Children's Health Fund

Children Under Siege: Safeguarding Provisions for Children in the New Health Law

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INTRODUCTION

Children's Health Fund (CHF) estimates that approximately 34% of children age 17 and under are experiencing barriers accessing critical health care services.[1] The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010 in part to address society's failure to adequately meet the health needs of children. The intent of the legislation was to significantly reduce the number of uninsured Americans, improve quality of and access to care, and to reduce overall cost of health care services. Even with existing safety net programs such as Medicaid and the Children's Health Insurance Program (CHIP), ***prior to the enactment of ACA, 8.7 million U.S. children age 17 and under were without health insurance coverage and if you add 18 year olds, it jumps to 9.8 million.***[2] By 2019, when the new health reform law is scheduled to be fully implemented, the number of uninsured children will be significantly reduced due to the new law. ***CHF estimates that at least 4.3 million children ages 17 and under will be newly covered as a result of the ACA provisions and if you add 18 year olds that number climbs to over 5 million***[3]***.***

When analyzing health coverage of children, it is critical to focus not solely on insurance coverage status, but also on the quality of coverage and actual access to care the child is experiencing. ***CHF estimates that approximately 16.9 million of <u>insured</u> children are experiencing barriers to accessing care, meaning that even though they technically have insurance coverage, covered benefits may be insufficient, out-of-pocket costs for families may be unaffordable, there may not be appropriate medical providers in their area, or they may not have access to transportation to get to care.***[4] Provisions of the ACA begin the process of addressing these issues and breaking down barriers to care for children. Though much work remains to be done to eliminate underinsurance and to address non-insurance barriers to care, the new health law takes important first steps in the right direction and will result in millions more children gaining access to the care they need and deserve.

INSURANCE COVERAGE

Health insurance coverage is not the sole factor in child health access, but it is certainly a critical one. Decades of research on children and insurance coverage has shown that, "…lack of health insurance among children and adolescents is associated with delays in needed health care; foregone care; poor access to preventive, acute, or chronic services; lower quality of care; and in many cases suboptimal health outcomes."[5] In other words, children with insurance coverage are more likely to access preventive care services, and have minor illnesses treated by a health professional before they develop into more serious problems. In addition, insurance coverage is

essential for children with chronic illnesses. For example, children with asthma who are either uninsured or have gaps in coverage are more likely to go without the treatment they need to managed this chronic condition, often having to rely instead on hospital emergency department for care that is not only more costly but also more traumatic for the child.[6] According to the Institute of Medicine, "Health insurance coverage, whether private or public, improves children's access to health care services and the regularity with which children receive medical care. This improved access to care leads to better health for insured children compared to uninsured children."[7] Getting timely care for acute problems and chronic illnesses can have a far-reaching positive impact on the overall quality of life for a child. When children have access to care, they are likely to miss fewer days of school and be able to participate in sports and other healthy activities.

Ensuring that children have comprehensive and continuous health insurance coverage is good not only for a child's health and quality of life in the short-term, but also a smart investment for the long-term. On average, child health coverage is exponentially less expensive than adult coverage. Studies have demonstrated that the health care costs of children are about one-tenth the health care costs of adults.[8] [9] Targeted health interventions, such as providing comprehensive asthma care to children, have the potential to reduce public health care costs in short and long term, i.e. through reduced emergency room use.[10] In addition, providing coverage for children today means potentially spending less for adult health care down the road. Children who receive regular check-ups and are taught to embrace preventive care have an improved chance of becoming healthy adults with medical needs less expensive than what they would be otherwise. For example, an obese child may receive family-centered nutritional counseling to assist in learning better eating habits and other lifestyle changes to reduce his or her weight, potentially preventing type 2 diabetes and cardiovascular disease. Adolescents with diabetes can learn how to successfully manage the disease with insulin treatments, appropriate diet, and regular health screenings to avoid later complications like vision impairment and limb amputations.

Unfortunately, not all children in America have health insurance coverage. According to the most reliable federal study, 8.7 million children age 17 and under were without health insurance coverage in the U.S. prior to the enactment of the ACA.[11] For this reason, many of the new law's provisions are designed to significantly increase insurance coverage for all Americans, including children. The Congressional Budget Office estimates that 94% of non-elderly legal Americans will have health insurance once the law is fully implemented.[12] CHF estimates that this means at

least 4.3 million children ages 17 and under will gain access to health insurance coverage as a result of the ACA, and if you add 18 year olds that number climbs to over 5 million.[13]

Approximately 4 million children will still be left uninsured even after the ACA provisions are implemented. There are various reasons why a child may be left without insurance including: legal status (the new law prohibits any benefits to non-legal residents), insurance costs that may still be too expensive for parents to afford, or parents may expect health care costs for them and their child are to be relatively low in respect to the premium required for coverage or any applicable penalty. Some parents may choose to simply forgo coverage for their children even though it may be in their best interest and they have access to insurance.[14] For mixed status families, wherein the parents are non-legal residents, but children are legal residents or citizens, this situation is painfully apparent. Parents may fear that enrolling the child in Medicaid, or CHIP or accessing a premium subsidy for the child's coverage on the exchange may put the family at risk for deportation.

Even though some children will remain among the dwindling ranks of the uninsured, the new health law brings the number of uninsured children in this country to an unprecedented low. It accomplishes this feat in several ways. First and foremost, it includes a requirement that all children, as well as all adults, have health insurance. This new mandate begins in 2014, and shortly thereafter, phases in penalties over a few years to ensure that parents are signing their children up for coverage and signing up for coverage themselves. To help parents comply with the mandate, the ACA seeks to improve and enhance the current public and private child health coverage infrastructure in the following ways.

Strengthening Medicaid and CHIP

- The law expands Medicaid coverage. States are currently required to extend Medicaid eligibility to children under 6 years old living in families with incomes at or below 133% of poverty and to children ages 6-18 living in families with incomes at or below 100% of poverty. Under the new law, states must now cover all children and their parents up to 133% of poverty level.
- The law extends Medicaid coverage to children in foster care. Currently, states are required to cover foster children up to 18 years old. Starting in 2014, states will be required to extend Medicaid eligibility to all youths below the age of 25 who were formerly in foster care for a period of six months or more.

- The law preserves the Children's Health Insurance Program (CHIP). CHIP was due to expire in 2013. However, the ACA reauthorizes this successful program through 2019 and includes funding through fiscal year 2015.

Improving Private Coverage

- The law extends private coverage for young adults. Until now, insurers often stopped covering children under their parents' health plans at age 19, sometimes older for full-time students. Beginning six months after enactment, the law allowed dependent children to stay on their parents' health plan up to age 26, depending on the parent's insurance policy open enrollment date.
- The law eliminates pre-existing condition exclusions and annual/lifetime limits. According to a recent government analysis, 24% of all children have some type of pre-existing health condition that placed them at risk of losing health insurance or being denied coverage altogether when they need it most.[15] Starting six months from enactment, no child can be denied health insurance coverage based on a pre-existing condition. Also effective six months after enactment, insurers may no longer place lifetime limits on the dollar value of coverage. Beginning in 2014, insurers may not impose annual limits on coverage.

Establishing New Health Insurance Marketplace

- The law creates new state insurance marketplaces, called "exchanges," where parents can go online to shop and compare coverage for just their children or the whole family. Starting in 2014, the law provides refundable and advanceable credits to families with incomes between 133-400% of the federal poverty level to help buy insurance through the new exchanges. Subsidies, available on a sliding scale, will help pay for monthly health insurance premiums and cost-sharing, such as co-pays. This is essential to making sure that low- and moderate-income families have the ability to purchase insurance for their children if their employer does not provide coverage.
- The law requires plans on the exchange to cover an appropriate and necessary range of services for children. In order for insurance plans to be listed on the exchanges, they must comply with the standards of pediatric care set forth in the law. Plans must provide comprehensive, essential benefits, including cost-free preventive care, pediatric services, oral, and vision services. In addition, all plans must limit annual out-of-pocket expenses to $5,000 per individual and $10,000 per family.

ACCESS TO CARE

When analyzing the health coverage of children in this country, it is important to focus not solely on the status of health insurance coverage, but also on the quality of coverage and the actual access to care the child is experiencing. Beyond insurance coverage, children face numerous barriers to getting the care they need, including high out-of-pocket costs that their family must pay, a limited number of physicians, dental, and mental health care professionals, lack of provider participation in the Medicaid program, rising rates of chronic disease in underserved populations, and difficulty getting transportation to care. Medically underserved children often face alarming challenges even if they have health insurance, including psychosocial challenges and geographic isolation. The integration of mental and dental health care, along with other services in an enhanced medical home model of comprehensive, coordinated and continuous care, has the best potential to meet the needs of our nation's most vulnerable population.[16] CHF estimates that approximately 16.9 million of insured children are experiencing various types of barriers to accessing care[17]. The ACA seeks to improve coverage for these children by addressing barriers to care by in the following ways.

Improving Access to Pediatric Medical Care

The new health reform law's major impact will be to cover the majority of children that are currently uninsured. However, having insurance does not always equal access to a physician. If a child is a Medicaid recipient, the outlook is even bleaker, as they currently face long wait lists for appointments with physicians who accept Medicaid and limited access to subspecialists.[18,19] The law seeks to remedy this situation in several ways.

- The health reform law improves access to physicians by increasing reimbursement for primary care. Starting in 2013, reimbursement for primary care services will be 100% of the Medicare rate and fully funded by the federal government for 2 years.
- The law removes co-payments for preventive services and screenings, removing a critical financial barrier for low-income children.
- Through the expansion of the National Health Service Corps (see Workforce), the law encourages primary care physicians to work in shortage areas.

Expanding Community Health Center Capacity

Twenty million Americans currently receive care through 1,080 community health centers located in 7,000 medically underserved urban and rural areas.[20] By 2019, the ACA will double the capacity of community health centers to serve 20 million more Americans.[21] Almost 7 million of the new recipients of care will be children.

- The law increases overall funding for community health centers by $11 billion over five years, starting in 2011. Of this, $9.5 billion will allow health centers to expand their operational capacity to enhance their medical, oral, and behavioral health services and $1.5 billion will fund expansion through capital expenditures. In doing so, the law helps community health centers provide comprehensive primary care to medically underserved populations—the target populations of community health centers—including low-income, poor, uninsured, migrant and immigrant communities.

Strengthening Pediatric Workforce

Currently there is a significant concern regarding the inadequacy of the nation's health care workforce. Prior to the ACA's passage it was estimated that the nation would face a shortage of 21,000 physicians by 2015.[22] The ACA works to meet both the current demand for primary care physicians and also the future need, which will be increased when 30 million Americans gain coverage under the law. The law also:

- Dedicates $1.5 billion to the National Health Service Corps (NHSC) to place an additional 15,000 primary care providers in health professional shortage areas.[23]
- Increases the amount of loan repayment available to NHSC members from $35,000 to $50,000 a year.
- Allows part-time clinic practice and time spent teaching medical students and residents to be included as components of NHSC loan repayment eligibility, creating a degree of flexibility that will attract new physicians willing to serve.
- Provides grants for the construction and operation of school-based health centers – pediatric clinics located in schools -- with priority given to those that serve areas with a higher concentration of children eligible for Medicaid and CHIP.
- Establishes a Workforce Advisory Committee to develop a national strategy to address workforce shortages and develop solutions.

Improving Access to Mental Health Care for Children

Mental health care is a vital part of the medical home, but one that is often undermined by a lack of providers and funding. The impact of workforce shortages is especially pronounced for children and youth. Recognizing this challenge, the law does the following:

- Provides grants to integrate mental health services through co-location of primary and specialty care in community-based mental and behavioral health settings.
- Encourages medical home models that address health care needs alongside mental health and substance abuse needs.[24]

- Improves access to health insurance for persons with mental health illness, a pre-existing condition to many insurance providers.

Expanding Dental Health Care

The law provides grant assistance and scholarship programs for dental professionals, with priority given to those who work in collaboration with primary care providers as well as those who choose to serve vulnerable populations. The ACA also establishes grants to demonstrate the effectiveness of training programs for alternative dental health care providers, including supervised dental hygienists, primary care physicians, dental therapists, and other appropriate health professionals. Currently, primary care providers often see patients who have never been to a dentist. This is often the case with Medicaid patients, because Medicaid oral health reimbursement rates are so low. Recognizing the needs of patients and the lack of dental professionals, the ACA addresses the need to expand access to dental care for millions of children.

Promoting Prevention and Public Health

Further prioritizing prevention, the law establishes a National Prevention, Health Promotion, and Public Health Council and creates a Prevention and Public Health Fund that is already at work in communities across the country. For children, this means focused national attention on obesity, nutrition, physical activity, and tobacco prevention. In the first year alone, $16 million has gone to obesity prevention and fitness programs. Priority is given to activities and research that aim to reduce chronic disease rates and address health disparities, especially in rural areas.

CONCLUSION AND RECOMMENDATIONS

The Patient Protection and Affordable Care Act is an important first step in reforming our broken health care system. For children, it means improving the insured rate to an unprecedented high, and extending access and improving coverage for children who currently have health insurance coverage but experience barriers to getting the care they need. Congress and the President have acknowledged that certain parts of the bill need to be fixed, and significant work remains to be done to ensure that all children have access to the care they need and deserve. This law represents society's call to action to improve the health and well-being of all Americans by reforming the insurance market and working to extend care to the most vulnerable among us. This being the case, there are several actions that both the federal and state governments, as well as health care professionals, should consider going forward:

1. In the face of heated debate, provisions in the ACA that extend insurance coverage and improve access for children, including workforce enhancements, support for community health centers, and access to mental and dental care, should be preserved during any revision of the law.

2. In addition, Congress should support the work of federal agencies that are responsible for managing health care reform, including the Department of Health and Human Services and the Health Resources and Services Administration, especially their work on innovative solutions to reduce the uninsured and underinsured rates of children and improve quality of care for children and families.

3. States should take advantage of all opportunities for funding within the health reform law, especially those provisions which aim to improve service delivery for medically underserved patients, specifically those related to establishing community health teams to support patient centered medical homes and community transformation grants. Patient centered medical homes have the opportunity to reduce costs to the health system, especially as it relates to avoidable emergency room visits for children suffering from asthma.[25]

4. Health care organizations and professionals should familiarize themselves with the law and how it will impact patients, and then inform them of changes and the benefits that they may receive, including subsidies to purchase coverage and reduced co-payments for preventive services.

Health Care Reform Law Implementation Timeline Provisions that Affect Children	
2010	• Prohibits denial of coverage for children under the age of 19 with a pre-existing condition. • Young adults are allowed to stay on their parents' plan until they turn 26 years old. • Eliminates lifetime dollar limits on insurance coverage. • Regulates annual limits on insurance coverage. • All new insurance plans must provide free preventive care. • Initial investments from the Prevention and Public Health Fund go to initiatives focused on primary care workforce, obesity prevention, tobacco cessation, nutrition, HIV/AIDS prevention, and racial disparities. • Provides states with funds to cover more people on Medicaid. • Prohibits insurance companies from rescinding coverage for children. • Initial investments in community health centers are funded.
2011	• Chain restaurants and vending machines are required to disclose nutritional content of food products. • Requires that 85% of premiums collected by insurance companies for large employer plans be spent on health care services and quality improvement.
2013	• New funding for preventive care available to states under Medicaid that cover preventive services for patients at little or no cost. • Increased Medicaid payments to primary care doctors available for two years. • Children's Health Insurance Program (CHIP) funding continues for two years starting October 1, 2013.
2014	• Individual mandate goes into effect, requiring everyone to have insurance in 2014. Those who do not have health insurance may be subject to an individual fine, subject to affordability and certain exemptions. • State-based Health Insurance Exchanges will be operational. • Companies with 50 or more employees must provide health insurance. • Tax credits will be available for those with an income between 100 and 400 percent of the poverty line (400% of FPL is $43,000 for an individual and $88,000 for a family of four in 2010). The tax credit will be available in advance for the purchase of insurance. • All Americans who make less than 133% of FPL will have access to Medicaid. • Eliminates annual limits on insurance coverage. • Requires states to provide Medicaid coverage to children aging out of foster care, up to age 26.
2015	• CHIP expires, the Secretary of HHS must certify that plans available on the exchanges offer at least comparable benefits and cost sharing protections provided under each state's CHIP plan.

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