All Healthy Children Act
Section by Section

Section 1 – Short Title, Table of Contents, and Findings

Section 2 - Creation of New Title XXII of the Social Security Act as follows:

Section 2201. All Healthy Children Program.

Section 2201(a). In General. This section establishes a new State-operated program receiving Federal financial assistance to provide comprehensive health coverage for children and pregnant and post-partum women in place of benefits previously provided under Medicaid and SCHIP.

Section 2201(b). State All Healthy Children Plan Required. In order to receive funds, a State must have an approved state plan that meets the requirements of section 2202.

Section 2201(c). State and Individual Entitlement. This section provides that States are entitled to receive payments authorized under section 2204 and eligible individuals are entitled to the benefits authorized under the title.

Section 2201(d). Private Right of Action. This section provides that any person aggrieved by a violation of the title may bring a private right of action to protect their rights. "Aggrieved persons" are defined as individuals entitled to benefits under the program as well as providers or entities representing the interests of eligible individuals.

Section 2201(e). Effective Date. The effective date for the new program is October 1, 2008.

Section 2202. General Contents of State All Healthy Children Plan; Eligibility; Enrollment.

Section 2202(a). General Contents. The state plans are required to describe how the program will operate, including the methods of delivery of services, outreach and enrollment activities and methods of assuring the quality of care and access to all medically necessary health services.

Section 2202(b). Eligibility Standards and Methodology. All children under age 19 and pregnant and post-partum women whose family incomes do not exceed 300% of the federal poverty level, or FPL ($61,950 for a family of four in 2007) are eligible for benefits under the program along with other children currently eligible for Medicaid benefits, including former foster children through age 20 and certain children with special needs. In addition, individuals whose family income is over 300% FPL would be permitted to buy coverage under the program.

A three-month transitional eligibility is provided for families whose income rises above 300% of the FPL, with cost-sharing amounts to remain at the same levels as those prior to such transition.

Rules for determining income may not be more restrictive than those used in certain provisions of Title XIX. No asset or resource test for eligibility may be imposed.

Individuals are eligible for benefits if they are residents of the state, defined as present in the state with intent to remain and includes any individual who would be treated as such a resident under Medicaid. No citizenship or documentation requirements are permitted nor does receipt of coverage or services under this program constitute a public benefit within the meaning of the 1996 welfare law.

The Secretary is authorized to adjust income eligibility levels for the territories of the United States, taking into account factors such as average income, costs of living, and availability of health coverage.

Section 2202 (c). Enrollment. The state plan must provide a streamlined enrollment system incorporating the best practices and lessons from Medicaid and SCHIP. This would include a simple, short application form allowing self-attestation of eligibility; no asset or resource test; options for submitting applications in person, on-line, by mail or as part of an application for other federally-funded, means-tested programs; 12-month continuous eligibility periods; presumptive eligibility; and application assistance that is culturally and linguistically competent and accessible to those with limited ability to communicate. Automatic enrollment (no separate applications) would occur for children who have already applied or qualified for other means-tested programs including the National School Lunch Program, food stamps, WIC, and subsidized child care, unless the parent or guardian declined such coverage. Parents would be provided the opportunity to enroll their children in the program at other critical junctures such as birth, issuance of a Social Security card, school enrollment, or discharge of a child from a public facility, and would have the right to decline coverage. States would be required to develop information technology infrastructures needed for automated transmission of data to expedite enrollment and to ensure, after enrollment, that parents or guardians receive confirmation of coverage and benefits. The state plan shall ensure individuals covered through auto-enrollment do not receive fewer services than those enrolled through other means.

Section 2202(d). Avoiding Crowd-Out and Coordination with Other Health Coverage Programs. The state plan would be required to include a description of procedures, similar to those used under the current SCHIP program, to ensure that benefits provided under this program do not substitute for coverage under group health plans, except that no individual can be denied enrollment as a result of such policies if they were eligible for Medicaid under the state law in effect on October 1, 2005 or have an income below 150% of the FPL. Further, the state plan could not exclude individuals who had been without coverage for more than four months or lost coverage because of the death of a parent, a job loss, or other circumstances. Coverage cannot be denied because of the failure of a parent or other individual to enroll in an available group health plan.

In order to coordinate benefits with other available health coverage, the state plan must provide supplemental coverage in the case of children with disabilities as defined under SSI, who are enrolled in group health plans or individuals who would have qualified for such supplemental coverage under Medicaid prior to October 1, 2005. The state plan may provide such supplemental coverage to other eligible children who have group health insurance. The supplemental coverage includes benefits covered by the state plan that are not included in the

group health plan and reimbursement of premium and out of pocket costs payments for such coverage.

Section 2202(e) and (f). Assistance for Children Who Age Out of Assistance and Emergency Coverage. The state plan must also provide assistance in obtaining health coverage to individuals who lose eligibility because of age. Further, the state plan must provide immediate and automatic presumptive eligibility when an eligible individual enrolled in one state moves to another state because of a natural disaster or for other reasons.

Section 2203. Benefits; Premiums, Cost-Sharing, Provider Payment Rates.

Section 2203(a). Benefits. The program would cover all medically necessary services, including the early and periodic screening, diagnostic, and treatment services (including dental, vision, and mental health services) now covered under Medicaid but not currently required under the SCHIP program. The legislation creates an entitlement to these benefits and services, enforceable by eligible individuals and/or their representatives.

Section 2203(b). Premiums. No premiums are imposed for those with family incomes at or below 300% of the FPL; families over 300% of the FPL would be charged premiums at levels to cover the full, average per capita cost of the coverage, provided that premiums can not exceed 7.5% of the family income (or 15% in the case of multiple eligible individuals in the same family). However, these limits on premiums would not apply if the family failed to enroll in an available employer provided group health plan (or other sponsored plan) for which at least 50% of the premium was paid. States would also be permitted to reduce the level of premiums for reasonable classifications of eligible individuals, such as those with special health needs or who would have been eligible under an optional Medicaid category.

States are required to develop systems for collection of premiums that promote continuity of coverage, such as allowing premium payments to be made by credit or debit card, electronic fund transfers, or payroll withholding, or payment locations in the community, and provide reasonable opportunities to correct any default in premium payments.

Section 2203(c). Cost-Sharing. No out-of-pocket cost-sharing payments for services may be imposed for families with incomes at or below 200% of the FPL. Families with incomes between 201% and 300% of the FPL may be charged nominal out-of-pocket cost-sharing, and for those families with incomes over 300% of the FPL, out-of-pocket cost-sharing may not exceed levels consistent with charges under employer-based health insurance nationally. However, in no case may a child in a family whose income is at or below 300% of the FPL be denied services because of a failure to pay out-of-pocket costs.

Section 2203(d). Limitation on Out-of-Pocket Costs. The combined premiums and out-of-pocket costs must be kept to affordable levels, both for individual and total family costs, and in no case can they exceed the levels that would have been charged under state Medicaid or SCHIP law as of October 1, 2005, updated based upon changes in average earnings for families at or below 200% of the FPL. States may also waive these out-of-pocket cost-sharing payments.

Section 2203(e). Choice of Plans. To the extent feasible where benefits are provided through enrollment in a health plan, a state plan must provide enrollees a choice of at least two health plan options.

Section 2203(f). Reimbursement Rates. Payments rates shall be established by the states, in consultation with appropriate child health providers and experts, so that payment rates for providers are not less than 80% of the average payment rates for similar services under private health plans, at levels sufficient to ensure that enrollees have adequate access to all services covered under the program. Payments to capitated plans must be actuarially sound, based on comprehensive encounter data.

Section 2204. Payment to the States.

Section 2204(a) and (b). Payments and Computation of Federal All Healthy Children Matching Rate. States will receive federal payments for benefits under this program based upon a federal matching rate designed to provide funds sufficient to cover all additional required services and mandatory eligibility categories, subject to a state's continuing to pay a base amount based upon its 2006 child health expenditures, adjusted to account for changes in state child population and the medical care component of the consumer price index. The projected matching rate would require states to contribute above current level of adjusted expenditures for any optional coverage provided under the program. The Secretary is required to establish a formula for providing, in addition to the base federal matching amounts, automatic supplemental assistance to states that experienced a sustained economic downturn.

Section 2204(c). Bonus for Meeting Enrollment Targets. The Secretary is authorized to provide bonuses to states that meet or exceed enrollment targets established for each state.

Section 2204(d). Advance Payment; Retrospective Adjustment. The Secretary is authorized to make payments for each quarter on the basis of advance estimates of expenditures submitted by the states and may reduce or increase the payment as necessary to adjust for any overpayment or underpayment for prior quarters.

Section 2204(e). Treatment of Territories. The Secretary is required to establish, by regulation, an equitable formula for allocating funds to provide benefits to all eligible individuals residing in the territories of the United States.

Section 2205. Application of SCHIP, Medicaid and Related SSA Provisions; Waivers; Administration.

Section 2205(a). SCHIP Provisions Relating to Plan Submission, Strategic Objectives and Performance Goals and Audits. Except to the extent inconsistent with the provisions of this title, various provisions of SCHIP relating to state plans and goals are applicable to the new program.

Section 2205(b). Medicaid Provisions. Except to the extent inconsistent with the provisions of this title, various provisions of Medicaid and title XI of the Social Security Act, including section 1115, are applicable to this title.

Section 2205(c). Limitation on Waivers. The Secretary may, pursuant to section 1115, grant waivers to states with respect to this title, but no waivers can be granted that increase health care or health premiums costs or reduce benefits, eligibility, guaranteed eligibility, health care access, or health care quality.

Section 2205(d). Annual Reports. The Secretary is required to present annual reports to Congress describing the implementation of this title, including optional coverage chosen by the states, and nation-wide and state-specific data showing the number and characteristics of enrollees, services provided, categories and amounts of expenditures.

Section 2206. Definitions. This section defines, for the purposes of this title, various terms.

Section 2207. Effective Dates: Transitions.

Section 2207(a). Effective Date. Benefits and payments to states are available for services on or after October 1, 2008.

Section 2207(b). Transition Provisions. Any child under 19 years of age, any pregnant woman or any independent foster care adolescent who is enrolled in SCHIP or Medicaid on the day before the effective date of this title shall be automatically qualified for and enrolled in the state plan under this title.

Any adults enrolled in the SCHIP program through an existing program waiver shall be eligible for enrollment in the state Medicaid plan for the duration of the period for such program waiver, with the enhanced SCHIP federal matching rate to continue for that time.

The Secretary is required to provide guidance to the states in carrying out these transitions.

Section 2207(c). Medicaid and SCHIP Transition. Any individual eligible for this program after the effective date shall not be eligible for coverage under Medicaid or SCHIP, and no federal matching payments shall be made available under either program with respect to such individual.

Section 3. Commission on Children's Health Insurance.

A Commission on Children's Health Insurance is established, with members appointed by the majority and minority leaders of the House of Representatives and the Senate, the Secretary of Health and Human Services, the American Academy of Pediatrics, Institute of Medicine of the National Academies of Science, and two members appointed by the Secretary, one of whom shall be a representative of parents of children with special needs, and the other a representative of a children's advocacy group. Two non-voting members shall be appointed by the National Governors Association. Members shall be appointed for terms of two years, with vacancies filled in the same manner as the original appointment, and, with the exception of Federal officers or employees, shall be eligible for compensation at a per diem rate, including travel expense reimbursement.

The Secretary shall designate a Commission member as chair, and a supermajority (approval of at least six members) shall be required for commission actions. The commission shall have the power to hold hearings, acquire information from federal agencies, and hire staff. Funds for the operation of

the Commission shall be allocated by the Secretary from general operating funds of the Department of Health and Human Services.

The Commission shall be responsible for an annual report evaluating the status of children's health coverage in the United States, including evaluation of this program and recommendations for improvements at the state and national levels, and in the private sector to improve such coverage. Not later than three years after the date of enactment, the Commission shall submit a report to Congress containing a legislative proposal that would assure health benefits coverage for all children in the United States, that may include a requirement that parents obtain coverage for their children or that employers fund coverage for the children of their workers. The recommendations of the Commission shall receive expedited Congressional consideration, and the President may submit an alternative proposal that will receive expedited consideration.