Senate Finance Committee Presents Options for Healthcare Reform

On May 14, 2009, the Senate Finance Committee released a detailed paper on policy options for expanding healthcare coverage to the uninsured. It is the second of three papers that will guide the committee's markup of comprehensive health reform, expected to occur in June or July. What follows is a summary of the proposals issued by this committee—proposals that will likely form the basis for the Senate version of healthcare reform legislation.

The Finance Committee approach is designed to:

- **Achieve near-universal access** by subsidizing lower-income people to purchase coverage, raising income-eligibility thresholds in Medicaid for some covered groups and creating a Medicare buy-in for those who are 55-64 years old.
- **Give individuals a choice of plans—**including a public plan if that option is adopted**—** through a Health Insurance Exchange that has standardization and transparency requirements designed to help consumers make informed choices about their insurance.
- **Require private plans to offer a choice of four plans differing by the level of benefits—**high option, medium option, low option and lowest option—while requiring all to have certain benefits, including mental health and substance abuse coverage.
- **Include insurance-market reforms** that (1) eliminate discriminatory practices which make it difficult for people with pre-existing health conditions to obtain coverage at a fair price, (2) limit the amount insurers can vary premiums among individuals in a plan, and (3) prohibit lifetime or annual visit limits.
- **Improve public programs** so that people with limited means have health care coverage, whether through private insurance or public programs (Medicaid, SCHIP and Medicare).
- **Create a shared responsibility by** requiring individuals to have health coverage while employers and government also share the costs of universal coverage.
- **Improve health outcomes and achieve better value** for health spending by promoting preventive care, improving care for people with chronic conditions and adopting strategies to prevent chronic disease and promote wellness.
- **Make changes to long-term care,** including improvements to the home- and community-based waiver services in Medicaid that would focus on consumer needs and preferences and reduce unnecessary confinement in institutions.

- **Adopt strategies to address avoidable health disparities** that result in premature death and impairments for low-income and minority populations, as well as for people with disabilities.

Section 1: Insurance Market Reforms

Individuals who try to buy coverage for themselves may find that they are unable to obtain policies that cover their pre-existing conditions and ongoing health care needs at a price they can afford. To address barriers to purchasing insurance, the committee proposes to:

- Prohibit insurers from denying policies to individuals with pre-existing conditions;
- Require insurers to offer and renew policies to all individuals who want health coverage, regardless of health status; and
- Prohibit insurers from excluding pre-existing conditions from coverage.

To address barriers caused by high costs, the committee proposes to:

- Prohibit insurers from using health status as a basis for varying the amount that an individual is charged. Premium rates could vary based only on these factors: tobacco use, age and family composition, and would not be allowed to vary by more than a 7.5:1 ratio.
- Create a system for risk adjustment to compensate plans for serving a greater proportion of individuals with higher healthcare needs (such as older and sicker individuals) than other insurers.

These changes would benefit people with mental illnesses and chronic conditions in states that have not already adopted these or similar policies. They would end the practice of medical underwriting that runs counter to the very idea of insurance, which is to share risk over a large population.

People with serious mental illnesses often have very low incomes, however, and the market reforms may not put health coverage within their reach, even with tax credits and subsidies, if those subsidies are too low.

Health Insurance Exchange

The committee proposal would establish a Health Insurance Exchange, modeled on the Massachusetts Connector. The exchange would act as an intermediary to assist individuals in acquiring health insurance. As an alternative to a single exchange, the committee includes the option to create competing exchanges.

Each insurer would be required to offer a choice of four plans that differ by level of benefit: high, medium, low and lowest. All plans would be required to include a fairly broad range of benefits, including mental health and substance abuse coverage at parity, and prescription drugs.

Individuals and small businesses could choose to purchase plans through the exchange or go directly to an insurer or agent to purchase plans. Individual tax credits, however, would only be available to those purchasing through the exchange. All private insurers in the non-group and small-group market in a state, and the public-plan option if that is adopted, would be required to participate in the exchange.

Individuals and small employers with existing coverage could keep their current policies until the contract is changed, at which point their plan would need to meet the new federal benefit requirements.

To achieve organizational efficiencies, provide purchasers and individuals with consumer support and information, the federal government, through the exchange, could play an important role by establishing:

- Standardized practices and requirements for marketing, consumer information, enrollment, appeals and eligibility-determination processes; and
- Create a customer service call center and de-centralized locations for people to enroll in plans (e.g., Departments of Motor Vehicles, Social Security offices and emergency rooms).

Section II: Making Coverage Affordable

Benefit Options

All health insurance plans in the non-group and small-group market would be required to provide, at a minimum, a broad range of benefits, including preventive and primary care, emergency services, hospitalization, physician services, outpatient services, medical/surgical care, prescription drugs, and mental health and substance abuse services. Plans could not include lifetime limits on coverage or annual limits on any benefits. The requirement that plans include mental health and substance abuse services would be of great benefit to people with mental illnesses, as there is currently no federal requirement for health plans to cover mental health and substance abuse services. (The federal parity requirements are only applicable to plans that choose to cover mental health and substance abuse conditions).

To encourage preventive care, the committee proposes eliminating any cost-sharing (i.e., deductibles and co-payments) or charging only nominal amounts for these services. Since few people with mental illnesses currently obtain medical screening and preventive health care on a regular basis, removing financial barriers could be very significant and could help avert avoidable premature chronic illness or death.

Low-Income Tax Credits

To help address affordability, a tax credit is proposed for low-income taxpayers to purchase health insurance through the Health Insurance Exchange. Refundable and paid in advance, the tax credit would be available to those with modified adjusted household gross income ("MAGI") between 100 and 400 percent of the federal poverty level (FPL) on a graduated basis. The subsidized coverage would be divided into three levels: high benefit option for

those between 100 and 200 percent of the FPL; medium benefit option, between 200 and 300 percent of the FPL; and low benefit option, between 300 and 400 percent of the FPL. Individuals would be able to buy a higher level of coverage but they would pay the difference between their subsidy and the premium.

Small Business Tax Credits

Small employers would receive a tax credit for the purchase of employer-provided health insurance. It would be provided for each full-time employee covered and would be equal to 50 percent of the average total premium cost paid by employers for coverage in the employer's state. The full amount of the credit would be available to the smallest employers. The credit would be available only to offset actual tax liability.

Section III: Public Health Insurance Option

Three alternatives for a public health insurance option are proposed, along with the option not to include a public insurance option. The committee will choose between these approaches at a later date.

Approach 1: Modeled on Medicare, it would have the same rating requirements, delivery system reforms, eligibility rules, risk adjustment and income-related tax credits as other plans offered through the exchange. All Medicare providers would be required to participate. This approach has some organizational economies since the Medicare system is already in place and because some requirements for private health plans that are necessary to protect the public—like reserves and solvency requirements—would not be necessary.

Approach 2: This option would be administered through multiple, regional, third-party administrators that would establish networks of participating providers and negotiate payments for providers. Plans would be required to adhere to solvency requirements. This approach is similar to self-insured plans and some state Medicaid programs, where the plan sponsor bears the insurance risk but hires a third party to administer the plan and pay claims.

Approach 3: This approach would allow each state to choose whether to have a public option and how to run it. Under this scenario, for example, a state could opt to allow individuals to purchase state-employee health coverage.

Section IV: Role of Public Programs in Coverage

As part of healthcare reform, the committee proposes changes to federal Medicaid law that would:

- Require states to cover all parents, pregnant women and children in households up to 150 percent of FPL (or other some other level yet to be determined).
- Require the federal government to assume all expenditures through 2015 in order to ease the burden on the states for the cost of newly eligible people. After that, states

assume responsibility for their share of Medicaid for newly eligible individuals on a phased-in basis over a five-year period.

- Require states to set provider payments so that they do not fall below a given percent (e.g., 80 percent of Medicare reimbursement rates) in order to ensure provider participation in Medicaid.

The committee also offers three approaches for Medicaid expansions:

Approach 1 would expand Medicaid coverage through the current Medicaid structures. Individuals who are eligible for Medicaid would be deemed ineligible for tax credits in the Health Insurance Exchange. State Medicaid programs would have the option, or would be required, to provide premium assistance to Medicaid-eligible individuals who have employer-sponsored insurance. Requiring premium assistance would decrease the likelihood that these Medicaid-eligible individuals will drop their employer insurance.

Approach 2 would increase coverage through the exchange. People with disabilities, dual eligibles and other special-needs populations would continue to receive coverage through existing state Medicaid program structures. Children, pregnant women, parents and childless adults would access coverage through low-option insurance plans in the exchange. Premiums for Medicaid-eligible populations in the exchange would be fully subsidized. The state Medicaid program would reimburse insurers for any additional costs of Medicaid cost-sharing and premium requirements and seek reimbursement from the federal government, consistent with existing law on Medicaid match. States would have to meet Medicaid legal requirements (such as EPSDT, services provided in education settings and transportation).

Other options under this approach include:

- Providing eligible populations with a choice of high option plans through the exchange and allowing states to choose between this option and existing Medicaid;
- Allowing a state to limit coverage through the exchange to non-pregnant, childless adults;
- Allowing states to create or act as a Heath Insurance Exchange plan; and
- Allowing states to create Medicaid-only plans to participate in the exchange.

Approach 3 would provide coverage through both the current Medicaid structure and the exchange.

- Children, parents and pregnant women would receive Medicaid in its current structure.
- Childless adults below 115 percent FPL would be eligible for federal tax credits to purchase coverage—either through the exchange or through a state's Medicaid program. The public coverage alternative would treat the tax credit as a "voucher" that could be used to buy into the state's Medicaid program. Recipients would get all of the same benefits and protections that Medicaid offers to parents enrolled in the program. The private-coverage option would be achieved by subsidizing the full amount of the premium of a qualified exchange plan. Because individuals with low incomes and high healthcare needs are deterred from seeking services because of cost-sharing requirements, Medicaid limits on cost-sharing would be needed. Plans would also be required to include safety-net providers (like public hospitals and community health centers) in their networks.

The Children's Health Insurance Program (SCHIP) The Committee envisions that once the exchange is fully operational, the need for CHIP as it is currently structured will diminish. States would be prohibited from lowering household income limits for currently eligible children until the end of the current authorization period for CHIP (September 2013) or until the Exchange is fully operational, whichever is later. After that point:

- CHIP income eligibility would be increased to 275 percent of FPL and income would be based on modified adjusted gross income.
- CHIP enrollees would obtain their primary coverage through the exchange.
- State CHIP programs would provide services that exceed or fall outside the requirement of exchange coverage (e.g., EPSDT).
- Cost-sharing would be limited to Medicaid's cost-sharing rules.
- For children in family plans in the exchange, the portion of the premium that goes toward coverage of the CHIP-eligible child would be fully subsidized.

Variations for this option include allowing states to create or act as an exchange plan and allowing states to create Medicaid-only plans to participate in the exchange.

Other Options for Improving Medicaid and CHIP

Other proposals from the committee include changes to Medicaid services rules:

- Make prescription drugs a mandatory benefit under Medicaid.
- Change Medicaid law so that smoking-cessation drugs, barbiturates and benzodiazepines are not excluded from federal Medicaid coverage.

Changes to Medicaid-eligibility rules:

- Require states to provide 12 months of continuous eligibility for anyone who becomes eligible for Medicaid.
- Simplify enrollment and eliminate the state option to rely on face-to-face interviews and impose assets tests when determining eligibility.
- Develop a process for the coordination of enrollment, retention and coverage among states to prevent gaps in coverage for those who move to another state.
- Establish a Medicaid enrollment website to promote enrollment in Medicaid if an eligible person applies for tax credits through the exchange website.
- Permit states to enroll and re-determine Medicaid eligibility for all Medicaid beneficiaries at Disproportionate Share Hospitals, Federally Qualified Health Centers (FQHCs) and at any of the state's offices of the Department of Motor Vehicles.

Changes designed to improve quality:

- Establish quality measures for all Medicaid populations.
- Require prior authorization for expensive band name drugs when generic equivalents are available and not medically justified.
- Create a new CMS office for coordinating benefits for dual eligibles. This office would lead efforts to align Medicare and Medicaid financing, administration, oversight rules and policies, provide outreach and training, and develop strategies to improve care coordination.

Changes to make certain state Medicaid processes more transparent:

- Adopt new statutory requirements to give the public timely access to Medicaid-waiver and state-plan amendment proposals and the opportunity to comment on them before they are approved.

Increases in federal match for the states under certain circumstances:

- Automatically increase the Medicaid FMAP during periods of a national economic downturn occurring after January 1, 2012.

Medicare—Reduction or Phase-out of Disability Waiting Period

Four options were identified for changing the current 24-month waiting period before individuals who qualify for Social Security Disability Insurance (SSDI) become eligible for Medicare.

Approach 1, while not eliminating the waiting period, reduces it to 12 months beginning in October 2009.

Approach 2 reduces the 24-month waiting period by one month every quarter beginning in October 2009 until the waiting period is eliminated in July 2015.

Approach 3 phases out the waiting period based on the date of the individual's disability. After April 1, 2011, the waiting period would be eliminated.

Approach 4 retains the 24-month waiting period for individuals with access to private health insurance coverage (not including COBRA) that meets or exceeds a specified actuarial standard. For others, the waiting period would be phased out according to one of the schedules described above.

Medicare Buy-In

People ages 55 through 64 who do not have employer-sponsored insurance (ESI) or Medicaid coverage could voluntarily enroll in Medicare beginning January 1, 2011. After the initial enrollment period, enrollment would also be allowed for people of those ages who lose their employer coverage and people who turn 55. The option would end once the exchange is up and running, though people who are already enrolled could stay in Medicare.

Enrollees would pay a premium equal to the expected average cost of benefits for Medicare participants plus an administrative fee of five percent. If the actual costs incurred by Medicare exceed the premiums collected for a particular cohort of enrollees, individuals in that cohort would be required to pay an additional premium once they reach normal Medicare eligibility age and continue to do so until they turn 85. Conversely, if the actual costs plus administrative fees were less than the premiums collected for a particular cohort, individuals in that cohort would receive a rebate on their Medicare premiums once they reach normal eligibility age.

Section V: Shared Responsibility

At this time there is no federal law that requires individuals to obtain health insurance. Massachusetts is currently the only state requiring individuals to have insurance that meets minimum state standards, with penalties for those who are not in compliance. The committee proposes a similar approach to encourage the acquisition and retention of health insurance coverage nationwide.
Effective January 1, 2013, individuals would be required to obtain health insurance. Open enrollment periods would be created and individuals would be required to purchase coverage meeting minimum standards through the individual market or any grandfathered plan, or in the group market. To ensure compliance, taxpayers and insurers would be required to report on annual tax returns the months during which they maintained minimum coverage The consequence for remaining uninsured would be a phased-in excise tax. Exemptions could be applied for under three circumstances:

- if the lowest cost option exceeds 10 percent of an individual's income;
- if the individual's household income is below 100 percent of poverty; or
- hardship.

The initial enrollment period would last three months and special enrollment periods would be allowed for qualifying events (such as marriage or birth) and those consistent with enrollment periods allowed under Medicare Part D. An annual open-enrollment period would also be offered.

Another option is to offer guaranteed coverage without limits on pre-existing conditions during a 45-day open-enrollment period. For those who do not elect to enroll during this 45-day period, insurance carriers could charge higher premiums and exclude pre-existing conditions for up to nine months. An additional open-enrollment period could also be provided, with the same conditions. Enrollees who are in plans could only change plans during the yearly enrollment period and at the time of special changes that are allowed under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272).

The committee also proposes changes to current law regarding employer-sponsored health insurance. One option is a pay or play system, in which all employers that have more than $500,000 in total payroll per year must offer health insurance coverage to full-time employees (30+ hours) and contribute 50 percent of the premium or pay an assessment in the form of an excise tax. Plans offered must meet minimum standards and include preventive services. Employees who accept coverage offered by their employer will receive a tax exclusion for employer-provided health insurance, but cannot receive the income-based tax credit. Employees who opt out are potentially eligible for income-based tax credit.

Workers would pay into the Health Insurance Exchange and be subsidized in the same way as others seeking coverage. The employer's contribution is contributed to the exchange and should not be treated as taxable income to the worker. States would continue to be required to offer Medicaid premium assistance.

The committee proposes an additional option in which employers are not required to pay or play, but would still require coverage for individuals.

Section VI: Options to Improve Access to Preventive Services and Encourage Healthy Lifestyles

Promotion of Prevention and Wellness in Medicare and Incentives to Utilize Preventive Services and Engage in Healthy Behaviors

Medicare currently covers a one-time initial preventive physical examination and specific preventive services. The Committee recommends expansion of these benefits to allow a personalized prevention plan for all enrollees every five years. Such a plan would include a comprehensive health-risk assessment and coverage of a subsequent visit to a qualified health professional to develop a personalized prevention plan. No co-payment or deductible would be applied to either the health-risk assessment or personalized prevention-plan appointment.

Medicare currently covers certain preventive services and has reduced cost-sharing requirements for many of these services to encourage elderly adults and people with disabilities to utilize preventive services. The committee proposes further limitations or removal of beneficiary cost-sharing for Medicare preventive services rated A or B by the United States Preventive Services Task Force (USPSTF), as well as incentives to Medicare beneficiaries who utilize certain preventive services.

The committee proposes to give the Secretary of Health and Human Services the authority to eliminate Medicare coverage for preventive services that are not evidence-based, unless deemed medically necessary by a prescribing physician.

Promotion of Prevention and Wellness in Medicaid

Access to Preventive Services for Eligible Adults Under Medicaid, states have the option of covering preventive and screening services for adults with the exception of a handful of services outlined in section 1905(a)(13).

The committee proposes to clarify the definition of "screening and preventive" services for adults to include services rated A or B by the USPSTF and immunizations recommended by the Advisory Committee on Immunization Practices. A state electing to provide coverage for all approved preventive services would receive a 1-percent increase in the federal share (FMAP) for those services. States would be required to cover with no cost-sharing comprehensive tobacco-cessation services for pregnant women.

Incentives to Utilize Preventive Services and Encourage Healthy Behaviors: Traditional Medicaid allows states to have cost-sharing requirements except for certain specific services. The committee proposes to remove or limit cost-sharing for clinical preventive services rated A or B by the USPSTF. The committee would also allow states to develop incentives for Medicaid beneficiaries who successfully complete certain evidence-based and comprehensive prevention programs.

Options to Prevent Chronic Disease and Encourage Healthy Lifestyles

"Right Choices" Grants and Prevention and Wellness Innovation Grants: The Committee proposes grants to states to provide access to certain evidence-based primary preventive services, as well as competitive grant programs that promote health and human service integration and improve coordination of care and access to and integration of preventive services to improve health and wellness outcomes. Grants would allow states to:

- Promote team-based care through the creation of integrated delivery systems that include multidisciplinary community health teams;
- Provide individualized plans for health and human service needs of low-income beneficiaries; and
- Develop other innovative approaches that meet the goals and objectives of the grant.

Evaluations of best practices would be completed upon the conclusion of the grant.

Employer Wellness Credits: Employers may deduct the expense of employer-provided wellness programs for employees under section 162 of the Internal Revenue Code. The committee proposes to establish a non-refundable tax credit for 50 percent of the costs of a "qualified wellness program" paid by the employer during a taxable year. Certain restrictions on per-employee costs of the program would apply. Qualified wellness programs would need to meet certain criteria and include specific components.

Section VII: Long-Term Care Services and Supports

Under the Medicaid Home and Community Based Services (HCBS) waiver (Section 1915(c) of the Social Security Act), states are given the option to offer a range of home- and community-based services to certain populations who would otherwise be served in more restrictive institutional settings. States may offer services such as day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services for individuals with chronic mental illness. Additional services may be offered if approved by the Secretary of HHS, but cannot cover room and board. Average expenditures for waiver participants may not exceed the average expenditures that states would be spending for these beneficiaries in more restrictive settings. States have generally not used this waiver for peope with mental illnesses (three states have adult waivers for people with serious mental illnesses and eight have waivers for children with serious emotional disturbance).

Under the Deficit Reduction Act (DRA; P.L. 109-171), states have the option (under Section 1915(i) of Medicaid law) to provide home- and community-based services without a waiver. This HCBS state plan option allows states to select one or more services from a limited list of services in the law.

The committee proposes allowing states to request approval to offer additional services under section 1915(i), as is now allowed for HCBS under a waiver.

Eligibility for Home- and Community-Based Services

Individuals are eligible for section 1915(c) HBCS waivers if they require a level of care equal to that which would otherwise be offered in restrictive settings and they are among a waiver's targeted population group. Individuals who are already enrolled in Medicaid and meet the above criteria may enroll if space is available, and states have an option to include individuals with slightly higher incomes. Under the state-plan option, states can establish less-stringent needs-based criteria that take into account an individual's support needs and ability to perform activities necessary to independent living. However, eligibility for state-plan services can only be extended to current Medicaid enrollees whose income does not exceed 150 percent of the federal poverty level.

The committee proposes to eliminate the existing institutional level-of-care requirement for section 1915 (c) waiver services, as well as eliminating the exclusion of individuals with income above 150 percent of poverty from eligibility for 1915(i) state-plan option services.

The committee proposal gives states the option to extend eligibility for section 1915(i) state plan services, and full Medicaid benefits, to individuals with incomes up to a state-determined level that is no greater than 300 percent of the maximum Supplemental Security Income payment applicable to individuals living at home.

Increase Access to Medicaid Home- and Community-Based Services

Currently, both sections 1915(c) and 1915(i) allow enrollment caps. There are no enrollment caps on other essential Medicaid state plan services. Section 1915(c) allows states to put enrollment caps on each waiver, and section 1915(i) allows states to limit participation to a projected number of enrollees. Section 1915(i) also allows states to modify their needs-based criteria if enrollment exceeds state projections without seeking prior approval from the Secretary, assuming certain conditions are met. The committee proposes options to increase access to waiver services:

- Increase the number of individuals under the cap whom states would be required to enroll in the waiver or state plan option, or both; or
- Prohibit the use of waiting lists by states to prevent access to HCBS by eligible beneficiaries.

Increase Federal Match for Medicaid HCBS

The Committee proposes to increase the federal Medicaid match to states for most Medicaid services (including HCBS), by one percent.

Medicaid Resources/Asset Test

States currently set criteria for the maximum amount of countable assets or resources a person may have in order to qualify for Medicaid. SSI program rules are typically followed for most types of assets, although states may use more liberal standards (using section 1902(r)(2) of the SSA) to allow access to Medicaid by individuals with higher levels of assets.

The committee proposes allowing states to let individuals applying for Medicaid HCBS to retain higher levels of assets, as well as continuing to allow states to use section 1902(r)(2) as mentioned above.

Long-Term Care Grants Program

There are currently many grants programs that aim to provide home- and community-based long-term care services. These programs include:

- *The Real Choice Systems Change Grant Initiative*, which awards grants annually to assist states with the expansion of community-based LTC options.
- *Aging and Disability Resource Centers*, a collaborative effort that provides grants to states to support efforts to streamline information and access to LTC services.
- *Informal Caregivers*, which provides direct support and assistance through information and referral assistance, respite care, and training and support for informal caregivers who are primarily caring for elderly individuals.
- *Prevention and Health Promotion*, which supports grantees who utilize physical activity, fall prevention, nutrition and diet, and depression/substance use interventions.
- *The Green House Model*, which provides skilled long-term nursing care for the elderly in a small group home.

The committee proposes making grants awarded by the Secretary of HHS available to such programs to facilitate the delivery of HCBS.

Money Follows the Person Rebalancing Demonstration

Established by the Deficit Reduction Act of 2005, The Money Follows the Person Rebalancing Demonstration authorizes grants to states to facilitate provision of HCB services for individuals who are institutionalized. The committee recommends extending this demonstration through September 30, 2016. Many of the grants awarded to date include people with mental illnesses in their target populations.

Section VIII: Options to Address Health Disparities

Data Collection

There are currently no federal regulations in place to ensure that federal data collection efforts produce reliable, statistically significant estimates of racial and ethnic disparities in quality of and access to health care. The committee includes a number of recommendations to improve federally funded data systems so as to collect data on race and ethnicity.

The primary source of racial and ethnic data on Medicare beneficiaries is the Medicare enrollment database. The form currently includes only five racial categories, and response to these categories is voluntary. The committee proposes requiring SSA to collect race, ethnicity and language data on Medicare enrollees.

The committee also proposes the establishment of uniform data collection categories using OMB Directive 15 standards and policy for aggregation and allocation of subgroups to be applied to Medicaid and CMS and the collection of language data on CHIP enrollees and parents.

The committee further proposes that collection of access and treatment data for individuals with disabilities be required by CMS, including where primary care services are accessed, the number of providers with accessible facilities and equipment, access to intensive care units, and quality reporting requirements that include provisions to collect data on patients with disabilities by disability type.

Elimination of Five-Year Waiting Period for Non-Pregnant Adults

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows states meeting certain criteria to waive the five-year ban on coverage to pregnant immigrant women and children lawfully residing in the United States, provided they are otherwise eligible for such coverage. The committee proposes to apply this provision to non-pregnant adults.