



National **MCH** Workforce
Development Center
Advancing Health Reform Implementation

January 2015



THE AFFORDABLE CARE ACT: A WORKING GUIDE FOR MCH PROFESSIONALS





Access to Care



About the National MCH Workforce Development Center and Access to Care Core

The National MCH Workforce Development Center, in cooperation with the Maternal and Child Health Bureau, and in partnership with the Association of Maternal & Child Health Programs and national experts in maternal and child health innovation, offers state and territorial Title V leaders training, collaborative learning, coaching and consultation in implementing health reform using a variety of learning platforms.

Staff from the Association of Maternal & Child Health Programs (AMCHP, <http://www.amchp.org>) the Catalyst Center (<http://www.catalystctr.org>) and the National Academy for State Health Policy (NASHP, <http://www.nashp.org>) comprise the Access to Care Core of the National MCH Workforce Development Center. The Access to Care Core provides training support and helps foster partnerships between state MCH programs and Medicaid and CHIP programs, insurance agencies, and Marketplaces to improve access for MCH populations.

Authors

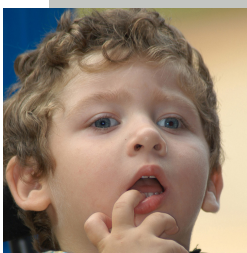
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INTRODUCTION TO THIS GUIDE

The Affordable Care Act (ACA) was signed into law on March 23, 2010. Since then, key features of the national health care reform law have been implemented over time. In January 2014, major expansions of public and private health insurance went into effect. Moving forward, additional provisions will be phased in and other provisions, such as the Essential Health Benefits, will be revisited.

In keeping with the purpose of the National MCH Workforce Development Center to support workforce development for State Title V program leaders, staff, and future maternal and child health (MCH) professionals, the Access to Care Core has prepared this guide, which consists of the six modules listed on the right side of this page.

The first three modules provide an overview of the ACA and its implications; the final three modules address new and expanded ways individuals can access health care coverage and provide an explanation of the covered services.

Because each state and territory had some choice in how to implement the ACA, there is state-to-state variability in how the law affects MCH populations. These modules provide the building blocks for current and future MCH professionals to learn the basics of the law. Each module includes a Test Your Knowledge quiz to help clarify what has been learned, a Find Out in Your State section with questions to delve deeper into the specifics for your state or territory, and resources for further exploration.

With this knowledge, the National MCH Workforce Development Center hopes to enhance the capacity of the MCH workforce to:

- Foster partnerships between state MCH programs and Medicaid, Children's Health Insurance Program (CHIP), insurance agencies, and Marketplaces to improve access to care for MCH populations
- Lead and/or engage in ongoing ACA implementation and public health transformation
- Help women, children and youth, including children and youth with special health care needs, and their families navigate the health system in an era of national health reform

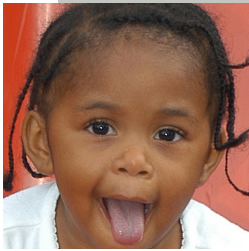
What's Inside

This guide consists of six modules that provide:

- An introduction to the national health care reform law (page 7)
- A glossary of terms related to health care financing and new terms which are specific to the ACA (page 13)
- An explanation of the new consumer protections (page 19)
- Pathways to coverage (page 23)
- The Marketplace (page 29), and
- Benefits (page 35)

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INTRODUCTION TO THE AFFORDABLE CARE ACT (ACA)

Overview & History of the Patient Protection and Affordable Care Act (ACA)

Prior to the passage of the Patient Protection and Affordable Care Act (ACA) there were over 47 million uninsured non-elderly individuals in the United States.ⁱ Additionally, the U.S. health care system faced many complex challenges related to access to care as well as costs and quality of care. When compared to other developed nations, the U.S. spends the most on health care per capita, but fails to produce better health outcomes. In this comparison, the U.S. ranked last in measures including access, patient safety, efficiency, and equity.ⁱⁱ With the urgent need to reduce spending, increase health insurance coverage and improve health care outcomes in mind, health care reform became a policy priority for President Barack Obama. The legislative details of the law were crafted jointly by the House and Senate dating back to early 2009.ⁱⁱⁱ After several iterations, the ACA was signed into law on March 23, 2010 (Public Law 111-148).

The Affordable Care Act was signed into law on March 23, 2010. Prior to the ACA, there were over 47 million uninsured non-elderly individuals in the United States.ⁱ

Initial Challenges to the Affordable Care Act

Immediately following the ACA's passage in March 2010, a lawsuit was filed challenging the constitutionality of two key components of the law: the individual shared responsibility provision, also known as the individual mandate, which requires everyone who can afford health insurance to purchase it or face a penalty, and the universal, mandatory expansion of Medicaid eligibility to all individuals with income under 133% of the Federal Poverty Level (FPL). The lawsuit, filed by several states and the National Federation of Independent Businesses, went before the Supreme Court two years later as *National Federation of Independent Business (NFIB) v. Sebelius*. The Supreme Court of the United States (SCOTUS) issued its ruling on June 28, 2012.

Supreme Court Ruling on the Individual Mandate

Under the individual mandate, the ACA requires that everyone carry health insurance coverage that is deemed affordable and meets minimum requirements. Failure to comply with the individual mandate can result in a

ⁱ Kaiser Family Foundation, Key Facts About the Uninsured Population, <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>, (September 26, 2013)

ⁱⁱ The Commonwealth Fund, Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update, <http://www.commonwealthfund.org/publications/fund-reports/2010/jun/mirror-mirror-update>, (June 23, 2010)

ⁱⁱⁱ Cannan, John, "A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History," Law Library Journal 105:2, <http://www.aallnet.org/main-menu/publications/llj-archives/vol-105/no-2/2013-7.pdf>, (July 2013)

INTRODUCTION TO THE ACA

financial penalty in which the greater of \$95 or 1 percent of income is assessed on 2014 individual tax returns, \$325 or 2 percent of income in 2015, and then increasing yearly to a maximum amount equal to the least expensive level health plans in the state health exchanges for that year.

In the *NFIB v. Sebelius* Supreme Court case, the plaintiffs argued that Congress does not have the power to require the majority of Americans to purchase health insurance. On this matter, SCOTUS recognized that the individual mandate functions similarly to a tax, in that it is collected by the IRS and may produce some revenue for the government. Therefore, the court ruled in favor (5-4) of the individual mandate noting that it does not exceed Congress's constitutional power to levy taxes.

Supreme Court Ruling on Medicaid Expansion

Medicaid is administered by the states and funded jointly by the states and the federal government. As such, the federal government gives states the flexibility to set eligibility thresholds that will cover certain segments of the population. Prior to the ACA, the groups mandated for coverage included low-income children and their parents, low-income pregnant women, low-income elderly individuals, and individuals living with disabilities. These groups had to meet certain income requirements based on family size and income in relation to the FPL.

The ACA sought to expand Medicaid's mandatory coverage by requiring states to cover all individuals under 65 whose household income was below 133 percent of the FPL. This would mean that previously ineligible populations, for example adults who were not disabled, and those who did not have dependent children, could now apply to gain coverage through the Medicaid program. If states expanded Medicaid, the federal government would fund 100 percent of the expansion through 2016 and gradually decrease thereafter, to 90 percent. Failure to meet the new mandatory Medicaid coverage could result in withholding of *all* Medicaid funding for the state, as enforced by the Secretary of Health and Human Services (HHS). In its June 2012 ruling, SCOTUS found that the Medicaid expansion was unconstitutionally coercive because states did not receive appropriate notice to consent to the expansion and the

HHS secretary had the power to withhold all Medicaid funds to the state. The Supreme Court found a solution to this violation by restricting the Secretary's enforcement authority, which means that the Medicaid expansion is now optional for the states. Overall programmatic changes to Medicaid as a result of the ACA remain intact.

Key Provisions of the ACA

The ACA is an historic law aimed at addressing key challenges facing the U.S. health care system including:^{iv}

Increasing access to health care by:

- Providing enhanced federal funding to support states opting to expanding Medicaid to all non-elderly individuals at or below 133% of the FPL
- Creating state-based health insurance Marketplaces (Exchanges) that offer subsidized health insurance plans
- Extending coverage for young adults through age 26
- Implementing an individual shared responsibility provision (individual mandate). This requires most¹ individuals to acquire a minimum level of health care coverage for themselves and their legal dependents
- Incentivizing employment in primary care (physicians, nurses, physician assistants) through scholarships and loan repayment
- Strengthening and expanding support for community health centers, school-based health centers, and workplace wellness programs
- Providing higher reimbursements to rural health care providers
- Creating essential health benefits, which requires all new insurance plans and existing plans offered through marketplaces to cover the following benefits: ambulatory patient services (outpatient care without admission to hospital); emergency services; hospitalization, maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drug coverage; rehabilitative and habilitative services/devices; laboratory services; prevention and

^{iv} U.S. Department of Health and Human Services, Key Features of the Affordable Care Act by Year, <http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html>

¹ Exemptions may apply to individuals in certain religious groups, individuals that are undocumented, or those that are incarcerated.

wellness services; chronic disease management; and pediatric services (including oral and vision care).^v

Improving quality of health care by:

- Requiring reporting on health disparities, which will be used to reduce existing disparities
- Promoting integrated health care systems (i.e., Accountable Care Organizations)
- Establishing the Center for Medicare and Medicaid Innovation to analyze and assess strategies for quality improvement and health care cost containment
- Supporting patient-centered medical homes (PCMH)
- Creating value-based purchasing that ties physician and hospital payments to improved health outcomes

Protecting consumer rights by:

- Prohibiting discrimination based on pre-existing conditions and gender
- Eliminating annual dollar limits on coverage of essential benefits
- Making it illegal for insurance companies to rescind coverage based on an inadvertent omission or technical mistake in the application
- Creating the 80/20 rule requiring insurers to spend 80% of premiums (or 85% depending on size of company) on health care services and quality improvement

Lowering health care costs by:

- Reducing paperwork/administrative costs through electronic health records
- Promoting preventive health care services through investment in the Prevention and Public Health Fund
- Bundling payments based on one episode of care
- Investing in demonstration projects that test new models of care designed to improve outcomes and lower costs

The ACA and Implications for the MCH Population

The majority of the provisions of the ACA impact the MCH population of women and infants, children and youth with special health care needs (CYSHCN), and children and adolescents. Some examples:

- The ACA ends gender rating that previously allowed insurance companies to charge women higher premiums than men for the same insurance plans.
- The ban on denial of coverage due to pre-existing conditions offers protections for the CYSHCN population.
- Young adults will gain access to coverage through their parents' health care plans up to age 26.
- Youth aging out of foster care can retain Medicaid benefits to age 26.
- CYSHCN on Medicaid or CHIP may receive both hospice care and care related to their illness simultaneously.
- Essential health benefits apply to all plans sold on the marketplaces or all new non-grandfathered plans sold outside of the marketplaces. Essential health benefits include maternal and newborn care and pediatric dental and vision care for children.
- In the states that are moving forward with Medicaid expansion, women who were previously ineligible may now gain coverage.
- There are no co-payments for preventive care. New insurance plans are required to cover screening for breast and/or cervical cancer, well woman exams, screenings/vaccines for HPV and/or sexually transmitted infections, and screening for domestic violence.^{vi}
- Coverage for reproductive health services, including contraception and abortions, is variable and subject to change.

^v U.S. Department of Health and Human Services, What Marketplace Health Insurance Covers, <https://www.healthcare.gov/what-does-marketplace-health-insurance-cover/>

^{vi} Healthy Generations, The Affordable Care Act: Goals and Mechanisms, http://www.epi.umn.edu/mch/wp-content/uploads/2012/05/HG_Fall20132.pdf, (Fall 2013)

INTRODUCTION TO THE ACA

- Maintenance of Effort (MOE) stipulations, in effect until 2019, prohibit states from changing the income eligibility criteria of Medicaid and CHIP that were in place when the ACA took effect.
- In 2010, 1.5 billion dollars in initial funding for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) was authorized under the ACA.^{vii}
- Seventy-five million dollars is provided annually between 2010-2014 for the Personal Responsibility Education Program (PREP) to provide comprehensive sexual education to youth.
- Reinstated funding—\$50 million annually between 2010-2014—for the Title V abstinence-only education program

^{vii}<http://mchb.hrsa.gov/programs/homevisiting/homevisiting.pdf>

Test your knowledge

1. Under the ACA, new insurance plans will not charge co-pays for preventive care. Which of the following is considered a preventive service?
 - a. Screening for domestic violence
 - b. Screening for HPV or sexually transmitted infections
 - c. Screening for breast and/or cervical cancer
 - d. All of the above
2. True or False: Under certain circumstances, an individual may be exempt from the individual mandate.
3. Which of the following is false?
 - a. The ACA contains several provisions to increase access to care.
 - b. The ACA seeks payment reform by promoting a fee for service reimbursement model.
 - c. The ACA prohibits discrimination based on pre-existing conditions.
 - d. The ACA is incentivizing workforce development in primary care.



Find Out in Your State

1. What is the status of contraceptive coverage services in your state? Are new insurance plans covering these services? Are pre-ACA insurance plans expanding coverage for these services?
2. What services are covered in your state's essential health benefit benchmark plan? Are there any gaps in coverage of services deemed important for your state's population?
3. Is your state using ACA funds to develop and expand community health programs? If yes, how can MCH populations better utilize those services?

Test Your Knowledge Answers: 1. d
2. True
3. b

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GLOSSARY OF KEY HEALTH INSURANCE CONCEPTS

Overview

A fundamental first step in accessing health care in the United States is having a way to pay for it, either out of pocket, or through some form of private or public health insurance coverage. Since health care costs are often unpredictable as well as prohibitively expensive, health insurance is vital. The health insurance and coverage system is made up of a dizzying array of individual components, each with its own terminology. The Patient Protection and Affordable Care Act of 2010 (ACA) built new coverage options and expanded on the existing health care system. This created a number of new concepts and vocabulary words. The following describes several key health insurance concepts that are important in understanding aspects of the law and the potential impact of health care reform on maternal and child health populations.

Cost-Related Concepts

Premiums

A premium is the cost of an insurance policy. Premium payments are usually made on a regular schedule and for a fixed amount. A health insurance premium can be paid by an individual, or in full or part by an employer on behalf of an employee. They are not considered cost-sharing.

Cost-sharing and its Implications

Whether an individual has private health insurance (usually through an employer) or a public benefit program (Medicaid, Medicare, or the Children's Health Insurance Program (CHIP)), the individual usually has to share the cost of each health care service with the payer covering the bill. Cost-sharing generally includes deductibles, co-insurance, or co-payments. Private insurance cost-sharing comes in a variety of forms and at varying amounts. Typically, the more an individual pays in premiums, the lower the cost-sharing requirements. Insurance companies contract with specific providers (individuals, practices, hospitals, etc.) and create a list of them for their enrollees. These providers are considered "in-network." Using an out of network provider usually means

higher cost-sharing, if the service is covered at all. There are strict federal limits on cost-sharing that public benefit programs can require of enrollees.

Cost-sharing Types

- **Deductibles:** A deductible is the amount an individual has to pay out-of-pocket before the insurer begins to pay its share for covered health care services. A plan or policy with a \$1,000 deductible means the insured individual (or family) has to pay the first \$1,000 for allowable health care services before the insurer reimburses any costs. The amount of the deductible varies, depending on the type of plan. Depending on the type of health care service, there may not be a deductible (such as for preventive services). Conversely, some out-of-pocket costs that individuals pay do not apply towards the deductible. This includes services that the plan does not cover or that are provided by an out-of-network provider.
- **Co-insurance:** Unlike premiums, which are typically paid on a regular schedule and don't vary month-to-month, co-insurance is based on a percentage of the allowable cost of a specific health care service. A typical co-insurance split is 80/20, although this varies. An 80/20 split means the insurer will pay 80 percent of the cost it has defined as appropriate (or "allowable") for a health care service, while the insured individual pays 20 percent. If a plan includes a deductible, the individual has to pay the deductible before the insurer begins paying. For example, once the deductible is met, if a doctor visit costs \$200—and the visit is an allowable service under an individual's plan—the insurer will pay \$160 (80 percent) and the individual will pay \$40 (20 percent).
- **Co-payments or co-pays:** A co-pay is a set amount that an individual has to pay to use a particular kind of health service, regardless of the total cost. Most clinicians collect co-pays at the time of service. Typically, a co-pay for a visit with a primary care doctor ranges from \$15 to \$25. Co-pays are often higher for specialty providers. Generally, co-pays for name brand prescription medications are higher than for generic brands.

GLOSSARY OF KEY HEALTH INSURANCE CONCEPTS

Eligibility Determination Concepts

- **Federal Poverty Level (FPL):** Every year, the U.S. Department of Health and Human Services (HHS) issues updated guidelines on the Federal Poverty Levels (FPL.) Various percentages of the FPL are used to determine eligibility for programs and benefits funded or subsidized by public dollars. Examples include Medicaid and CHIP enrollment eligibility and premium tax credits and subsidies under the State Health Insurance Marketplaces. A family's income in relation to the FPL is computed based on both family size and household income.
- **Modified Adjusted Gross Income (MAGI):** The Modified Adjusted Gross Income (MAGI) is the standardized formula used to determine income eligibility for Medicaid and CHIP enrollment and lower premium costs in the Marketplace. Generally, MAGI is an individual's gross income plus any tax-exempt Social Security, interest, or foreign income. Under the ACA, a standard 5 percent is subtracted from gross income to figure out adjusted gross income. Income eligibility for Medicaid under the optional expansion for states is 133 percent of the FPL, but is often referenced as 138 percent of the FPL. Both are correct; 133 percent comes directly from the ACA and 138 percent accounts for the 5 percent MAGI adjustment.

Marketplace-Related Concepts

Health Insurance Marketplace

According to HHS, the State Health Insurance Marketplace is a starting place “where individuals, families, and small businesses can learn about their health insurance options; compare health insurance plans based on costs, benefits, provider network, and other important features; choose a plan; and enroll in coverage.”ⁱ It's a centralized resource that is accessible through websites and toll-free call centers. In-person assisters can also help individuals enroll. When individuals apply for coverage through the Marketplace, their eligibility for public benefit programs will be assessed. Each state has a Health Insurance Marketplace, although some are run by the state, some by the federal government and some are state/federal partnerships.ⁱⁱ

Qualified Health Plan (QHP)

The qualified health plans (QHPs) are the plans sold through the Marketplace. These plans must meet certain consumer protection standards set by federal and state governments.

Essential Health Benefits

Essential health benefits (EHBs) are a set of broad health care service categories. EHBs are intended to ensure that all individual policies and small group insurance plans (sold inside or outside the Marketplaces) and coverage under the Alternative Benefit Plans for the Medicaid expansion population not only provide affordable coverage to enrollees but also include a comprehensive set of benefits.

The essential health benefit categories include the following:

1. Ambulatory (outpatient) care
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Employer plans covering large groups and grandfathered plans are **exempt**, as are self-funded plans. A self-funded (also known as ERISA) plan pays employees' health care costs directly, instead of contracting with an insurance company to do so. Self-funded plans are exempt from many state mandated benefit laws, as well as several ACA provisions.

ⁱ <https://www.healthcare.gov/glossary/health-insurance-marketplace-glossary/>

ⁱⁱ <http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-marketplaces/>

Private Insurance-Related Concepts

Grandfathered Health Plan

Not every provision of the ACA applies to every type of insurance coverage. One of the terms that is important to be aware of in this context is “grandfathered health plan.” A grandfathered health plan is one that was in place on or before March 23, 2010, the day the full ACA became law. An individual health insurance policy can have grandfathered status if it was purchased before that date. Grandfathered plans are exempt from most of the provisions of the ACA, including the essential health benefits. If a plan or policy changes significantly (by reducing benefits and/or increasing costs to enrollees above a certain level), it will lose its grandfathered status. Over time, grandfathered plans and policies will gradually phase out as insurance companies make changes to their products and/or prices. Once a plan or policy loses its grandfathered status, it becomes a “new” plan and is subject to all the consumer protections and provisions under the ACA.

One of the easiest ways for a person to know if they are in a grandfathered plan is to ask their employer’s human resources department or their insurance company. Insurers are also required to put this information in their plan materials.

New Plan

A health plan or policy that is not grandfathered (i.e. was NOT in place as of the signing into law of the ACA) is known as a “new” plan or policy. Unlike grandfathered plans, new plans/policies are subject to all the consumer protections provisions under the ACA.

Just because a plan or policy is new to an individual, it does not mean that it is a new plan. Individuals should check with their insurer to find out whether the plan they are signing up for is grandfathered or a new plan.

Individual Responsibility Requirement (the “Individual Mandate”)

The ACA requires that everyone who can afford health insurance have it. Terms for this include the “individual responsibility requirement” and the “individual mandate.” If an individual can afford insurance and does not sign up for it, that individual will have to pay a fee known as the individual shared responsibility payment. The payment is collected when taxes are filed.

Situations that may qualify as exemptions from this requirement include being:

- Uninsured for less than three months of the year
- In the situation where the lowest-priced coverage available would cost more than 8 percent of an individual’s household income
- Without needing to file a tax return because income is too low (Learn about the filing limit.ⁱ)
- A member of a federally recognized tribeⁱⁱⁱ or eligible for services through an Indian Health Services provider
- A member of a recognized health care sharing ministry
- A member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare
- Incarcerated (either detained or jailed), and not being held pending disposition of charges
- Unlawfully present in the U.S.^{iv}

Situations based on hardship may also qualify an individual for an exemption. To find out if they qualify for an exemption, individuals may visit their state Marketplace website, healthcare.gov, or speak with a navigator, consumer-assister or broker to learn more about applying.

Minimum Essential Coverage (MEC)

Certain kinds of coverage count towards meeting the individual mandate for having insurance coverage. These plans are called “Minimum Essential Coverage” – they meet requirements laid out in the ACA for affordability and adequacy. Types of minimum essential coverage include QHPs purchased through the Marketplace, employer-sponsored coverage, Medicare, Medicaid, CHIP, TRICARE and certain other kinds of coverage.

ⁱⁱⁱ<https://www.healthcare.gov/glossary/federally-recognized-tribe/>

^{iv} <https://www.healthcare.gov/immigrants/immigration-status/>

Test your knowledge

1. **True or false:** Co-pays, co-insurance and deductibles are all types of cost-sharing.
2. **True or false:** The essential health benefits in the ACA apply to all kinds of private insurance.
3. **True or false:** Public benefit programs like Medicaid and CHIP are considered minimum essential coverage.



Find Out in Your State

1. What type of Marketplace operates in your state?
(See <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/> for a list of Marketplace types by state)

Test Your Knowledge Answers: 1. True
2. False; the EHBs do not apply to large group, grandfathered or self-funded plans
3: True

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Module 3

THE PATIENT'S BILL OF RIGHTS

The Affordable Care Act includes several protections for consumers known as the Patient's Bill of Rights, which took effect in June 2010. The U.S. Departments of Health and Human Services, Labor, and Treasury each issued regulations to implement the Patient's Bill of Rights. These protections apply to nearly all health insurance plans.

These protections are especially beneficial to those who are most vulnerable, such as maternal and child health (MCH) populations, which include children and youth with special health care needs (CYSHCN). Title V leaders need to understand the new and expanded pathways to coverage, benefits, and consumer protections so they can help the MCH population navigate the new health care environment.

Provisions of the Patient's Bill of Rights

The Patient's Bill of Rights includes the following provisions:

Prohibition on Pre-existing Condition Exclusions

Insurers can no longer deny coverage to individuals with pre-existing conditions. Pre-existing conditions exclusions are defined as a limitation or denial of benefits related to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. The ACA prohibits exclusion of benefits associated with a pre-existing condition or complete exclusion from a plan or coverage based on a pre-existing condition. It is still allowed, however, for a plan to not cover every service, as long as they do not cover it for anyone, not just those with pre-existing conditions.

Note: grandfathered individual plans are exempt from this provision.

Ban on Rescissions

The ACA prohibits the rescission or cancellation of a policy due to an inadvertent mistake or omission on an application, except for cases of fraud or intentional misrepresentation of a material fact. Before this change in the law, insurers could cancel an individual's plan due to misrepresentation of material facts even if it was not intentional. Plans may still be cancelled for: nonpayment of premiums; fraud or intentional misrepresentation of material fact; withdrawal of a product or withdrawal of an issuer from the market; movement of an individual or an employer outside the service area; or cessation of association membership if coverage is through that association. An

The Patient's Bill of Rights includes:

- Prohibition of pre-existing conditions
- Ban on rescissions
- Ban on lifetime and annual limits
- Choice of health care professional
- Emergency services
- The right to appeal decisions made by health plans
- Coverage for young adults on parent's plan up to age 26
- Covering preventive care with no cost

Learn more at:

The White House: Patient's Bill of Rights
<http://www.whitehouse.gov/files/documents/healthcare-fact-sheets/patients-bill-rights.pdf>

Families USA: The Affordable Care Act: Patient's Bill of Rights and Other Protections
http://familiesusa.org/sites/default/files/product_documents/Patients-Bill-of-Rights.pdf

THE PATIENT'S BILL OF RIGHTS

insurer must give a consumer 30 days advance written notice if it is cancelling a policy and consumers have the right to an appeal.

Ban on Lifetime and Annual Limits

The ACA prohibits issuers from imposing lifetime or annual limits on the dollar value of health benefits. These protections apply to the essential health benefits which are: outpatient care, trips to the emergency room, treatment in the hospital for inpatient care, care before and after a baby is born, mental health and substance use disorder services, prescription drugs, habilitative and rehabilitative services, lab tests, preventive services and pediatric services.

An issuer may impose annual or lifetime dollar limits per individual on specific covered benefits that are considered non-essential.

Choice of Health Care Professional

If a health insurance plan or issuer requires a participant to designate a primary care provider, or assigns a primary provider to the participant, the individual has the right to designate an in-network primary care provider of his or her choice.

Emergency Services

When a health plan covers emergency services, it must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services. Also, a plan should treat services, co-payments or co-insurance the same as it does those that are in-network.

The Right to Appeal Decisions Made by Health Plans

Consumers have the right to appeal decisions made by health insurance companies internally and decisions must be made in a timely manner. The law also states that consumers have the right to further appeal a decision to an outside, independent decision-maker, such as an insurance ombudsman or consumer-assister program.

Covering Young Adults on Parent's Plan

Insurers that offer dependent coverage for children must make this coverage available for children until the age of 26. Dependent coverage for those up to the age of 26 is not reliant on student status, residency, marital status, or financial support of the dependent.

Covering Preventive Care with No Cost

The ACA now requires health plans to provide coverage for recommended preventive services with no out-of-pocket costs such as deductibles, co-payments or co-insurance.

These preventive care services are:

1. Preventive items or services that have a current A or B rating from the U.S. Preventive Services Task Force (USPSTF). Notably, the law currently requires insurers to cover breast cancer screening every one to two years for women over the age of 40, in keeping with the 2002 USPSTF guidelines.
2. Vaccines recommended in the Immunization Schedules of the Centers for Disease Control and Prevention (CDC)
3. Services recommended in the guidelines for preventive services for infants, children, and adolescents from the Health Resources and Services Administration (HRSA), which include the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Screening Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children
4. Services recommended in guidelines for women's preventive services supported by HRSA.

Test your knowledge

1. Insurance plans that offer dependent coverage must now offer coverage for dependents up to what age?
 - a. 23
 - b. 24
 - c. 25
 - d. 26
2. **True or False:** Because of the Affordable Care Act, insurance companies can cancel an individual's plan if they unknowingly make a mistake on their application form.
3. **True or False:** An issuer may impose annual or lifetime per-individual dollar limits on specific covered benefits that are considered non-essential.

Resources

The White House: Patient's Bill of Rights

<http://www.whitehouse.gov/files/documents/healthcare-fact-sheets/patients-bill-rights.pdf>

Families USA: Patients' Bill of Rights and Other Protections

http://familiesusa.org/sites/default/files/product_documents/Patients-Bill-of-Rights.pdf

Test Your Knowledge Answers: 1. d
2. False
3. True

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PATHWAYS TO COVERAGE FOR MCH POPULATIONS

A major focus of the Affordable Care Act (ACA) is to ensure every U.S. citizen and lawfully residing individual has access to affordable, adequate health insurance.ⁱ The ACA works towards this goal by

- Expanding pathways to Medicaid eligibility for new and current populations
- Creating health insurance Marketplaces

Expanding Pathways to Medicaid for New and Current Populations

Prior to the passage of the ACA, in the majority of states childless adults were not eligible for Medicaid at any income level, unless the state created a waiver.

New Population

In January 2014, a provision of the ACA went into effect that created a pathway to Medicaid for 19- to 65-year-old childless adults who are not pregnant, not disabled, and whose income is less than 133 percent of the federal poverty level (FPL). The Modified Adjusted Gross Income (MAGI) provision of the ACA standardized the way states calculate household income and established a 5 percent income disregard for certain populations.ⁱⁱ As a result, minimum income eligibility for the adult Medicaid population is now effectively 138 percent of the FPL.

On June 28, 2012, the U.S. Supreme Court ruled that the ACA was constitutional. However, the Court also said that the provision of the ACA that required state Medicaid programs to increase eligibility to childless adults contained a “coercive” penalty, whereby a state would lose all Medicaid funds if it did not expand Medicaid. Therefore, the Medicaid expansion provision is optional. States may

choose to implement it, but it is not mandatory for them to do so. Each state can decide whether to implement this provision of the ACA. As of August 28, 2014, 27 states and the District of Columbia have expanded Medicaid to include the new population of adults. This also expanded the income eligibility for the parents of dependent children in some states.ⁱⁱⁱ The federal government will pay for the full cost of the expansion through 2016. Thereafter the federal share will gradually decrease to 90% by 2020.

Parents of Dependent Children

Parents of dependent children were eligible for Medicaid prior to the ACA. But, depending on the state, income eligibility varied widely, ranging from 16 percent to 215 percent of the FPL. In states opting to expand Medicaid eligibility, the minimum eligibility level for parents is now 133 percent of the FPL. In those states which are not moving forward with the adult Medicaid expansion, household eligibility levels generally remain low (some as low as 50 percent) for parents.

6- to 19-Year-Olds

Prior to January 2014, states were required to provide Medicaid to children birth to 6 years old with household income less than 133 percent of the FPL.^{iv} The Medicaid benefit for 6- to 19-year-olds could be capped at 100 percent of the FPL. This was called stair-step eligibility. While many states had income limits that were more generous than the federally required minimum, when the ACA was passed in March 2010, 21 states used the federal minimum of 100 percent of the FPL to determine Medicaid eligibility for six- to 19-year-old children.^v

The ACA includes a mandatory Medicaid expansion for six- to 19-year olds. Starting January 1, 2014, states

ⁱ <http://www.hhs.gov/strategic-plan/goal1.html>

ⁱⁱ <http://www.healthlaw.org/publications/agmagi#.VLPMMYvF-6M>

ⁱⁱⁱ <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

^{iv} <http://www.cbpp.org/cms/index.cfm?fa=view&id=2223>

^v <http://kff.org/report-section/aligning-eligibility-for-children-moving-the-stairstep-kids-to-medicaid-issue-brief/>

PATHWAYS TO COVERAGE FOR MCH POPULATIONS

that capped Medicaid eligibility at 100 percent of the FPL for this age range of children had to expand eligibility to 133 percent of the FPL. This change created a single minimum income eligibility limit for children from birth to age 19. As a result, more than 560,000 children moved from CHIP to Medicaid.^{vi} This age group of children now receives comprehensive Medicaid benefits, including the comprehensive child health benefit package called Early, Periodic Screening, Diagnostic and Treatment^{vii} or EPSDT, and families have reduced out-of-pocket health care costs, as states do not impose premiums or cost sharing for children's Medicaid at family income less than 150 percent of the FPL.^{viii}

Youth/Young Adults Who Have Aged Out of Foster Care

Children in the foster care system receive Medicaid benefits until they age out, generally at age 18, although some states have expanded their foster care programs to age 19 or 21. Youth who have aged out of foster care can continue to receive Medicaid benefits until they turn 21 in the 30 states that had implemented the Chafee Option.^{ix}

As of January 1, 2014, young adults who aged out of foster care prior to the new year and are younger than 26, can reenroll in Medicaid.^x This provision of the ACA levels the playing field, allowing former foster youth and youth who will transition out of foster care in the coming years, to reenroll in or retain Medicaid benefits to age 26,^{xi} much like other young adults who can remain on their parents' health insurance until their 26th^{xii} birthdays. Unlike the new adult pathway to Medicaid, this extension of Medicaid is not subject to the 133 percent of the FPL income limit.

Youth who left the foster care system prior to aging out (at 18 or older as determined by the state) are not eligible to reenroll in Medicaid. States do not have to offer this benefit to youth who aged out of foster care in one state and moved to another.

Pregnant Women

Before the passage of the ACA, pregnant women were a mandatory Medicaid population. However, a woman's eligibility for full Medicaid benefits or for specific pregnancy-related Medicaid coverage depends on the state.^{xiii} When states filed their State Plan Amendments (SPA) for MAGI for pregnant women, they noted if they would be providing full Medicaid benefits to pregnant women or establishing an income level above which pregnant women would only be eligible for pregnancy-related Medicaid, which is not minimal essential coverage (MEC).^{xiv} Therefore, pregnant women who are receiving pregnancy-related Medicaid benefits may also enroll in Marketplace plans and receive tax credits if household income is less than 400 percent of the FPL. If income is less than 250 percent of the FPL and they purchase a silver level health plan, they may also receive cost-sharing reductions.^{xv}

The ACA ensures pregnant women who are not eligible for Medicaid can receive comprehensive health benefits during their pregnancy. All new individual policies and small group health plans sold in and out of the Marketplaces have to include the essential health benefits,^{xvi} which includes maternity and newborn care. There is no cost-sharing for prenatal visits, which are considered well-woman visits. There will be cost-sharing related to labor and delivery.

^{vi} <http://kff.org/report-section/aligning-eligibility-for-children-moving-the-stairstep-kids-to-medicaid-issue-brief/>

^{vii} <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>

^{viii} <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing.html>

^{ix} <http://www.urban.org/UploadedPDF/412786-Providing-Medicaid-to-Youth-Formerly-in-Foster-Care-Under-the-Chafee-Option.pdf>

^x <http://childwelfareparc.org/wp-content/uploads/2013/09/Medicaid-to-26-for-Youth-in-Foster-Care.pdf>

^{xi} <https://www.federalregister.gov/articles/2013/01/22/2013-00659/medicaid-childrens-health-insurance-programs-and-exchanges-essential-health-benefits-in-alternative#h-26>

^{xii} <http://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/xml/CFR-2011-title45-vol1-sec147-120.xml>

^{xiii} <http://www.healthlaw.org/publications/browse-all-publications/QA-Pregnant-Women-Coverage-Medicaid-and-ACA#.VD11OfldWz4>

^{xiv} <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>

^{xv} <https://www.statereforum.org/weekly-insight/coverage-for-pregnant-women-aca>

^{xvi} <https://www.healthcare.gov/glossary/essential-health-benefits/>

Creating Health Insurance Marketplaces

As noted in module 2, the ACA included the creation of Affordable Health Insurance Exchanges,^{xvii} also called Health Benefit Marketplaces (Marketplaces). The Marketplaces (learn more in module 5) provide a pathway to health coverage for U.S. citizens and legally residing individuals and families who are not eligible for Medicaid or CHIP and who do not have access to employer-sponsored insurance that is affordable and adequate. First, a premium is calculated based on location, age, family size, tobacco use, and plan category. Then, a tax credit is calculated on estimated household income and family size. The amount of the tax credit will depend on family size and income, state of residence, and tobacco use. The Kaiser Family Foundation developed a Subsidy Calculator^{xviii} for estimating premium assistance for Marketplace coverage. If household income is between 100 and 250 percent of the FPL, individuals and families can also receive cost-sharing reductions that will reduce their out-of-pocket costs for deductibles, co-payments, and co-insurance, but only if their income is less than 250 percent of the FPL and only if they enroll in a silver level health plan.

Items of Note

- U.S. citizens whose income is less than 100 percent of the FPL who are not eligible for Medicaid and who live in states that are not expanding Medicaid are not eligible for Marketplace coverage. They are exempt from the individual mandate to have health insurance.
- Lawfully residing immigrants who are not eligible for Medicaid due to immigration status can purchase Marketplace plans and receive tax credits if their income is between 100 and 400 percent of the FPL.^{xix} Many states have waived the 5-year waiting period for lawfully residing immigrant children and pregnant women.
- Individuals and families with income in excess of 400 percent of the FPL are not eligible for federal subsidies (tax credits or cost-sharing reductions), but they can purchase Marketplace insurance plans.
- Individuals who have access to other MEC^{xx} can purchase Marketplace insurance, but they will not be eligible for federal subsidies, regardless of income.
- Undocumented immigrants are not allowed to purchase private health insurance at full cost in state insurance exchange(s).^{xxi}

^{xvii} <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>

^{xviii} <http://kff.org/interactive/subsidy-calculator/>

^{xix} <http://www.cbpp.org/files/QA-on-Premium-Credits.pdf>

^{xx} <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html>

^{xxi} <https://www.healthcare.gov/immigrants/coverage/>

Test your knowledge

1. **True or False:** Youth/young adults who age out of foster care can continue to receive Medicaid benefits to age 26, regardless of income.
2. Name two advantages of standardizing Medicaid income eligibility for children birth to 19.
3. **True or False:** A pregnant woman who receives pregnancy-related Medicaid benefits may also purchase a Marketplace health plan and receive tax credits if her income is between 100 and 400 percent of the FPL.



Find Out in Your State

1. Did your state implement the adult Medicaid expansion?
<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>
2. What are the Medicaid income eligibility limits for children and for pregnant women in your state?
Income eligibility for Children's Medicaid: <http://kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-at-application-as-of-april-1-2014/>
Medicaid eligibility limits for Pregnant Women: <http://kff.org/medicaid/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-at-application-as-of-april-1-2014/>
3. Does your state waive the five-year ban for Medicaid and/or CHIP for lawfully residing pregnant women and/or children who meet residency and income requirements in your state?
http://www.insurekidsnow.gov/professionals/eligibility/lawfully_residing.html

Test Your Knowledge Answers: 1. True
2. Eliminates state-step eligibility; 6- to 19-year-olds who move from CHIP to Medicaid receive EPSDT; families have fewer out-of-pocket costs
3. True

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Module 5

HEALTH INSURANCE MARKETPLACES

Health Insurance Marketplaces (sometimes called exchanges) facilitate the purchase of health insurance by individuals and small businesses and play a central role in the implementation of the Affordable Care Act (ACA). Marketplaces in each state offer consumers a way to compare and shop for private health insurance plans. Subsidies are available to individuals with family income between 100 percent and 400 percent of the Federal Poverty Level (FPL). Marketplaces also screen individuals for eligibility for Medicaid and Children's Health Insurance Program (CHIP) coverage, ensuring that individuals experience "no wrong door" to health coverage.

Marketplace Structure and Operations

Marketplaces opened for enrollment in every state on October 1, 2013. As of December 2014, 14 states ran their own state-based Marketplace; 3 states ran a federally-supported Marketplace; 7 states ran a state-partnership Marketplace; and 27 states ran a federally-facilitated Marketplace. State-based Marketplaces are responsible for all Marketplace functions, including selecting the private plans that are sold on the Marketplace, determining individual eligibility, and providing consumer assistance. Consumers in these states apply for and enroll in coverage through the state's own website. Similarly, federally-supported states maintain their own enrollment website and are responsible for performing all Marketplace functions, however on the back-end, these states rely on the federal Marketplace IT platform. State-partnership states use the federal Marketplace website, healthcare.gov, to enroll consumers, but the state administers certain Marketplace functions such as consumer assistance. Finally, in federally-facilitated states, consumers enroll through healthcare.gov and the Department of Health and Human Services performs all Marketplace functions.ⁱ

Qualified Health Plans

Plans certified to be sold through Marketplaces are known as Qualified Health Plans (QHPs). All QHPs must cover, at a minimum, the same basic categories of health care services, known as essential health benefits (see Module 6 for a more detailed discussion). All plans charge a monthly premium, which varies depending on the deductible, percent of costs covered by the plan, and other factors. Marketplaces allow consumers to compare QHPs by dividing them into four categories: platinum; gold; silver; and bronze. Bronze plans charge the lowest premiums and platinum plans charge the highest premiums. However, when individuals and families access health care, those with bronze plans will have to pay more out of pocket before the plan contributes, while those with platinum plans will be required to pay less before the plan contributes. Thus, families who use many health services may find a "higher metal" plan more affordable overall. On average, platinum plans cover 90 percent of health care costs, while bronze plans cover 60 percent of health care costs. It is important to remember that each category of health plans only tells you the *average* amount of health care costs that the plan will pay.ⁱⁱ

Eligibility

Adults and children without other options for affordable health coverage (for instance through employment), can purchase insurance on Marketplaces and may receive federal subsidies to reduce the costs. Individuals who have access to affordable coverage through employer sponsored coverage, or individuals who are eligible for Medicaid or CHIP, will not receive tax credit subsidies toward the purchase of a Marketplace QHP.

ⁱ <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/>

ⁱⁱ <https://www.healthcare.gov/choose-a-plan/plans-categories/>

Affordability

Two kinds of federal subsidies are available on a sliding scale to help individuals and families with incomes between 100 and 400 percent FPL afford Marketplace QHPs. Advance Premium Tax Credits (APTC) help reduce the price of premiums. Individuals with income between 100 and 400 percent FPL can choose to have tax credit subsidies paid in advance directly to the insurance company, thereby lowering monthly premiums, or can claim the entire credit when filing taxes for the year. The tax credit amount is calculated based on household income, family composition, and the price of a silver-level plan. In addition to offering APTC, the federal government also provides cost-sharing reductions (CSR) for individuals with income between 100 and 250 percent of the FPL who purchase a silver plan. CSRs help reduce out-of-pocket costs—such as copayments, co-insurance, and deductibles—associated with health insurance. The ACA places a limit on total out-of-pocket costs associated with any non-grandfathered plan; for 2015, the maximum out-of-pocket amount anyone must pay is \$6,600 for an individual plan and \$13,200 for a family plan. Premiums do not count towards the maximum out-of-pocket amount.ⁱⁱⁱ

Applying for Marketplace Coverage

Each Marketplace maintains a website where individuals and families can shop for and purchase QHPs. The federal Marketplace, healthcare.gov, serves this function in the 34 federally-facilitated and state-partnership states. Healthcare.gov also provides links to state Marketplace websites. Individuals and families can apply for Marketplace coverage online, by telephone or in person. Individuals can enroll in Marketplace coverage only during an annual open enrollment period or during specified special enrollment periods. There are qualifying life circumstances such as getting married, having a baby, losing employer coverage, or aging out of a parent's plan, when individuals can qualify for a special enrollment period. By completing a Marketplace application, individuals and families can learn whether they are eligible for:

- **Financial aid to buy private insurance plans** – Marketplaces tell individuals if they are eligible for subsidies to buy qualified health plans and whether they qualify for lower out-of-pocket costs based on income and household size; or

- **Medicaid or CHIP** – These programs provide coverage to millions of children and families with limited income. If it looks like an individual qualifies for one of these programs, the individual's information is transferred to the appropriate state agency for an eligibility determination and further processing.

Consumer Assistance

To help connect individuals to coverage, all Marketplaces are required to set up consumer assistance programs. Consumer assistance programs provide individualized counseling to help consumers understand their coverage options, apply, and choose a QHP. Consumer assisters are known by various names: navigators; in-person assisters (IPAs); and certified application counselors (CACs). Consumer assisters provide impartial information about QHP options, help consumers compare and select a QHP, and help consumers complete and file applications. They can also help consumers report changes during the coverage year, assist consumers with renewing coverage, and connect consumers who have grievances, questions, or complaints to the appropriate agency for resolution. Consumer assisters receive federal training that includes: methods to address the needs of underserved and vulnerable populations, basic information on qualified health plans, eligibility and enrollment rules and procedures, and privacy and security requirements. States can provide additional training as well. Insurance agents, brokers, and certain federally qualified health centers also can help people choose and enroll in QHPs.

Issues for MCH Populations

There are three issues related to Marketplace coverage that are important to note, as they may have significant impact on coverage for women, children, and families:

1. **The “family glitch”** – According to Internal Revenue Service (IRS) regulations, if an individual has access to employer-sponsored insurance, the cost to the employee for such coverage must not exceed 9.5 percent of the employee's income, based on the cost of an individual-only policy. This rule does not take into consideration the often significantly higher cost of a family plan. This is known as the family glitch.

ⁱⁱⁱ<https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/>

HEALTH INSURANCE MARKETPLACES

Average annual premiums for employer-sponsored insurance in 2013 were \$5,884 for individual coverage and \$16,351 for family coverage.^{iv} As a result, families with low- to moderate-income may not be able to afford either the employer sponsored insurance or Marketplace coverage without the subsidy.

2. **“Premium stacking”** – The calculation for premium tax credits does not take into account premiums that families might already pay for children enrolled in CHIP or Medicaid. In 2013, 29 states charged premiums for some children in Medicaid or CHIP.^v The need to pay Medicaid or CHIP premiums in addition to premiums for parents’ QHP coverage imposes an additional financial burden on families where coverage is split across multiple programs. Premium stacking may be particularly burdensome for families purchasing stand-alone dental coverage through the Marketplace (see module 6 on Benefits for more information).

3. **Continuity for Pregnant Women** – The introduction of QHPs creates new complexity for coverage of some pregnant women. As noted in module 4, prior to the ACA, pregnant women were a mandatory Medicaid population. When states filed their State Plan Amendments (SPA) for MAGI for pregnant women, most noted they would be providing full Medicaid benefits to pregnant women, which is minimum essential coverage (MEC); individuals who are eligible for MEC are not eligible for subsidized Marketplace coverage. Depending on the state and household income, a woman who is eligible for and enrolled in a subsidized QHP who becomes pregnant may be eligible for full Medicaid benefits. In order to ensure continuity of care, under these circumstances, she may choose to forego Medicaid to retain her subsidized QHP coverage. Or she can unenroll in the QHP and enroll in Medicaid, but she cannot have full Medicaid benefits and subsidized Marketplace coverage simultaneously.^{vi}

^{iv}<http://kff.org/private-insurance/report/2013-employer-health-benefits/>

^v<http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf>

^{vi}<http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>

Test your knowledge

1. Marketplaces in every state offer:
 - a. A website where consumers can compare and enroll in QHPs
 - b. Call centers to assist individuals with eligibility and enrollment questions
 - c. In person assistance with QHP selection and enrollment
 - d. All of the above
2. **True or False:** If the premiums for employee-only coverage offered by an employer are less than 9.5 percent of the employee's household income, the coverage is deemed affordable. Even if family coverage exceeds 9.5%, the family will not be eligible for subsidized Marketplace coverage.
3. Which of the following is NOT correct?
 - a. Plans sold on all Marketplaces must offer a basic set of benefits called essential health benefits.
 - b. Marketplaces may be run by an individual state, a state-federal partnership, or by the federal government.
 - c. Individuals need to submit separate applications to be considered for Medicaid/CHIP coverage or Marketplace coverage.
 - d. Subsidies are available to individuals between 100 and 400 percent FPL to purchase QHPs through the Marketplace.



Find Out in Your State

1. What kind of Marketplace does your state operate (state-based Marketplace, federally supported Marketplace, state-partnership Marketplace, or federally facilitated Marketplace)? If your state has a state-based Marketplace, what is the agency or entity that runs the Marketplace?
2. What are the consumer assistance entities in your state?
3. What type of training is provided in your state for consumer assistance? Who provides the training? Does it include information specifically related to challenges MCH and CYSHCN populations may face?

Test Your Knowledge Answers: 1. d
2. True. Under the ACA, "affordable" is defined as individual coverage lower than 9.5 percent of household income.
3. c

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Section 6

BENEFITS

In addition to expanding access to affordable health coverage options, the Affordable Care Act (ACA) makes several changes to public and private health insurance benefits that will affect the populations served by Title V MCH and CYSHCN programs. This module gives an overview of the ACA's broad requirements for health insurance benefits and the ways these requirements affect MCH/CYSHCN populations.

Preventive Services

The ACA requires most health plans to cover preventive services without charging patients any fees, known as copayments, co-insurance, or deductibles. The preventive services that plans must cover are all services given “A” or “B” ratings by the U.S. Preventive Services Task Force plus routine immunizations recommended by the Centers for Disease Control and Prevention. As these agencies update their recommendations, plans may have to cover additional preventive services and immunizations to match the recommendations.

In addition, the ACA requires plans to cover specific preventive services for women and children:

- **Preventive services for women** – Plans must cover eight preventive services for women without charging fees: annual well-woman visits; screening for gestational diabetes; human papillomavirus (HPV) testing; sexually transmitted infection (STI) counseling; contraception; HIV screening; domestic violence screening; and breastfeeding support. These services are based on recommendations from the Institute of Medicine.
- **Preventive services for children** – Plans are required to cover specific preventive services and screenings for children and adolescents without charging fees. These recommendations include behavioral and developmental assessments, routine screening tests, and well-child care. The preventive services for children that plans must cover are all services recommended by the Health Resources and Services Administration (HRSA)-supported Bright Futures initiative for children from birth to age 21.

Exceptions

Some health plans are exempt from the ACA's requirements for preventive services. The main categories of plans exempt from this requirement are 1) self-funded plans, and 2) “grandfathered plans,” which are plans that existed before the ACA was signed on March 23, 2010 and that have not changed in a way that substantially changes benefits or increases costs for the consumer. In practice, this means that all Marketplace plans, known as Qualified Health Plans (QHPs), and many other private health insurance plans must cover nearly 50 specified preventive services free of charge to consumers.

Essential Health Benefits

The ACA requires all health plans sold inside the Marketplaces and all new individual and small group plans sold outside of marketplaces to offer a core package of services known as essential health benefits (EHB). EHB requirements also apply to Medicaid plans offered in states that have expanded Medicaid eligibility up to 133 percent of the federal poverty level for newly eligible adults. All of these plans must cover EHB in the following 10 categories:

1. Ambulatory (outpatient) services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

While EHB rules set a baseline, there can still be great variation among health insurance plans related to the extent of covered services and cost sharing for those

services. In 2012, every state selected an existing health insurance plan, known as a benchmark plan. The benchmark plan established the state's minimum definitions for the extent of covered services and cost-sharing limits within each EHB category. Most states selected the largest small group market plan in their state as their initial benchmark plan. In cases where the state-selected benchmark plan did not include a particular EHB category, states were required to supplement the benchmark benefits.

Generally, small group plans have coverage and cost-sharing policies for children that are less comprehensive than those available in Medicaid or CHIP programs. The differences in benefits between public and private coverage options may be particularly striking in habilitative and rehabilitative services, and pediatric oral, vision, and hearing services.ⁱ These are benefit categories that are particularly important to MCH and CYSHCN populations. State EHB benchmark selections will remain in place for 2014 and 2015. The federal Department of Health and Human Services (HHS) plans to reevaluate the definitions for EHB, with any changes effective January 1, 2016.

Exceptions

EHB requirements do not apply to traditional Medicaid, Children's Health Insurance Program (CHIP), large employer health plans, or "grandfathered" plans. In practice, this means that all QHPs sold on Marketplaces as well as new plans sold outside the Marketplaces must provide EHB.

Pediatric Dental Benefits

Pediatric dental benefits are one of the 10 EHB, but dental benefits have traditionally been covered through dental insurance separate from medical insurance. In most states, insurers selling plans on marketplaces have the option to continue offering stand-alone pediatric dental plans or to sell plans with embedded pediatric dental services. There is no federal requirement that families purchasing coverage on a marketplace must also purchase stand-alone pediatric dental coverage for their child if it is not included in the selected medical plan.

Some parents may forgo dental coverage for their child due to affordability concerns. Tax credit subsidies are calculated based on the second-lowest cost silver plan in a marketplace, which may or may not include pediatric dental benefits. For most families, this may mean that their tax credit subsidy amount might not be enough to cover the cost of a stand-alone pediatric

The ACA requires all health plans sold inside the Marketplaces and all new individual and small group plans sold outside of marketplaces to offer a core package of services known as essential health benefits (EHB). Plans must cover EHB in the following 10 categories:

1. Ambulatory (outpatient) services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

ⁱhttp://www.aap.org/en-us/about-the-aap/aap-press-room/Documents/AAP_EHB_Report_FinalPress.pdf

dental plan. Stand-alone dental plans may also require cost-sharing beyond the out-of-pocket limits that apply to medical plans. Some states have taken action to ensure children receive pediatric dental benefits. For example, Kentucky, Nevada, and Washington have implemented state requirements that families purchasing medical coverage for a child must also purchase pediatric dental coverage.

Habilitative Benefits

The EHB also include habilitative services, a set of benefits that were not traditionally covered by private health insurance plans. Habilitative services generally include occupational, physical, and speech therapy services. Unlike rehabilitative services, which help individuals recover lost skills, habilitative services help individuals attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. These benefits are particularly important for individuals with intellectual or physical disabilities, including CYSHCN. Since habilitative services were not traditionally covered in private insurance plans, many state benchmark plans do not recognize habilitative services as a distinct group of services. To fill

the gap, HHS has allowed states to define habilitative services. If a state chooses not to define habilitative services, health plan issuers can either provide habilitative services in parity with rehabilitative services or can provide a list of habilitative services they will cover, which the Centers for Medicare and Medicaid Services (CMS) must approve. In November 2014, CMS suggestedⁱⁱ developing a uniform definition of habilitative services to be applied across all states. In addition, CMS proposed that limits on habilitative services cannot be less than those for rehabilitative services. The definition of habilitative services will likely continue to evolve, with implications especially for CYSHCN.

Mental Health and Substance Use Parity

QHPs sold through marketplaces and private health plans sold in the individual and small group markets must comply with the Mental Health Parity and Addiction Equity Act of 2008. Plans must include mental health and substance use disorder benefits. These benefits must be treated the same way as medical benefits with regard to cost sharing and limits on services.

ⁱⁱ<https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-27858.pdf>

Test your knowledge

1. Under the ACA, all qualified health plans (QHPs) must cover:
 - a. Preventive services recommended by the U.S. Preventive Services Task Force
 - b. Routine immunizations recommended by the Centers for Disease Control and Prevention
 - c. Preventive services for children recommended by HRSA's Bright Futures
 - d. Preventive services for women
 - e. All of the above
2. **True or False:** All plans offering EHB must cover benefits and services in 10 categories, which means that all EHB packages will look the same.
3. Which of the following is NOT true about stand-alone pediatric dental plans?
 - a. Stand-alone dental plans may require cost-sharing beyond the out-of-pocket limits that apply to medical plans.
 - b. Families will receive tax credit subsidies that are guaranteed to cover the entire cost of purchasing a stand-alone dental plan.
 - c. There is no federal requirement that families shopping on a marketplace purchase stand-alone pediatric dental coverage for their child.



Find Out in Your State

1. What EHB benchmark plan did your state select? Did your state supplement its benchmark plan? If so, how?
2. How are pediatric dental benefits being sold in your state's marketplace—as stand-alone plans and/or embedded in medical plans? Has your state taken any policy or programmatic action to make pediatric dental coverage more affordable for children or to require purchase of pediatric dental benefits?
3. How has your state defined habilitative benefits requirements?

Test Your Knowledge Answers: 1. e
 2. False. There can still be great variation among EHB plans, particularly related to cost sharing and the extent of covered services
 3. b

This document, *The Affordable Care Act: A Working Guide for MCH Professionals*, is available in its entirety on the Web at <http://www.amchp.org/Transformation-Station/Pages/ACA-101.aspx>

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