



Early Wins for Children and Families in Health Care Reform

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Now that the Patient Protection and Affordable Care Act (PPACA; Public Law 111-148) has been signed into law, families across the country are interested to know what the legislation means for them. While many of the sweeping changes to insurance industry practices and other major provisions do not go into effect until January 1, 2014, there are some important early wins in health reform for children and their families. This issue brief reviews those early wins in some detail.

The brief also explores the opportunity created by health reform to inform families about the chance to enroll their uninsured children in Medicaid and the Children's Health Insurance Program (CHIP). Even prior to passage of health reform, almost two-thirds of uninsured children were already eligible for these public programs.¹ If passage of health reform is used to help spur the families of these children to enroll them in coverage, it may be one of the most powerful, early benefits of the legislation.

1. Strengthening the Opportunity for Families to Enroll Their Uninsured Children in Medicaid and CHIP

With health reform “in the news,” many families are seeking information about what the legislation means for them. This creates an important opportunity to raise awareness among eligible families that their children could secure coverage through Medicaid or CHIP. A similar dynamic occurred in 1997 after CHIP was enacted into law. The excitement in the media and among state leaders over the new program caused many families to come forward, seek more information, and apply. In many cases, it turned out that their children were eligible for the existing Medicaid program. This unintended boost to Medicaid enroll-

ment – or “welcome mat effect” – was one of the major reasons why the country succeeded in reducing the uninsured rate of low-income children by over a third in the past decade.²

“Holding Steady” on Medicaid and CHIP. Along with serving as a potentially powerful tool for raising awareness about Medicaid and CHIP, the health reform legislation includes some provisions that directly strengthen the programs. Most notably, as of the PPACA's March 23, 2010 enactment date, states are required to “hold steady” when it comes to Medicaid and CHIP coverage. Specifically, the PPACA requires that states maintain eligibility standards and enrollment procedures for children in Medicaid and CHIP until October 1, 2019, and for most adults – primarily parents – in Medicaid until January 1, 2014, when the new health exchanges are operational. This assures that Medicaid and CHIP will remain available to families as health reform is being implemented, and that states cannot impose new paperwork barriers to enrolling in and retaining coverage. In the absence of such a requirement, some states might have scaled back on Medicaid or CHIP coverage in light of their serious fiscal problems.³

New Coverage Portal. A complementary provision to reaching uninsured children eligible for Medicaid and CHIP is a new requirement that, by July 1, 2010, Health and Human Services (HHS) work in consultation with states to establish a website (and possibly other tools) that will provide state-level information about affordable health coverage options, including Medicaid, CHIP, and the new high risk pools (see item 5). While families still will need to apply for and enroll in Medicaid or CHIP through their states, the portal should help them to learn about and connect with these programs and other sources of coverage.

2. Covering Uninsured Young Adults on a Parent's Plan

For families with young adults up to age 26 who are in need of coverage, the health reform law includes an important new provision to cover them under a parent's insurance policy. Currently, most health plans that provide family-based coverage cover children only until age 19 or 20 (unless they are in college full-time or a state law requires coverage until an older age). As a result of the PPACA, young adults or "dependents" up to age 26 will qualify for coverage under a parent's policy that offers dependent coverage. The new policy goes into effect for health plan years that begin after September 23, 2010. It applies to all health insurance policies that provide dependent coverage, i.e., existing and new family coverage policies offered in the individual and group markets. (A group plan generally refers to one offered through an employer.) With young adults representing 28 percent of the uninsured population, this provision will provide an important new option for many families.⁴

HHS will issue regulations defining "dependents" for purposes of the new rule. The statutory language leaves open the possibility for a broad definition that includes, for example, a full-time student or a married adult child (although the law stipulates that plans are not obligated to cover any of the young adult's children). Before 2014, existing employer health plans are not required to cover a young adult who has access to coverage through his or her own job. This provision does not apply for plan years beginning after 2014.

The new coverage will not be free to families. Instead, they will need to select the family-coverage option from their employer plan (or when purchasing coverage in the individual market), which typically costs more than employee-only (or employee/spouse) coverage. Insurers may adjust their rates for family-based coverage upward across-the-board to reflect that they expect to cover more young adults, but any increases should be relatively modest, especially compared to the benefits of obtaining coverage for these uninsured young adults.

3. Providing Preventive Coverage and Screenings at No Cost

As part of the effort to encourage greater use of preventive care, the PPACA requires new insurance plans in the individual and group markets, issued after September 23, 2010, to provide specific preventive services without cost sharing. For children, this includes

KEY EARLY IMPROVEMENTS BENEFITING CHILDREN AND FAMILIES

March 23, 2010 (date of enactment)

- States must maintain Medicaid and CHIP eligibility and enrollment procedures for children until October 1, 2019. (This provision is effective for most adults until 2014.)
- States have the flexibility to expand eligibility further or to simplify enrollment in Medicaid and CHIP.
- States have the option to provide children of state employees with CHIP coverage under certain circumstances.
- Certain small employers can receive tax credits covering 35 percent (50 percent by 2014) of health care premiums.

By July 1, 2010

- Uninsured children and families with pre-existing conditions can seek coverage through newly established high-risk pools.

After September 23, 2010 (as a new health plan year begins)

- Everyone signing up for a new health plan will receive preventive services at no cost.
- Insured children cannot be denied coverage for a pre-existing condition.
- Young adults up to age 26 can obtain coverage through a parent's plan.
- New health insurance reforms make it easier for everyone to use and keep their insurance coverage.

preventive care recommended by Bright Futures, an initiative by the American Academy of Pediatrics and the HHS Health Resources and Services Administration (HRSA). For example, families with new plans are expected to no longer face co-insurance or co-payment charges for well-child visits, vision and hearing tests, various health and behavioral assessments, and developmental screenings. Further guidance is required to clarify what constitutes a "new plan."

In addition to the Bright Futures' requirements, the PPACA requires that new health plans cover preventive services for children and adults recommended by the United States Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. New health plans must also cover, at no cost, preventive care for women, such as screenings for cervical cancer and mammograms, recommended by HRSA.

Health reform is designed to very quickly ensure that children with pre-existing conditions can secure coverage.

4. Covering Children with a Pre-Existing Condition

A major purpose of the PPACA is to transform the way the insurance industry operates, such as by making it easier for people with illnesses or chronic conditions to secure affordable coverage. While many of these broader changes will not be implemented until 2014, health reform is designed to very quickly ensure that children under age 19 with pre-existing conditions can secure coverage and to ban the insurance industry's use of other particularly egregious practices (see item 6 for other early improvements).

Currently, "pre-existing condition exclusions" can be applied to families with insurance in many situations, which means that they may be denied coverage for services related to a child's (or other family member's) particular health condition. Such exclusions can be applied on a time-limited (e.g., 12 months) or even permanent basis, depending on the type of health plan and a person's previous coverage history.⁵ Beginning with health plan years in effect after September 23, 2010, the PPACA bans the use of pre-existing condition exclusions for children's coverage. As a result, a child with asthma, for example, who is on a parent's employer plan can never be denied coverage for services related to his or her asthma.

Along with banning the use of pre-existing condition exclusions, HHS officials have said that they will issue regulations to ensure that the insurance industry no longer engages in the practice of simply not selling an insurance policy to families with a sick or disabled child.⁶ This would take the early insurance reform improvements for children one step further, providing much-needed relief for families with sick or disabled children who simply cannot secure any insurance for their children in the current individual insurance market.

While health reform provides immediate relief from pre-existing condition exclusions for children, it is not until January 1, 2014 that insurance companies are expected to face legal constraints on raising premiums for someone who is ill or has a chronic condition. As a result, it will be important to monitor whether insurers respect the law's intent to ensure that children with health care problems can immediately secure affordable coverage or if they will attempt to disregard it, such as by sharply raising premiums for those families with disabled or sick children.

5. Establishing Temporary High-Risk Pools for Uninsured People with Pre-Existing Conditions

Currently, 35 states operate some type of high-risk pool to provide coverage to those who are uninsurable, although many have sharply limited enrollment. In 2008, these pools provided coverage to about 200,000 enrollees.⁷ The PPACA establishes a new \$5 billion national high-risk pool program to help increase the number of people who can obtain coverage due to a pre-existing condition while broader health reform is being implemented. The pools are expected to operate in every state, and to be available from July 1, 2010 through January 1, 2014. States will have the option to set up a pool (alongside a current state high risk pool or through other existing coverage options) or leave implementation to HHS.⁸

Eligibility. To enroll in a pool, a person must be a citizen or lawfully present immigrant, have a pre-existing condition, and be uninsured for six months prior to applying for coverage.⁹ There are no age limits to the pools so children, their parents, and other adults presumably could be eligible for the program, although it is not clear whether family coverage will be available in the pools (meaning that children may need to obtain an individual coverage plan). With funding limited, HHS may need to establish guidelines on enrollment caps and waiting lists, and potentially consider setting enrollment priorities.¹⁰

Premiums and Benefits. Premiums in the pools will be based on the "standard rate for a standard population."¹¹ As a result, enrollees with pre-existing conditions will pay premiums that are comparable to what someone without their conditions would pay. Plans will be expected to cover at least 65 percent of health costs that an average family will incur¹² and to limit out-of-pocket costs (including co-payments and deductibles) based on the federal limits established for high-deductible plans (in 2010, \$5,950 for an individual or \$11,900 for a family). These cost protections will be a significant improvement for these families, however, without a subsidy to help families purchase the coverage, a "standard" premium for high-risk pool coverage could still remain too expensive for some families.

6. Implementing Other Early Reforms Important for Children and Families

Some additional “early wins” for children and families include:

Support for new Medicaid and CHIP expansions.

Health care reform provides states with the flexibility to expand eligibility further or simplify enrollment in Medicaid and CHIP. This includes exercising the options made available to them under the Children’s Health Insurance Program Reauthorization Act (CHIP-RA), which was signed into law by President Obama in February 2009. In addition, through the PPACA, states can phase in coverage for adults up to 133 percent of the federal poverty level prior to 2014. To implement this option, states will only need to submit a state plan amendment. Until 2014 (when states will receive an enhanced match rate in Medicaid for this “newly eligible” group), states will receive their regular Medicaid match rate for this population.

Children of state employees eligible for CHIP. To date, children eligible for family coverage through a state employee health care plan have been excluded from CHIP, even when they meet the eligibility criteria. Now states can enroll such children in CHIP under certain conditions, including if a state agency has not decreased its annual premium contribution for family coverage below 1997 levels (adjusted for inflation). Alternatively, a state can apply this provision on a case-by-case basis for children where the annual aggregate amount of premiums and cost sharing a family pays exceeds five percent of income.

Tax credits for small businesses. To encourage small employers to offer health insurance coverage, the PPACA immediately provides tax credits to employers with less than 25 full-time employees. Eligible employers must pay an average salary of \$50,000 or less per year and cover at least 50 percent of their workers’ health costs. From 2010 through 2013, these employers can receive a tax credit up to 35 percent for premiums paid to their workers. In 2014, the credit is available to fewer employers and is time-limited but the rate increases to 50 percent.

Insurance market reforms. There are a number of early reforms that will make it easier for families to keep and use their insurance coverage. Unless otherwise noted, each of these provisions goes into effect after September 23, 2010, when a new health plan year begins.

- All insurance plans, current and new, can no longer establish lifetime limits. In addition, new individual plans and all (existing and new) group plans cannot have “restrictive” annual limits (with no annual limits after 2014).
- No insurer can rescind coverage once a person is enrolled (for example, if a person is sick) except in cases of fraud and misrepresentation.
- New plans must establish internal and external processes through which people can appeal coverage determinations and claims.
- People enrolling in new plans will have greater flexibility in designating who they want as a primary care provider (such as an OB/GYN) and will no longer have to obtain prior authorization for emergency health care.
- Beginning in fiscal year 2010, states will receive grants (\$30 million in the first year) to develop consumer assistance programs to help families with enrolling in coverage, educating them on their rights with respect to insurance coverage, and helping them to file complaints and appeals.
- Starting in 2011, large group policies must spend at least 85 percent, and small group or individual policies at least 80 percent, of premium dollars on medical care and quality improvement. If insurers spend less than is required by these “medical loss ratio” standards, they must refund the difference to enrollees.
- The Secretary of HHS and states will establish, starting in the 2010 plan year, an annual review process to identify “unreasonable increases in premiums.” States will receive grants until 2014 to support this process. After 2014 the Secretary of HHS will monitor the Exchange plans.

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Endnotes

1. G. Kenney, A. Cook, & L. Dubay, "Progress Enrolling Children in Medicaid/CHIP: Who is Left and What are the Prospects for Covering More Children," Urban Institute (December 2009).
2. Johns Hopkins University Bloomberg School of Public Health, analysis of the National Health Interview Survey for the Center for Children and Families (March 1, 2008).
3. For more information on state requirements for maintaining Medicaid and CHIP coverage, see Georgetown Center for Children and Families and Center on Budget and Policy Priorities, "Holding the Line on Medicaid and CHIP: Key Questions and Answers about Health Care Reform's Maintenance-of-Effort Requirements" (March 2010).
4. J. Holahan & G. Kenney, "Health Insurance Coverage of Young Adults: Issues and Broader Considerations," Urban Institute (June 2008).
5. See Public Health Service Act §1204, 42 U.S.C. §300gg(a). Currently, insurers in the employer group market are barred from applying pre-existing condition exclusions for more than 12 months after initial enrollment (18 months in the case of those not enrolling when initially eligible), although some plans may have a shorter time period or none at all. A person's prior health coverage can be used to offset the 12-month pre-existing condition exclusion, as long as there was no interruption in coverage of more than 63 days. Also, group plans cannot apply a pre-existing condition exclusion to pregnancy, genetic information, or newborns enrolled within 30 days of birth. Finally, a group plan can only look back 6 months for a health condition that was present (and for which a person received treatment) before the start of coverage. Under federal law, individual insurers face no restrictions on the use of pre-existing condition exclusions except that states are required to make sure that people who leave group plans with pre-existing conditions are subsequently able to get health insurance (which many states provide through high-risk pools). Note that state law may offer more generous protections.
6. Letter from Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services to Karen Ignagni, America's Health Insurance Plans (March 29, 2010).
7. K. Pollitz, "Issues for Structuring Interim High-Risk Pools," Kaiser Family Foundation (January 2010).
8. Office of the Secretary of the U.S. Department of Health and Human Services, "Sebelius Continues Work to Implement Health Reform, Announces First Steps to Establish Temporary High Risk Pool Program," (April 2, 2010).
9. An individual enrolled in most health coverage programs, including a state high-risk pool, will not be eligible unless they drop coverage and are uninsured for the six-month period.
10. HHS intends to allocate funding to states based on population and state costs. The funds can be used to pay administrative costs and claims in excess of premiums collected. A state opting to participate cannot displace current state high-risk pool expenditures.
11. Premiums also may not vary by more than 4 to 1 based on age.
12. The PPACA states that the plans must have an actuarial value of 65 percent. This is a measurement of the percentage of medical expenses paid by a health plan for a standard population.

Georgetown Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. CCF is based at Georgetown University's Health Policy Institute.

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