.