(September 4, 2007, reflects bill as passed by
the House of Representatives on 08/01/07)

Key Disability Improvements in the CHAMP Act

There are many provisions in the Children's Health and Medicare Protection Act of 2007 (H. R. 3162, CHAMP Act) that affect people with disabilities, and several provisions reflect key legislative priorities of various parts of the disability community. While not providing an exhaustive list, the following highlights key provisions. Because these provisions are included only in the House-passed bill, the disability community must educate its elected officials so that they understand the importance of these provisions in a conference report.

TITLE I (CHIP)

Section 121 — Ensuring Child-Centered Coverage (including Mental Health Parity)

(CBO Cost Estimate: 5 years = $0.7 billion; 10 years = $2.2 billion)

Under SCHIP, states have the option to establish stand-alone plans that are separate from their Medicaid programs and modeled after private insurance benchmark plans. Unfortunately, many states have adopted into these plans private-insurance style limits on mental health services that would not be permissible in Medicaid, including caps on inpatient and outpatient mental health care. Furthermore, language in the CHIP statute even allows states to provide significantly less mental health coverage in their separate CHIP plans than is covered in the benchmark plan they select. The law allows states that opt to create a separate plan to reduce the actuarial value of the mental health benefit (including vision and hearing services and prescription drug coverage) by 25 percent—that is, these services in CHIP need only be actuarially equivalent to 75% of the benefit in the benchmark plan itself. Section 121 would eliminate this discriminatory provision in current law that authorizes states to lower the amount of mental health coverage (including vision and hearing services and prescription drug coverage) they provide to children in CHIP.

NOTE: The Senate-passed bill addresses this issue in a different way. Section 607 provides for mental health parity by ensuring that mental health benefits are no more restrictive than medical/surgical benefits, but (unlike the House) does not address the current weaker coverage for vision and hearing benefits. While the policy details are important, both approaches could lead to an acceptable solution that would be supported by the mental health community.

Section 141 — Children's Access, Payment, and Equality Commission

(CBO Cost Estimate: 5 years = $0 billion; 10 years = $0 billion)

Establishes a payment advisory commission akin to the Medicare Payment Advisory Commission to review federal and state payment policies under Medicaid and CHIP. This includes reviewing access to and affordability of coverage for Medicaid and CHIP enrollees (not just kids). Topics to be reviewed include the impact of Medicaid and CHIP policies on reducing health disparities, the overall financial stability of the safety net (including FQHCs, school-based clinics, public hospitals, Ryan White grantees and providers, and others).

TITLE II (Medicare)

Section 201 — Coverage and waiver of cost-sharing for preventive services

(CBO Cost Estimate: 5 years = $1.1 billion; 10 years = $3.4 billion)

Establishes new Medicare coverage of a variety of listed preventive services, and eliminates cost-sharing for these services. Covered preventive services include: prostate and colorectal cancer screening, medical nutrition therapy for certain individuals, an initial preventive physical examination, pneumococcal and hepatitis B vaccine, and mammography, pap smear, and bone mass measurement screening, and other preventive services.

Section 203 — Parity for mental health coinsurance

(CBO Cost Estimate: 5 years = $2.2 billion; 10 years = $4.7 billion)

Under current law, Medicare cost-sharing for outpatient mental health services is 50% of the cost of the service, compared to 20% of the cost of the service for most other services. This provision would eliminate this disparity so that outpatient mental health services would incur the same 20% beneficiary cost-sharing as physical health services starting on January 1, 2008.

Section 212 — Making QI program permanent and expanding eligibility

(CBO Cost Estimate: 5 years = $3.0 billion; 10 years = $8.8 billion)

Makes permanent the Qualified Individual (QI) program that provides Medicaid assistance with Medicare premiums and raises the income level to 150% of the federal poverty level ($15,315 for an individual in 2007).

Section 213 — Eliminating barrier to enrollment

(CBO Cost Estimate: 5 years = $3.6 billion; 10 years = $12.2 billion)

For moderate-income individuals, takes several steps to make it easier to obtain and retain the Medicare Part D low-income subsidy.

Section 215 — Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals

(CBO Cost Estimate: 5 years = $0.2 billion; 10 years = $0.5 billion)

Eliminates Part D cost-sharing for full-benefit dual eligibles in community settings who, but for the provisioning of home- and community-based care would require nursing facility care. Applies to persons covered under section 1915 (both HCBS waivers and HCBS option) and 1115 waivers.

Section 217 — Cost-sharing protections for low-income subsidy eligible individuals

(CBO Cost Estimate: 5 years = $0.7 billion; 10 years = $3.4 billion)

Starting in 2009, caps Part D out-of-pocket costs to 2.5 percent of annual income for individuals with income below 150 percent of the poverty level.

Section 221 — Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out of pocket threshold under Part D

(CBO Cost Estimate: 5 years = $0.1 billion; 10 years = $0.2 billion)

When Part D was established, it prevented drug spending by other government programs from counting toward the calculation of so-called true out-of-pocket costs (TrOOP), with one exception, state pharmaceutical assistance programs. The law excluded Indian Health Service (IHS) spending and federal regulators' interpretation of the MMA excluded AIDS Drug Assistance Programs (ADAPs) from being considered state pharmaceutical assistance programs. TrOOP spending is a critical issue because it determines when "catastrophic coverage" begins. Catastrophic coverage is the coverage level that individuals with exceptionally high drug costs ($3,850 in out-of-pocket costs in 2007) reach wherein their cost sharing falls from roughly 25% of drug costs to 5% of drug costs. Under current rules, ADAP and IHS spending does not count as out-of-pocket spending, so it does not help individuals reach the catastrophic coverage level. Because ADAP and IHS spending does not count toward TrOOP, these programs cannot stretch their limited funding as far as possible, despite unmet need and waiting lists for services. The House Mark will update the MMA to permit spending by ADAPs and IHS programs to count toward TrOOP.

Section 222 — Permitting mid-year changes in enrollment for formulary changes adversely impact an enrollee

(CBO Cost Estimate: 5 years = $0 billion; 10 years = $0 billion)

Beginning in 2009, permits Part D plan enrollees to change plans in the middle of the year if there is a “material” formulary change for a drug they have been prescribed.

Section 223 — Removal of exclusion of benzodiazepines from required coverage under the Medicare prescription drug program

(CBO Cost Estimate: 5 years = $0 billion; 10 years = $0.7 billion)

Under the Part D program, Part D plans are generally prohibited from covering drugs that are excludable under the Medicaid program. Excludable drugs include drugs perceived to be used for discretionary purposes. For example, excludable drugs include drugs when used for cosmetic purposes. However, the class of benzodiazepines are Medicaid excludable drugs that Part D plans usually cannot cover. Benzodiazepines are typically low-cost medications commonly used by individuals with mental illness. The CHAMP Act will ensure that individuals can access these drugs under Part D on par with other medication classes, starting on October 1, 2012.

Section 225 — Codification of special protections for six protected drug classifications

(CBO Cost Estimate: 5 years = $0 billion; 10 years = $0 billion)

Despite all of the challenges with the implementation of the Medicare Part D drug program, it could have been much worse. CMS implemented an essential consumer protection to require broad formulary access for drugs used by some of the most vulnerable populations. Instead of requiring Part D plans to cover only two drugs per class, CMS has required Part D plans to cover “all or substantially all” drugs in six key classes. Unfortunately, this protection is only granted on an annual basis, and every year it has the potential to be revoked. Drugs covered by the all or substantially all policy are: Anticonvulsants, Antidepressants, Antineoplastics, Antipsychotics, Antiretrovirals, and Immunosupressants. The CHAMP Act will codify into law that “all or substantially all” drugs must be covered in the six protected classes, and permits prior authorization or step therapy for new users of these drugs only as approved by the Secretary, except that prior authorization and step therapy may not be used for antiretrovirals and drugs on which individuals have already been stabilized.

TITLE IV (Medicare)

Section 401 — Equalizing payments between Medicare Advantage plans and fee-for-service Medicare

(CBO Cost Estimate: 5 years = -$50.4 billion; 10 years = -$157.1 billion
NOTE: Negative numbers indicate savings to the federal government.)

Phases out the overpayment to Medicare Advantage plans over four years from 2008-2011. The Medicare Advantage overpayment policy harms people who prefer to remain in the traditional Medicare program by artificially increasing their Part B premiums. This change would implement a critical recommendation from the Medicare Payment Advisory Commission (MedPAC). Also this section eliminates remaining spending authority in 2012 and 2013 under the regional PPO stabilization fund (so-called Medicare Advantage slush fund).

TITLE V (Medicare)

Section 502 — Payment for inpatient rehabilitation facility (IRF) services

(CBO Cost Estimate: 5 years = -$2.4 billion; 10 years = -$6.6 billion
NOTE: Negative numbers indicate savings to the federal government.)

Currently, CMS is phasing-in implementation of Medicare's "75% Rule", which requires that facilities maintain a certain percentage of patients with one or more of 13 specified conditions in order to retain their qualification as an inpatient rehabilitation hospital or unit. As a result, inpatient hospitals and units are often forced to deny access to individuals who meet the strict admission criteria, but who do not have one of the 13 conditions. Such individuals are often diverted into nursing homes and other less intensive settings. The CHAMP Act would freeze implementation of the 75% Rule at the 60% threshold indefinitely, as well as allow individuals' co-morbid conditions to count toward reaching the targeted percentage. While the bill includes some cost-savings payment provisions with respect to joint replacements that appear troubling, generally the CHAMP Act would help preserve access to inpatient rehabilitation for individuals in need of such intensive, coordinated rehabilitative care.

TITLE VI (Medicare)

Section 608 — Rental and purchase of power-driven wheelchairs

(CBO Cost Estimate: 5 years = -$0.6 billion; 10 years = -$0.9 billion
NOTE: Negative numbers indicate savings to the federal government.)

Prohibits immediate purchase of power-driven wheelchairs. This provision is OPPOSED by many people in the disability community, in that it would generate savings to pay for other provisions of the bill in a way that could be harmful to people with disabilities on Medicare who need access to power wheelchairs.

TITLE VIII (Medicaid)

Section 803 — Authority to continue providing adult day health services approved under a State Medicaid Plan

(CBO Cost Estimate: 5 years = $0.2 billion; 10 years = $0.2 billion)

In the past, the adult day services programs for people with intellectual and other developmental disabilities were covered under the Medicaid rehab option. In 1989, the Congress grandfathered those states which were then providing habilitation services, and imposed a moratorium on CMS to prevent disallowance of those states' coverage of habilitation until CMS publishes regulations to describe covered services.. Recently, the ability of states with these programs to continue operating them has been challenged by CMS when they have sought to make other changes to their Medicaid state plan. The CHAMP Act prohibits the Secretary of HHS from withholding, suspending, disallowing, or otherwise denying matching Medicaid payments to states for providing adult day services under their state plan that was approved during or before 1994.

Grandfathered States

The following states are believed to be the ones that were originally protected by the moratorium. Over time, some of these states have dropped their rehab option programs and have shifted coverage of some of these services to the home- and community-based services (HCBS) waiver program. However, it has been estimated that roughly eleven states continue to operate day habilitation programs under the rehab or clinic services option and need this provision to be able to continue operating their programs.

–Arkansas
–Connecticut
–District of Columbia
–Idaho
–Illinois
–Iowa
–Maine
–Massachusetts
–Michigan
–Missouri
–Mississippi
–New York
–Ohio
–Rhode Island
–Virginia
–Washington
–West Virginia

Section 804 — State option to protect community spouses of individuals with disabilities

(CBO Cost Estimate: 5 years = $0.2 billion; 10 years = $0.5 billion)

Clarifies that states have the option to protect the community spouses of individuals with disabilities who are participating in home- and community-based services programs

under section 1915 (including the HCBS option) and persons covered by 1115 waivers. This addresses a problem faced by New York in which, in a reversal of longstanding policy, CMS has told the state that they cannot extend spousal impoverishment protections to medically needy home- and community-based services (HCBS) waiver participants. This provision restores the previous policy and has implications for all states wishing to protect spouses of people receiving community-based long-term services.

Section 814 — Moratorium on certain payment restrictions

(CBO Cost Estimate: 5 years = $0.1 billion; 10 years = $0.1 billion)

Imposes a one year moratorium from the date of enactment that prohibits the Secretary from taking any action (through promulgation of regulation, issuance of regulatory guidance, use of federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to restrict coverage or payment for rehabilitation services, or school-based administration, transportation, or medical services if such restrictions are more restrictive in any aspect than those applied to such coverage or payment as of July 1, 2007.