Strengthening Families Learning Community

Tuesday, June 18, 2013
1:00 to 3:00 p.m.
Magnolia Family Center
1910 Magnolia Place
Los Angeles, CA 90007

MEETING AGENDA

1:00 **I. Welcome and Introductions**
Kathy Malaske-Samu, Chief Executive Office

1:15 **II. Achieving Child, Family and Community Well-Being: Aligning Networks**
Pat Bowie, Casey Family Programs

1:45 **III. Initiative Spotlight: Opportunities for Collaboration under the Affordable Care Act**
Karen Bernstein, Department of Health

2:15 **IV. Community Practice Change in Action**
Lila Guirguis, Magnolia Community Initiative
Frank Enriquez and Maria Chavez, Department of Public Social Services (DPSS)

2:45 **V. Check-in/Wrap Up**

Meetings Scheduled for 2013-14

September 17, 2013
December 17, 2013
March 18, 2014

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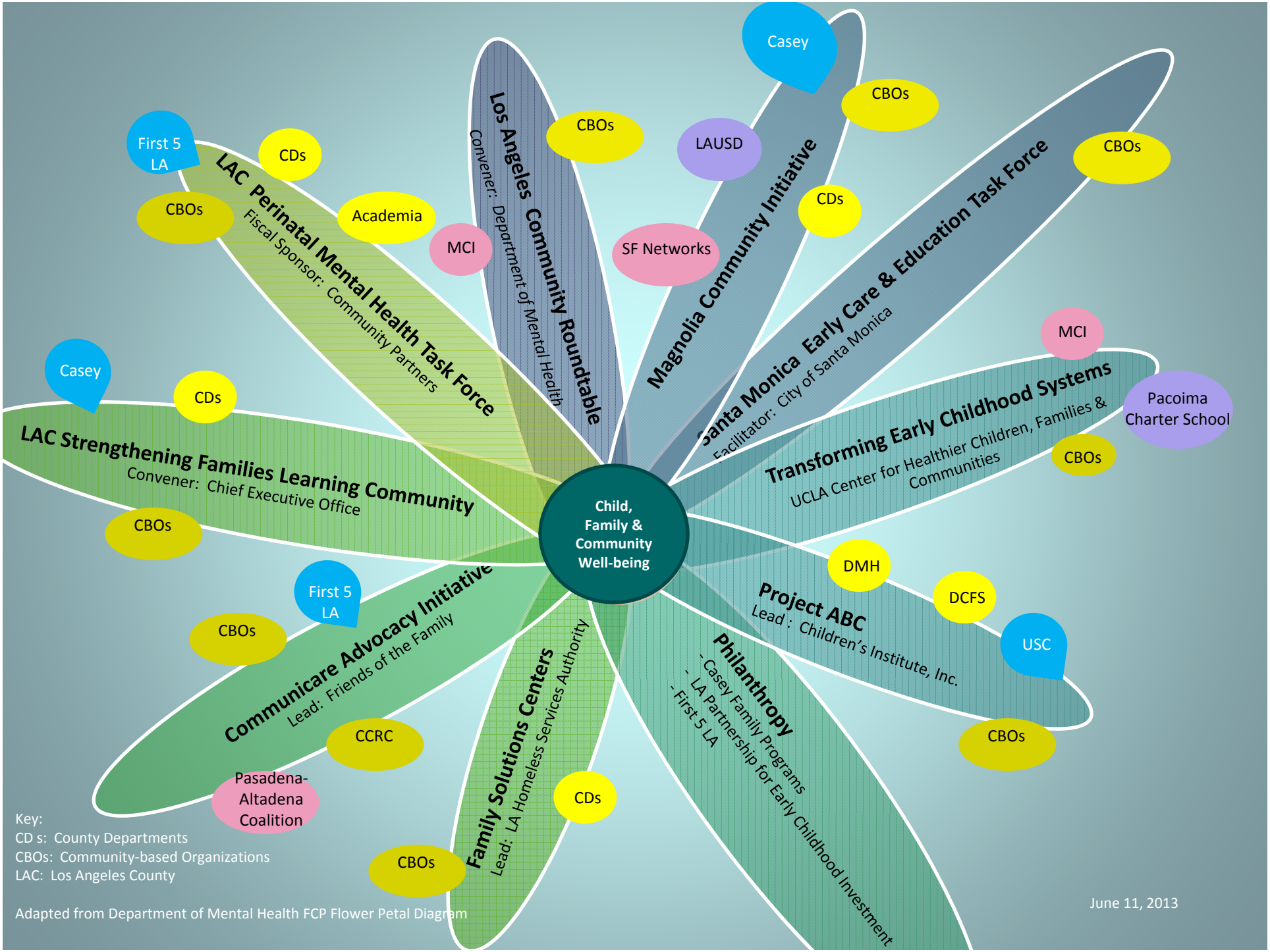
Child, Family & Community Well-being
LAC Perinatal Mental Health Task Force
Fiscal Sponsor: Community Partners
First 5 LA
CDs
CBOs
Academia
MCI
Los Angeles Community Roundtable
Convener: Department of Mental Health
CBOs
LAUSD
SF Networks
Magnolia Community Initiative
Casey
CBOs
CDs
Santa Monica Early Care & Education Task Force
Facilitator: City of Santa Monica
CBOs
Transforming Early Childhood Systems
UCLA Center for Healthier Children, Families & Communities
MCI
Pacoima Charter School
CBOs
Project ABC
Lead : Children's Institute, Inc.
DMH
DCFS
USC
CBOs
Philanthropy
- Casey Family Programs
- LA Partnership for Early Childhood Investment
- First 5 LA
Family Solutions Centers
Lead: LA Homeless Services Authority
CDs
CBOs
Communicare Advocacy Initiative
Lead: Friends of the Family
First 5 LA
CBOs
CCRC
Pasadena-Altadena Coalition
LAC Strengthening Families Learning Community
Convener: Chief Executive Office
Casey
CDs
CBOs
Key:
CD s: County Departments
CBOs: Community-based Organizations
LAC: Los Angeles County
Adapted from Department of Mental Health FCP Flower Petal Diagram
June 11, 2013

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Network Weaver Checklist

What kind of Network Weaver are you? Mark each from 1 to 5, with 5 being "major strength" and 1 being "lack this quality."

You are opportunity seeking

_____ 1. Focus on the positive, are optimistic

_____ 2. Continually unearth new resources and add to the network's periphery

_____ 3. See problems and needs as opportunities

_____ 4. Every new relationship is an opportunity to connect that person to others

_____ 5. Ask a lot of questions

_____ 6. Identify peoples' strengths and gifts

You help people have big dreams but facilitate doable projects

_____ 1. Have a big vision but see the importance of taking small steps

_____ 2. Love to unearth other peoples dreams and visions

_____ 3. Comfortable with uncertainty but persistent in making things happen

_____ 4. See patterns in the network: where there is energy, where there is isolation

_____ 5. Able to learn from experience; decide next step after reflecting on previous step

_____ 6. Not attached to specific next step but strategic

_____ 7. Able to see when something doesn't work and move on

You help people understand and apply network concepts, values and behavior

_____ 1. Share information and resources without expectation of a direct return from that person

_____ 2. Often express the importance of collaboration

_____ 3. Point out the value of knowing people with different perspectives and from different backgrounds

_____ 4. Help people map, analyze and enhance their networks

_____ 5. Treat everyone as peer – of equal value but not the same

_____ 6. As an individual, you are unique, a "character," but with little ego

_____ 7. Help people understand Smart Networks concepts and translate into practice.

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Network Weaver Checklist

You help people deepen the quality of relationships

_____ 1. Help people deal with differences and conflict

_____ 2. Encourage people to listen to each other

_____ 3. Insist that people check assumptions about what others are saying

_____ 4. Encourage people to identify their shared beliefs and values and overlapping interests

_____ 5. Model an approach to relationships that is positive and appreciative and focused on strengths

_____ 6. Help people make accurate assessments of others

_____ 7. Show people how to build trust through low-risk collaborations with others

You work with others to create scale and impact

_____ 1. Encourage others to become network weavers & take responsibility for increasing the health of their networks

_____ 2. Mentor others in project coordination skills

_____ 3. Encourage people to initiate collaborations with others

_____ 4. Help people bring innovation and new perspectives into their networks

_____ 4. Help small projects move to scale

_____ 5. Encourage people to see the "patterns of success" and apply them to other situations

_____ 6. Convince policy makers to be part of your network

Network Weaving Strengths:

Areas for Strengthening Skills:

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Affordable Care Act: DHS Impact and Collaborative Opportunities

LA County Department of Health Services
June 2013

ACA Overview: Medi-Cal Expansion

- Currently covered under Medi-Cal: low income parents with children, children, seniors, disabled, some special populations
- Under ACA, starting in 2014, Medi-Cal eligibility expanded to all adults under 138% FPL who are citizens or legal residents for 5 years.
- Federal government pays 100% of expansion costs through 2016, then 90% thereafter
  - 10% of cost estimated at $300-$400 million annually for State to cover
- Healthy Families enrollees transitioned into Medi-Cal starting in Jan 2013 – children up to 250% FPL covered.

ACA Overview: Health Benefit Exchange

- Individuals with income within 133%-400% FPL eligible
- "Covered California" established, offering bronze, silver, gold and platinum plans through existing insurance providers
- Subsidies based on family size and income
- Penalty for not purchasing insurance (phased in through 2016)

Other ACA Provisions Helping Families

- Already in place:
  - Coverage for children up to age 26 on parents' insurance
  - Prohibit lifetime coverage limits
  - Prohibit pre-existing condition exclusions for children
- In January 2014:
  - Prohibit annual coverage limits
  - Prohibit pre-existing condition exclusions for adults
  - Limit waiting periods for coverage to 90 days
  - Foster children aging out of system eligible for Medicaid through age 26

ACA and Strengthening Families

- Protective Factor:
  Concrete Support in Time of Need
- Strengthens:
  - Economic position of families
  - Health of family members

LA County DHS Services

- 4 Hospitals
- 2 Multi-Service Ambulatory Care Centers
- 6 Comprehensive Health Centers
- 11 Health Centers
- 161 Community Partner Clinic Sites
- Emergency Medical Services (911 ambulance system)
- Juvenile Court Health Services

LA County Safety Net Today

- About 2.3 million uninsured in LA County
- DHS and Community Partner clinics provide care to about 750,000 unique patients per year
  - About 75% currently uninsured
  - About 80% of uninsured report income <138% FPL (Medi-Cal expansion population)
- About 260,000 have been enrolled in Healthy Way LA (1115 Waiver Low Income Health Plan), all of whom will move into Medi-Cal under the ACA

The 'Residually Uninsured'

- About 70% of currently uninsured in LA County estimated to be eligible for Medi-Cal expansion or Exchange
- As many as 1.3 million could remain residually uninsured in LA County
  - Undocumented or legal status <5 years
  - Those unaware of requirement/options
  - Those who choose penalty as less costly option
- Children:
  - 195,000 in LA County currently uninsured
  - 30% expected to be ineligible for coverage under ACA

Three major challenges for DHS/Safety Net

Patients, referring providers, and health plans may not choose us

Funds for caring for the uninsured may drop

Capitation/bundled payments are lower than actual expenses

Provide more care, of a higher quality, for the same cost

Need to retain paying patients

- History of patients with choice leaving DHS
  - 43,000 deliveries/year prior to 1990's State expansion of Medi-Cal to pregnant women; currently 3,000.
- Working to transform system into one that's competitive with private sector and patient-centered.
- Working to increase HWLA enrollment to 300,000 goal

System transformation

- Implementing patient-centered medical home model in primary care clinics, with care teams
- Empaneling close to 300,000 patients in medical homes
- New disease management registry system to track care needed over time
- New eConsult system to allow primary care physicians to communicate with specialists
  - Handle some issues without specialty visit
  - Decrease wait times for specialty visits
- Electronic Health Record system under development to connect all sites
- Implementing patient-centered scheduling (same and next day appointment availability)

System Transformation, cont'd

- Change in reimbursement from cost-based to Per Patient Per Month (capitated) rate
- Need to decrease costs and simultaneously increase quality/ service levels
- Avoid unnecessary hospitalizations
- Move patients who no longer need to be in the hospital to less costly after-care settings (e.g., board & care, supportive housing)
  - New Housing for Health Division
- Centralize more functions across system, e.g., pharmacy refills

Interdepartmental Collaboration

- Goal of integrating Health, Mental Health and Substance Abuse services
- DMH also planning for ACA – health plans will include MH benefits
- DMH collaborations
  - DMH staff co-located in DHS clinics
  - HWLA enrollment, services
  - Creation of primary care homes for persons with serious mental illness
  - Pairing of DMH clinics with Community Clinics
  - Expanding placement resources for psychiatric patients leaving DHS hospitals

Interdepartmental Collaboration, cont'd

- DPH – Substance Abuse Prevention and Control Program
  - Improved Medi-Cal substance abuse treatment benefits under ACA
  - Co-location of Substance Abuse Counselors in DHS Emergency Depts.
  - Set-aside of beds for DHS patients at Antelope Valley Rehabilitation Center
  - Pairing of DHS clinics with Substance Use Disorder treatment providers
  - Up to 200 Certified Application Assisters to enroll HWLA patients in non-clinical settings

Interdepartmental Collaboration

- DPSS key role
  - Staff currently conducting HWLA enrollment and redetermination
  - Will be responsible for Medi-Cal expansion enrollment
  - Training for 7,150 eligibility and clerical workers on ACA, communicating with patients on navigating health insurance marketplace
- CEO leading Health Care Reform Implementation Task Force
  - Hiring, class/comp, contracting issues
- Many other opportunities – DCFS, CSS, Sheriff, Probation, etc.

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June 20, 2013

HUFF POST LOS ANGELES

Kids and the Affordable Care Act: A High-Stakes Recipe for Success

Posted: 04/10/2013 1:54 pm

Everyone who cares about children in California and around the country ought to be rooting for the Affordable Care Act (ACA) to succeed. If done right, it will mean kids who have never received regular check-ups, eye glasses, dental care, or screenings can get them and other needed health care -- on time and when needed.

But whether this historic law results in a meaningful step forward for kids depends on crucial and complicated decisions states and the federal government make between now and Oct. 1, 2013, when the doors open for enrollment in coverage. Large numbers of children will be covered through the publicly-funded Medicaid and CHIP (Children's Health Insurance Program) programs, administered by states. By contrast, the vast majority of adults will be covered through their employers and exchanges, not Medicaid. As a result, certain decisions have a disproportionate impact on children.

So what are the ingredients for success that matter most for kids?

First, getting the initial sign-up right for kids is essential and involves different priorities than those for most adults. When children enter the enrollment system required by the ACA, millions of kids -- more than half of all children in California -- will be transferred to Medicaid (Medi-Cal in California). This is because children in families with an annual income up to $58,875 for a family of four get their care through Medi-Cal or CHIP in this new health care landscape. To make sure kids are not lost in this transfer, the Medi-Cal service centers need to be up and running with trained staff from day one. If the centers are not ready, the exchange itself needs to step up to immediately enroll children as the federal law envisions. For the many parents who will apply online for their kids, states should make use of the federal model streamlined application, a breakthrough online tool that is being tested with consumers now, so states can take advantage of this in time for Oct. 1.

Second is making sure health care providers are available for kids. Consumers, providers, and employers alike are concerned about whether there will be enough doctors, dentists, and other medical personnel to handle millions more Americans gaining coverage in short order. In California, for example, it's a well-documented fact that Medi-Cal's reimbursement rates are a fraction of standard medical fees and that disproportionate numbers of children on Medi-Cal simply can't get to a specialist -- or even to providers that all children need to see, like dentists. With 49.9 percent of California's children on Medi-Cal not having seen a dentist even once during 2011, imagine the situation when an additional 1.2 million children in California alone get dental coverage once the ACA is implemented. But here, too, states like California are exploring reasonable ways to expand the dental and medical teams by training new providers and extending the scope of current providers to work in underserved areas under the supervision of doctors and dentists. Breakthroughs in technology like telehealth make these advances not only necessary but also realistic.

Third, covering parents matters. Another decision with a major impact on kids is the choice states make about whether to expand their Medicaid program to additional low-income adults. These adults, often parents, currently fall between the cracks of coverage because they can't afford private insurance but are not currently eligible for Medicaid. Research shows that when parents are eligible for coverage, they are more likely to enroll their children and more children are likely to receive needed care. In California, pressure on Governor Brown is mounting to finish the health reform job by expanding Medi-Cal for adults.

Fourth and fifth are two "sleeper kids' issues," important areas where kids' needs are at risk of being forgotten as policymakers instinctively focus on adults. Fourth has to do with the Small Business Health Options Program (SHOP) state exchanges will offer, designed to create a platform for delivery of small employer-sponsored health care. Because the majority of all children are currently covered through their parent's employer, the SHOP program needs to connect employees to health coverage for themselves and also their dependent children. SHOP programs should provide a way for every parent to access coverage options for their children, including Medicaid.

Fifth is the ACA's highly-touted requirement for plans to provide "Essential Health Benefits (EHBs)." Essential Health Benefits ensure that plans purchased through the exchange offer a wide array of services, such as preventive and wellness services and mental health services. However, one of the 10 EHBs -- pediatric benefits -- remains largely undefined by federal rulemakers, and states still have very important decisions to make about many of these benefits. In California, for example, questions remain about how pediatric dental care will be offered and paid for, and there are concerns about maintaining current levels of critically important mental health, hearing, and other important benefits for children.

Last, and arguably most important of all, is whether coverage under the ACA will be affordable to families with children. Today, 52 percent of uninsured Americans say the main reason they don't have insurance is because they can't afford it. Unless the ACA changes this situation, it cannot succeed. Astoundingly -- since it is in direct conflict with the central goal of the ACA -- the Internal Revenue Service recently issued a ruling on how subsidy levels will be determined. Their ruling poses a huge affordability problem for families with children. It says that subsidies for families will be based solely on whether the individual employee's coverage is affordable; if it is, the whole family is ineligible for subsidies, even where the employer's family coverage is unaffordable. As a result, nearly half of a million children across the country are expected to remain uninsured because parents would not be able to afford coverage for the whole family. The impact must be analyzed in 2014, and remedies must be found.

The ACA's potential to help kids is enormous. There is a recipe for how to get this right. Our collective job over the months ahead is to make good decisions on behalf of the millions of children in this country who are not at these decision-making tables but whose well-being -- and even lives -- depend on making the right choices.

NATIONAL ACADEMY *for* STATE HEALTH POLICY®

Health Care Reform and Children: Planning and Design Considerations for Policymakers

Jennifer Dolatshahi
Catherine Hess
Joanne Jee

June 2013

Health Care Reform and Children: Planning and Design Considerations for Policymakers

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- Convene state leaders to solve problems and share solutions
- Conduct policy analyses and research
- Disseminate information on state policies and programs
- Provide technical assistance to states

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Portland, Maine Office:
10 Free Street, 2nd Floor
Portland, ME 04101
Phone: [207] 874-6524

Washington, DC Office:
1233 20th Street, NW, Suite 303
Washington, DC 20036
Phone: [202] 903-0101

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Executive Summary

The Affordable Care Act (ACA) is estimated to expand health insurance coverage to 25 million individuals, primarily adults, by 2017[1] through insurance market reforms, health insurance exchanges or marketplaces, and the Medicaid expansion. Especially when their parents stand to gain coverage, these options will also benefit children.[2] Although the ACA has several key provisions aimed specifically at children, the majority of the law focuses on the much larger uninsured population, especially adults without dependent children. As January 1, 2014 draws near, states are focused on implementing these new coverage programs and other required systemic changes, and may concentrate less on children's coverage. Over the past 15 years, states have made important gains in children's coverage, in part due to greater focus on and support for targeted outreach, simplified enrollment strategies, and enhanced program eligibility levels for children. However, maintaining and building on the success of children's coverage may be difficult given the emerging emphasis on adult coverage and the potential for unintended consequences for children's coverage as a result of systemic changes that flow from the law. This report explains some of the major challenges for children's coverage under the ACA, and describes options for making health care reform work for children. The potential solutions draw upon lessons learned from state Medicaid and Children's Health Insurance Programs (CHIP), federal policy, and relevant research.

Outreach and Consumer Assistance

Outreach and consumer assistance can make enrollment in the ACA's health coverage programs seamless and straightforward for families, particularly when families have complex coverage situations. Factors such as differing immigration statuses among family members, varying family structures, differing program-eligibility requirements, and inconsistent availability of employer-sponsored insurance (ESI) for dependents could result in different family members being enrolled in different coverage programs. To facilitate enrollment of all family members in coverage programs, state policymakers could take a number of steps.

- **Family-centered outreach and consumer assistance.** With more parents becoming eligible for coverage in 2014, states may need to take a holistic approach to reaching out to and enrolling an entire family, rather than just a child or an adult. Outreach messages that advise families of the availability of health coverage for all family members and connect them with appropriate enrollment assistance will be critical to ensuring that families understand the new coverage environment. Getting parents enrolled in coverage not only helps enroll eligible children, but may also improve continuity of coverage and help children access necessary pediatric preventive care.[3]
- **Leverage CHIP and Medicaid assets and lessons learned.** In developing outreach and consumer assistance programs, states could leverage both the lessons learned and the established community relationships in CHIP and Medicaid programs to help enroll families in coverage. Over many years of conducting outreach for children's health coverage in CHIP and Medicaid, states have amassed considerable knowledge in and resources for reaching children, youth, and families. CHIP and Medicaid programs have also built strong relationships with community-based organizations and schools to help reach eligible children and youth, particularly in hard-to-reach populations.

Eligibility and Enrollment

As a result of the ACA's changes to Medicaid's eligibility threshold and how income is counted in Medicaid and CHIP, some children will move from one public program to another. Some children and youth will also face a waiting period before enrolling in CHIP if they have formerly had private insurance coverage.

Additionally, legal immigrant children residing in states that have not implemented the Children's Health Insurance Program Reauthorization Act (CHIPRA) option to cover them in the first five years of their residency will face a significant barrier to enrolling in coverage. Once children are enrolled in programs, the problem of churning—the movement of individuals on and off health coverage programs—could be exacerbated after 2014, and some children could move to potentially more costly and less comprehensive coverage in marketplaces. States are facing many fast-approaching deadlines for implementing eligibility and enrollment policy and system changes, and challenges for children's coverage related to these changes could lie ahead. However, thoughtful design and careful implementation of new requirements will help children maintain or gain coverage in 2014 and into the future. States may be able to implement strategies now to help streamline eligibility and enrollment for children and youth.

- **Move older children between 100 and 133 percent of the federal poverty level (FPL) before January 1, 2014.** All states are required to cover children under age six with incomes up to 133 percent FPL in their Medicaid programs. States with Medicaid eligibility levels below 133 percent FPL for children and youth ages six to 19 in 2013, however, must move these older children into Medicaid. This shift is a result of the ACA's mandatory expansion of Medicaid for children up to 133 percent FPL.[4] States can transition these children and youth from separate CHIP (S-CHIP) programs into Medicaid before January 2014 in order to learn from the experience of transitioning between programs. In particular, the early transitions can prepare states for educating families about program changes. The transitions may also alleviate some administrative burden during the later months of states' preparation for January 2014. Some states have already begun these transitions and may be able to provide early lessons learned.
- **Shorten or eliminate waiting periods.** CHIP rules require states to take measures to prevent "crowd-out"—the substitution of public coverage for private insurance—but do not specifically require that waiting periods be used. Thus, states could eliminate S-CHIP waiting periods all together. In 2012, Vermont eliminated the 30-day waiting period from its S-CHIP program and Colorado passed a law in March 2013 removing the three-month waiting period from its CHIP program. In states retaining waiting periods, exemptions from waiting periods—in addition to the exemptions now required in accordance with January 2013 proposed federal regulations[5]—could be implemented and could help minimize potential coverage gaps for children.
- **Address churn and simplify enrollment.** Churning—the movement of individuals on and off coverage programs—is an issue currently seen in Medicaid and CHIP programs and will continue to be one after 2014. Those with incomes near the newly created Medicaid floor of 133 percent FPL are especially prone to churning.[6] States can implement existing, tested strategies to simplify and streamline enrollment and retention while reducing their workload. Strategies that will help alleviate the magnitude of churn include 12-month continuous eligibility and ex-parte and administrative renewals. States can also use Express Lane Eligibility at enrollment, renewal, and for transitions between Medicaid and CHIP programs.[7]

Affordability

The ACA's provisions for subsidized marketplace coverage will expand the options for low-income families, but certain marketplace cost-sharing provisions may still create cost challenges for families. For example, in the marketplace, families with incomes between 200 and 400 percent FPL could pay as much as 6.3 to 9.5 percent of their incomes for premiums alone.[8] In Medicaid and CHIP, however, *total* cost sharing, including premiums, is limited to five percent of family income.[9] Even with premium subsidies and cost-sharing reductions in the marketplace after 2014, some families will still find it difficult to afford health

insurance. Families in states that charge cost sharing in Medicaid and CHIP could face "premium stacking" and find themselves responsible for those programs' premium costs on top of the cost of premiums in the marketplace because of the way the advanced premium tax credit (APTC) is calculated. (The APTC will help individuals with incomes up to 400 percent FPL with the cost of premiums for qualified health plans (QHPs) in the marketplace.) Additionally, some families may not have access to an APTC because a parent has an offer of ESI where employee-only coverage is less than 9.5 percent of a family's income, regardless of the cost of dependent coverage. Depending on the financing and structure of coverage programs, states may be able to address some affordability issues for families.

- **Further subsidize qualified health plans (QHP) in marketplaces for lower-income families.** In addition to the federal subsidies that will be available to qualified individuals in the marketplace, states could further subsidize coverage for some of their lower-income QHP-enrolled residents.[10] California, Massachusetts, and Vermont are considering plans to use state funds to assist some QHP-enrollees better afford marketplace coverage.[11]
- **Eliminate or waive premiums for families facing "premium stacking."** Eliminating or waiving premiums for families facing premiums in multiple coverage programs are options states could consider to help reduce the cost of health coverage for those families beginning in 2014. In states that rely on premiums as a way to finance their CHIP or Medicaid programs, waiving premiums may be less feasible. However, states that charge only nominal amounts in these programs may find that the cost of administering premiums is greater than the premiums themselves.

Access to Providers Appropriate for Children and Youth

Adequate and appropriate provider networks are essential for meeting consumers' health care needs, in particular, those of children and youth. However, the combination of the expected enrollment growth in health coverage programs and an anticipated ongoing shortage of certain providers makes the work of creating, maintaining or improving provider networks that meet children's needs all the more important.[12] States may be able to look to their Medicaid and CHIP programs to help ensure that children and youth have consistent access to appropriate providers.

- **Incorporate Medicaid or CHIP providers or plans in the marketplace.** States' Medicaid and CHIP programs have worked to build and strengthen pediatric provider networks that can provide a framework for developing provider networks in QHPs. States could align provider networks or insurance plans across Medicaid, CHIP, and the marketplace. This would help ensure that children and youth have access to appropriate providers and could keep families together in the same plan, regardless of whether family members are eligible for different coverage programs.
- **Include essential community providers (ECPs) that traditionally serve children.** Federal rules give states and QHPs a great deal of flexibility in determining the number and types of providers they will contract with to meet the ECPs requirement in the ACA.[13] Some state Medicaid and CHIP programs already require that their plans contract with entities that would qualify as ECPs, and states have the ability to require or incentivize QHPs to contract with these same providers, such as children's hospitals, school-based health centers (SBHCs), and Federally Qualified Health Centers (FQHCs). By including providers specific to children in the essential community provider requirements for QHPs, states can ensure that provider networks meet children's needsn even among children who do not qualify for CHIP or Medicaid coverage.

Access to Appropriate Benefits

Appropriate benefits will be important to all children in the marketplace, particularly low-income children who are more likely to have poorer health and have a higher prevalence of special health care needs than other children.[14] States must design their essential health benefits (EHB) packages—the minimum coverage that all private health plans both inside and outside of the marketplace and Medicaid benchmark and benchmark-equivalent plans are required to provide—to encompass 10 categories of benefits, including pediatric and habilitative services.[15] In order to design their EHBs states could choose from four types of benchmark plans. Federal guidance on state EHB design recognized that coverage for both habilitative services and pediatric services, including oral and vision care, would likely need to be supplemented for the available benchmark plans,[16,17] and research has shown that available benchmark plans are likely far less generous for children than Medicaid and CHIP. How benefits are defined under health care reform and how marketplace coverage compares to benefits available to children under CHIP and Medicaid will be important considerations for states.

- **Use CHIP or Medicaid as models for children's benefits**. In defining the habilitative services and pediatric services categories that are critical for children and youth, states could look to CHIP and the Medicaid Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) as models for benefits that are designed specifically for children.[18] S-CHIP programs often include habilitative services, which are an important benefit for children with special health care needs.[19] Under EPSDT, states' Medicaid programs cover all otherwise-optional Medicaid services that are necessary for children's health. The Centers for Medicare and Medicaid Services (CMS) recognized CHIP as a potential model when it named CHIP dental benefits as one of the potential EHB pediatric dental benchmarks.[20]
- **Align benefits across coverage programs.** Careful benefit design can help lessen the effects of churn and ease transitions for children. Aligning benefits across programs could ensure that children and youth have access to needed services regardless of which program they are eligible for. Such continuity is especially important for those with ongoing care needs. If federal funding is not extended for the CHIP program beyond 2015, or if a state's CHIP allotment runs out, a state must establish procedures to enroll CHIP-eligible children into the marketplace. Before this transition of children into the marketplace takes place, and no later than April 2015, the ACA requires that the Secretary of the U.S. Department of Health and Human Services certify which QHPs in the marketplace are comparable to CHIP in terms of benefits and cost sharing.[21] Although uncertified plans will still be offered in exchanges, the certification will provide families with important information about the children's benefits available, and families may perceive secretarial certification as a positive plan attribute.

Conclusion

With health care reform implementation, states have opportunities to develop and coordinate systems of coverage that meet the needs of many populations, including children and youth. However, without careful attention to specific issues affecting children, there is also the possibility of making policies and designing systems that unintentionally put children's coverage at risk. This report outlines steps that state policymakers can take to diminish negative consequences and maintain and improve upon the progress made in coverage of children and youth.

Introduction

Health insurance coverage for children has long been a national and state priority with strong public support, and children have historically fared better than adults when it comes to obtaining health coverage.[22] Higher insurance-coverage rates for children are partly due to generous eligibility standards in public programs; more and more tailored outreach; and innovative, streamlined enrollment systems. There are also more coverage options available for children. Unlike adults under age 65 who historically have had limited access to public coverage, children have options through both Medicaid and the Children's Health Insurance Program (CHIP). The Affordable Care Act (ACA) creates new opportunities for subsidized coverage and eliminates certain coverage exclusions, changes that are expected to result in coverage for millions more individuals, particularly adults.[23] However, the ACA's changes to public programs and the private insurance market may also create challenges for children's coverage.

Especially since the creation of CHIP at the national level in 1997, states have made great strides in increasing coverage of children and youth in the United States. Over the past decade, through CHIP and its larger sister program, Medicaid, states and the federal government have focused attention on children's coverage and on strategies to improve coverage for this population. As a result of this national and state commitment, the uninsured rate for low-income children and youth up to age 18 with incomes below 200 percent of the federal poverty level (FPL) decreased from 25.2 percent in 1997[24] to 15 percent in 2011.[25] The overall participation rate in CHIP and Medicaid—meaning enrollment among those children who are eligible—is 85.8 percent.[26]

The ACA provides opportunities to ensure that health coverage is more available and affordable and is expected to cut the uninsured rate by half.[27] It creates health insurance exchanges or marketplaces, gives states the opportunity to expand Medicaid for adults, and takes steps to help protect children's coverage. The ACA continues federal funding of CHIP through 2015, and the maintenance of effort (MOE) provision requires states to maintain at least the eligibility levels and enrollment improvements in place as of March 23, 2010 for CHIP and children's Medicaid through 2019. While the ACA has several key provisions aimed specifically at children, the majority of the law focuses on the much larger uninsured population, especially adults without dependent children.

This emphasis on the newly eligible adult population can also be seen in the financing available to states under the ACA. Until 2016, when the CHIP federal match rate increases, CHIP and Medicaid for children will continue to be funded at standard federal matching rates (on average 70 percent for CHIP[28] and 58 percent for Medicaid[29] in 2013). Meanwhile, effective in 2014, states will receive 100 percent federal funding for the newly eligible adult Medicaid population, and federal funding will cover 100 percent of advanced premium tax credits (APTCs) in the marketplace. Thus, federal financing creates an incentive to focus on new health coverage programs aimed primarily at adults.

However, the success of the state and federal concentration on health coverage for children does not mean that the work in regard to this population is finished. Nearly eight million children remain uninsured, and about five million of those children are known to be eligible for Medicaid or CHIP, but not currently enrolled.[30] For progress in children's coverage to be maintained and built upon into the future, it is important that a focus on children remains, even as states work to implement the major provisions of health care reform.

This report highlights potential challenges and issues policymakers and stakeholders may need to consider in order to ensure health care reform works for children and youth. Following a short overview of the coverage options available for children, this report describes some of the major implications of the ACA in regard to outreach, eligibility, coverage, and access for children. Quality measurement and improvement as well as community and public health are important to providing health care for children, but they are beyond the scope of this paper, which focuses on issues specific to coverage.

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Public Insurance: Medicaid and CHIP

About one-third of the nation's children and youth under age 18 are covered by either Medicaid or CHIP.[31] Under current Medicaid requirements, all state Medicaid programs must offer coverage to citizen children and certain legal immigrant children[32] under age six with net family incomes at or below 133 percent FPL, and from age six to 19 with family incomes at or below 100 percent FPL. Some states have expanded beyond these minimum eligibility levels.[33] Medicaid provides children with comprehensive benefits through the Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT), and affordability protections in regard to out-of-pocket expenses. No cost sharing[34] is permitted for children with incomes under 100 percent FPL, and only states that have expanded their Medicaid programs for children beyond 150 percent FPL can charge premiums. Certain services are also excluded from cost sharing, including emergency and preventive services, and all cost sharing, including premiums, is limited to five percent of a family's income.[35]

Low-income children with incomes too high for Medicaid are eligible for their state's CHIP program. States have more flexibility in designing their CHIP programs than they do in Medicaid and can choose to establish their CHIP programs as an expansion of Medicaid (M-CHIP), a separate program (S-CHIP),[36] or both. Separate CHIP programs tend to be more like private-market models than Medicaid, but with more comprehensive benefits for children than typically found in private plans.[37, 38, 39] CHIP cost sharing, including premiums, is limited to five percent of a family's income. Benefit packages for S-CHIP programs are based on the benchmark option chosen by the state and must cover well-baby and well-child care services, age-appropriate immunizations, and emergency services.[40]

Beginning in 2014, Medicaid eligibility will expand to a national floor of 133 percent FPL[41] for all children and youth under age 19 and for adults in states that choose to expand eligibility.[42] States that have not already done so will be required to expand their Medicaid programs to cover children and youth ages six to 19 with family incomes up to 133 percent FPL. Sixteen states currently cover children and youth in this income bracket in their S-CHIP programs and will be transitioning those beneficiaries into Medicaid when the minimum Medicaid eligibility limit is raised.[43]

Private Insurance: Marketplaces and Employer Sponsored Insurance

In 2011, 50 percent of all children under age 18 received health insurance coverage through employer-sponsored insurance (ESI), and another four percent had coverage through an individual plan in the private market.[44] Pre-ACA benefits for private health insurance plans have varied widely—partly due to differing state benefit mandates—but these plans typically have less comprehensive benefits for children than Medicaid and CHIP plans.[45] Additionally, private insurance plans are not subject to affordability protections and, therefore, generally provide less-comprehensive benefit packages with more out-of-pocket expenses than Medicaid or CHIP.[46]

The ACA includes a number of insurance market reforms such as the removal of pre-existing condition exclusions and the elimination of annual and lifetime coverage limits. These reforms will mean more people will be able to get coverage in the private market. The private coverage market will also be transformed through the establishment of health insurance marketplaces, giving an estimated 24 million people access to either subsidized or unsubsidized private coverage by 2023.[47] In 2014, an estimated 3.9 million children will be covered through employer or non-group plans in the marketplace.[48] Individuals

and families with incomes up to 400 percent FPL who do not have affordable ESI and are ineligible for Medicaid or CHIP will be eligible for advanced premium tax credits (APTC) to purchase marketplace coverage from a qualified health plan (QHP). Family out-of-pocket expenses will vary based on income, and premium payments for families up to 400 percent FPL may not be more than 9.5 percent of their income. Individuals and families with incomes up to 250 percent FPL will also be eligible for cost-sharing reductions in QHPs, which will lower costs for deductibles and other out-of-pocket expenses. All insurance coverage purchased from a QHP will need to meet a state-selected benchmark plan and cover essential health benefits (EHBs). Pediatric services must be included as part of the EHB package, and plans are prevented from imposing cost sharing on children's preventive services (as defined by the Health Resources and Services Administration's Bright Futures guidelines).

Potential Challenges and Opportunities for Children's Coverage under the Affordable Care Act

The ACA provides states with a framework to make coverage for most people a reality and includes a number of opportunities to improve upon the existing health care system. The overall vision for a seamless enrollment system where there is "no wrong door" to coverage means that states have the opportunity to make coverage work for not only an individual but also an entire family. The scope and complexity of the ACA also means that there is a possibility that some populations, including children, may get lost or overlooked in the transition to 2014 or in this new health coverage system. To support the seamless vision, the ACA made significant changes in requirements and options related to eligibility, enrollment, benefits, and access to care that create both opportunities and challenges for children's coverage. The following sections address key aspects of coverage systems, and each provides a brief overview of possible challenges followed by a discussion of potential policy or operational options to address the issue. Options discussed in this paper are drawn from state examples, federal guidance, and relevant research.

Outreach and Consumer Assistance

Outreach and enrollment assistance will be important to implementing health care reform, particularly in helping families understand and enroll in available coverage. Families with children who will move from CHIP to Medicaid and vice versa will need help understanding differences in eligibility and program features. Families with members eligible for different public and private coverage options will need assistance understanding and navigating those coverage programs, which could differ in several key ways. And while 90 percent of children now are insured,[49] there are still five million children who are eligible but not enrolled in Medicaid or CHIP.[50] How states develop and integrate consumer outreach, education, and assistance programs across coverage programs could influence how well families navigate the new health coverage environment and the extent to which children's coverage levels are maintained or further improved in future.

A New Focus for Outreach and Consumer Assistance

Of the 16 million people expected to enroll in Medicaid and CHIP (9 million) or marketplace coverage (7 million) in 2014, 14 million will be newly eligible for coverage or will have been previously eligible but uninsured.[51] Most will be adults under age 65, a population that many states traditionally have not covered in Medicaid programs. Thus, states' outreach and consumer assistance efforts for this population have been minimal and their experience developing effective outreach messages for adults limited. Effective outreach to newly eligible adults who are parents will not only facilitate their own enrollment into coverage, but as research has shown, can also increase child enrollment.[52]

To assist those newly eligible for coverage, marketplaces are required to create navigator programs that provide potential enrollees with information about premium tax credits in the marketplace and that facilitate enrollment in QHPs. States may require that navigators also enroll Medicaid and CHIP populations, but even in states not adopting this option, navigators will need to understand Medicaid and CHIP programs to meet the "no wrong door" vision of the ACA.[53] Entities selected by states to serve as navigators, particularly entities that have previously assisted individuals to enroll in private market coverage, may lack experience working with low-income populations or with the health coverage programs that serve them. Ensuring that all navigators have a firm and accurate knowledge of state Medicaid and CHIP programs will be important for all who might be eligible for those programs, including children.[54]

Families with Complex Coverage Scenarios

Obtaining health coverage will be more complex for some families than others. Factors such as differing immigration statuses among family members, varying family structures, differing program eligibility requirements, and the varying availability of ESI for dependents could result in different family members being enrolled in different coverage programs. For example, an estimated 16.7 million Medicaid- or CHIP-eligible children will have parents eligible for coverage in the marketplace. Another four million Medicaid, CHIP, or marketplace-eligible children will have parents who have insurance coverage through an employer-sponsored plan, or who are undocumented and therefore ineligible for coverage.[55] Families experiencing these complex coverage scenarios will need to sort out the eligibility requirements, health plan choices and rules, benefit packages, and provider networks in multiple programs, as well as juggle affordability issues (which are discussed in more detail later in this report). Consumer assistance will be vital to helping these families.

Children with parents who are undocumented may be especially vulnerable today and after 2014 and make up a particularly hard-to-reach population. In 2009, there were an estimated 3.5 million citizen or legal-immigrant children who did not have at least one citizen or legal-immigrant parent. Most of these children are eligible for Medicaid or CHIP, and an estimated 200,000 children would be eligible for subsidies in the marketplace.[56] Their parents, because of their immigration status, would not be eligible for coverage under Medicaid or for coverage in a marketplace. There is concern that because of these families' mixed immigration status and fear of deportation, some parents will not enroll eligible children in health coverage.

Options and Strategies for Addressing Potential Outreach and Consumer Assistance Issues

Outreach and consumer assistance programs can help make enrolling in health coverage under the ACA seamless and straightforward for families. State policymakers may be able to take steps to reach entire families through such programs, regardless of the coverage options for which each family member is eligible.

Leverage Assets and Lessons Learned from CHIP and Medicaid

Over many years of conducting outreach for children's health coverage in CHIP and Medicaid, states have amassed considerable knowledge in and resources for reaching children, youth, and families. For example, over the past decade CHIP and Medicaid programs have evolved from using mostly mass-marketing campaigns to also incorporating targeted outreach efforts focused on eligible but unenrolled individuals.[57] States have also found ways to effectively target unique populations such as specific racial and ethnic groups in their states.[58,59] States could leverage these and other lessons learned in CHIP and Medicaid to create culturally appropriate messages that are sensitive to different communities' views of public programs and health care and to enroll in Medicaid or through marketplaces those who are eligible for new coverage opportunities.[60] States' experiences in CHIP and Medicaid outreach to adolescents and young adults may also be useful to marketplaces. These age groups traditionally have been difficult to reach, and some states use sports-related promotions[61,62] and social media[63] to target them.

CHIP and Medicaid programs have also built strong relationships with community-based organizations (CBOs) and schools to help reach eligible children and youth, particularly in hard-to-reach populations. It is likely that families will continue to rely on trusted CBOs to help their children enroll in coverage. States could encourage experienced CBOs to become navigators or, for those CBOs that do not become

navigators, to work with navigator programs to ensure that these programs have the knowledge necessary to assist entire families seeking coverage through Medicaid, CHIP, or a marketplace. Some states are already considering how their current consumer assistance and outreach programs can inform the development of navigator programs under the ACA. Rhode Island is considering integrating into the navigator program its Family Resource Centers—a robust system of outreach, application assistance, and case management using outstationed Medicaid eligibility workers. California is developing a unified eligibility and enrollment determination system through the marketplace and plans to integrate or adapt into the new system the state's Medicaid managed-care enrollment broker program.[64]

Take a Family-Centered Approach to Consumer Assistance and Outreach

Getting parents enrolled in coverage not only helps enroll eligible children, but may also improve continuity of coverage and help children access necessary pediatric preventive care.[65] With more parents becoming eligible for coverage in 2014, states may need to take a holistic approach to reaching out to and enrolling an entire family, rather than just a child or an adult. Outreach messages describing the availability of health coverage for all family members will be critical to ensuring families understand that new coverage options may now be available for parents as well. Medicaid and CHIP currently use application assistors who provide families with on-the-ground support to enroll eligible children in Medicaid and CHIP. Whether or not application assistors become official navigators or newly defined application counselors, they will need to be knowledgeable enough to appropriately refer parents or whole families for coverage in the marketplace. (While still serving Medicaid and CHIP populations, becoming certified application counselors might be a significant change for current application assistors because counselors will now be required to meet Internal Revenue Service confidentiality requirements.[66]) Likewise, ensuring navigators have sufficient knowledge of Medicaid and CHIP and how to apply for that coverage will be important to families that initially attempt to access health insurance through the marketplace. Marketplaces can create navigator programs that also perform or assist with CHIP or Medicaid administrative functions beyond required referrals, and such programs will be able to use federal CHIP or Medicaid funds to support these functions.[67]

Allay Concerns Related to Immigration Status

Ensuring that citizen and legally residing children of undocumented immigrants receive the coverage they are eligible for will also mean alleviating families' concerns about the risk of deportation for enrolling an eligible child in coverage. For instance, states can emphasize that social security numbers are required only for those family members actually applying for coverage. This policy is intended to encourage families to enroll eligible children in coverage even if other family members are undocumented. However, states will also need to balance these assurances with messages about the importance of having parents or caretakers supply social security numbers, when possible, in order to verify a child's income through the federal hub. The federal hub will help states verify income, citizenship status, and other information for individuals applying for coverage.

Eligibility and Enrollment

One of the most significant changes under the ACA is the increased availability of affordable coverage through public programs and subsidized coverage in health insurance marketplaces. Although not all states are expanding Medicaid eligibility for adults in 2014, they all will have to retool or build new eligibility systems to meet ACA standards for streamlining, and all must convert to the new modified adjusted gross income (MAGI) standard for eligibility determinations. Additionally, states are required to

expand Medicaid eligibility levels for children from ages six to 19 up to 133 percent FPL. The ACA provides tools to coordinate and streamline eligibility processes and systems, including the alignment of eligibility rules; support for the development of integrated or linked eligibility systems; and development of one streamlined application for CHIP, Medicaid, and the marketplace. However, several potential challenges arise when considering children in the context of the large-scale eligibility and enrollment system changes under the ACA.

Changes to Children's Eligibility Under the ACA

The ACA raises the mandatory minimum Medicaid eligibility level for children and youth ages six to 19 from 100 percent FPL to 133 percent FPL. The 18 states with Medicaid eligibility levels below 133 percent FPL for these children and youth in 2013 cover them in S-CHIP programs. These states will have to transition this S-CHIP population into Medicaid to meet the new minimum eligibility levels. In many states, children and youth moving into Medicaid could benefit from the program's robust EPSDT benefit, which generally is not offered in S-CHIP, and lower cost-sharing requirements. However, some concerns have been raised about potential negative consequences of the move. In particular, some state S-CHIP programs may offer better access to providers than in Medicaid because of higher provider reimbursement in CHIP.[68] In states where CHIP and Medicaid programs are quite closely aligned, this transition may be less of an issue.

New requirements under the ACA also change the way that states count income in their Medicaid and CHIP programs and align it with the methodology that will be used for determining individuals' eligibility for subsidized marketplace coverage. This new MAGI methodology will change the way household size is counted in some states and eliminate states' income disregards and deductions that have been used to expand eligibility. Greater alignment of income-counting methods across programs could be beneficial, but it also has the potential to disrupt children's coverage. In some states, changes in counting family income and in rules for household composition will force some children to lose eligibility for their current coverage program.

The ACA requires that children who lose eligibility for Medicaid because of the elimination of income disregards as part of the conversion to MAGI must be automatically eligible for an S-CHIP program until their next scheduled renewal. However, not all states currently operate an S-CHIP program, and these states will have to set up a temporary S-CHIP for a small group of children beginning in 2014.

Waiting Periods

The ACA envisions a seamless coverage environment that minimizes uninsurance and requires all individuals to be enrolled in health insurance or potentially face a penalty. How any provisions requiring an individual to remain uninsured for a period of time will work under this vision remains to be seen, but some waiting periods will remain even after 2014.

Many S-CHIP programs have implemented waiting periods to meet the federal requirement that they adopt measures to deter families from dropping private coverage and enrolling in CHIP, a phenomenon referred to as "crowd out." States' S-CHIP waiting period policies generally require that children remain uninsured for a period of time before enrolling in the CHIP program if they previously had creditable, private group health insurance coverage.[69] Currently CHIP waiting periods are generally six months or less, and many states offer exceptions from waiting period requirements. There may be exceptions for families at certain income levels, for those who lose coverage for reasons beyond their control, because of unaffordable coverage, or other circumstances.[70,71] A proposed federal regulation, released on January 22,

2013, for the first time limited S-CHIP waiting periods to no more than 90 days and required exceptions for specific circumstances.[72] The new limit on S-CHIP waiting periods—which aligns with a similar limit on waiting periods of no more than 90 days in the marketplace[73]—will require that 18 states shorten their existing waiting periods. However, any period of uninsurance is an obvious barrier to coverage for children. It could potentially mean a parent must also go without coverage for, under the ACA, parents must enroll any eligible dependent children in CHIP, Medicaid, or other minimum essential coverage before enrolling themselves in Medicaid.[74]

Another much lengthier type of waiting period may apply for immigrant children and pregnant women. Prior to the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), legally present immigrant children and pregnant women were required to wait five years before they were able to enroll in CHIP and Medicaid. The enactment of CHIPRA gave states the option to cover these populations with federal matching funding as soon as they are otherwise eligible.[75] Some states retained the five-year ban, and in those states, legally present low-income immigrant children, youth, and pregnant women will have to seek coverage in the marketplace, which will likely be less comprehensive and require greater cost sharing than coverage through CHIP or Medicaid.[76]

Movement of Children Between Programs

One significant challenge for Medicaid and CHIP populations has been churning—the movement of individuals on and off health coverage programs. Individuals with incomes near the newly created Medicaid eligibility floor of 133 percent FPL are expected to be especially prone to changes in eligibility when family income changes. Estimates suggest that within six months 40 percent of adults under 133 percent FPL will experience a disruption in Medicaid coverage due to changes in income or family composition,[77] and within one year, 14 percent of children eligible for CHIP, Medicaid, or subsidized marketplace coverage will experience a change in their eligibility status.[78] Disruptions in coverage can lead to especially costly disruptions in care for children. A 2008 study in California found children who lost Medicaid coverage for just three months had expenditures 1.7 times higher in the month they returned to coverage than in the months preceding their disenrollment.[79]

Options and Strategies for Addressing Potential Eligibility and Enrollment Issues

In 2013, states face many fast-approaching deadlines for eligibility and enrollment policy and system changes. Challenges for children's coverage under health care reform implementation also lie ahead. Despite these pressures, thoughtful design and implementation of new requirements can help children maintain or gain coverage in 2014 and into the future.

Move Older Children between 100 and 133 Percent FPL Before January 1, 2014

States can implement certain ACA program changes ahead of the January 2014 deadline, such as moving six- to 19-year-olds in families with incomes below 133 percent FPL from S-CHIP to Medicaid. For example, New York began transitioning these children at renewals beginning May 1, 2012, and Colorado and South Carolina have already transitioned these older children and youth into Medicaid. Moving six- to 19-year-olds from S-CHIP into Medicaid early allows states to learn from the transition experience and alleviates some administrative burden during the later months of states' preparation for 2014. California is also moving children ages six to 19 into Medicaid prior to the January 2014 deadline. There the transfer is part of a move of the entire S-CHIP program into Medicaid through a four-phase, year-long transition, begun in January 2013. For states that will be transitioning the older children and youth in January 2014, experiences from other states that have already transitioned their programs could provide helpful

lessons learned. In particular, states such as California, Colorado, New York, and South Carolina may have experience encouraging CHIP providers to accept Medicaid patients and educating families on major program changes.

Create a Temporary Medicaid "Look-Alike" CHIP Program for Children Who Lose Medicaid Coverage

States that have only M-CHIP programs will need to set up a temporary S-CHIP program in 2014. This is in order to cover children who will lose Medicaid coverage due to the elimination of Medicaid disregards as part of the conversion to MAGI. In answers to frequently asked questions released on May 22, 2012, the federal Centers for Medicare and Medicaid Services (CMS) stated that one possibility is that affected states create small S-CHIP programs that are "substantively identical" to their existing M-CHIP programs. This option could reduce the burden on the state and create a continuous coverage option for children as eligibility requirements change.[80] In frequently asked questions released on April 18, 2013, CMS also proposed options for how states can identify children that would be eligible for coverage under this provision.[81]

Shorten or Eliminate Waiting Periods or Allow for Exclusions

The January 2013 proposed regulations set a maximum 90-day limit on the length of a CHIP waiting period, but all states have the option to set shorter CHIP waiting periods. CHIP rules require states to take measures to prevent "crowd-out," but do not specifically require that waiting periods be used. Thus, states could eliminate S-CHIP waiting periods all together. In 2012, Vermont eliminated the 30-day waiting period for its S-CHIP program and instead monitors for crowd-out using data collected from households in a state-administered survey. Colorado passed a law in March 2013 removing the three-month waiting period from its CHIP program. In states retaining waiting periods, exemptions from waiting periods—in addition to the exemptions now required in accordance with the January 2013 proposed regulation[82]—could be implemented and could help minimize potential coverage gaps for children. In a 2008 survey of state CHIP programs, NASHP found that all 29 of the S-CHIP programs with waiting periods already had implemented one or more exemptions. For example, 28 states exempted from waiting periods families experiencing an involuntary separation from employment, and 25 states had waiting period exemptions if an employer dropped an offer of coverage. Other state waiting period exemptions were for coverage that was too expensive (11 states) or for financial hardship (3 states).[83] States can also go beyond the required exemptions and provide exemptions if the private insurance offered is not comprehensive or for families below a certain income level. From the 2008 survey, NASHP found that three states had a waiting period exemption if coverage was not comprehensive.[84] Eleven states currently have waiting period exemptions for children below a certain income level.[85]

Implement the CHIPRA Option to Cover Legally Present Immigrant Children

As of January 2013, half of the states (25, including DC) had removed the five-year ban on coverage for legally present immigrant children, and 20 states had removed it for pregnant women.[86] States that have not already taken up the CHIPRA option may want to consider covering legally present immigrant children in CHIP or Medicaid during their first five years of legal residence.

Implement Strategies to Help Lessen Churn and Simplify Enrollment

While the ACA creates more options for coverage, those options increase the potential for churning between available coverage programs. However, states can take steps—such as implementing continuous

eligibility, administrative renewals, or ex-parte renewals—to alleviate the magnitude of churn. Twelve-month continuous eligibility guarantees coverage for an individual for a 12-month period regardless of changes in eligibility and has been shown to improve retention as well as reduce administrative cost and staff workload.[87,88] States also can help alleviate churn by reducing the burden on families at renewal through administrative or ex-parte renewals, which have been shown to be effective at increasing retention.[89] Administrative renewals range from the state pre-populating renewal forms with information provided by the client at first application to the state automatically renewing coverage for certain populations whose eligibility is unlikely to change and who meet specific criteria, such as a child whose guardian receives social security as his or her only income. Ex-parte renewals allow the state to obtain information from trusted data sources (i.e., unemployment records) to verify eligibility criteria without requesting documentation from the applicant unless there are changes.

States also have the option of using Express Lane Eligibility (ELE) at enrollment, renewal, or for program transitions between Medicaid and CHIP. Using ELE allows states to rely on eligibility findings from an Express Lane agency—for example, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or other programs—to determine the eligibility of an uninsured child for Medicaid or CHIP coverage. Ten states currently operate ELE in a variety of ways and have found successes in identifying, enrolling, and easing transitions between programs for children in Medicaid and CHIP.[90]

Ensuring that a robust consumer assistance program is in place will also help children and families maintain continuity of care regardless of program eligibility. These programs, which help families understand changes in eligibility status and differing program requirements, benefits, and cost sharing, are discussed in more detail earlier in this paper.

Affordability

Medicaid and CHIP have provided affordable insurance coverage for children in low-income families by limiting cost sharing at certain income levels and by requiring an aggregate cost-sharing limit of five percent of a family's income. The ACA's provisions for subsidized marketplace coverage will further expand the options for low-income families with incomes up to 400 percent FPL. However, certain marketplace cost-sharing provisions may still create challenges for families.

Cost Sharing

Although the ACA limits cost sharing in marketplaces, marketplace cost-sharing levels will be greater than those typically seen in Medicaid and CHIP programs. Even with cost-sharing reductions in the marketplace—intended to keep families with incomes up to 250 percent FPL from paying high out-of-pocket costs—families will pay more for marketplace coverage than for Medicaid or CHIP. For example, in the marketplace, families with incomes between 200 and 400 percent FPL who are eligible for APTCs could pay as much as 6.3 to 9.5 percent of their incomes for premiums alone.[91] In contrast, *total* cost sharing in Medicaid and CHIP, including premiums, is limited to five percent of family income.[92]

Medicaid has significant limits on cost sharing, particularly for the lowest-income children. Cost sharing in Medicaid is permitted only for children with family incomes above 100 percent FPL, and no premiums can be charged for families below 150 percent FPL. Although separate CHIP programs are often modeled after private insurance coverage,[93] cost-sharing limits have protected families enrolled in these programs from most of the out-of-pocket costs generally associated with private coverage. Unlike private coverage, where

families may contribute a considerable amount of their income to premiums alone before accounting for copays or deductibles,[94] state CHIP programs generally do not come close to the five percent of family income limit,[95,96] and premiums for the programs have remained low.[97] Research shows that the difference of even a few dollars can mean a loss of coverage for families with children in CHIP or Medicaid,[98] so higher out-of-pocket costs for families buying coverage through qualified health plans in the marketplace could be a significant barrier to coverage.

Cost Sharing for Stand-Alone Dental Plans

Under the ACA, insurers can offer a medical QHP without dental benefits if at least one stand-alone dental plan is available in the marketplace.[99] Therefore, some families may purchase a stand-alone dental plan if a child enrolls in a marketplace medical QHP that does not offer pediatric dental services. The services offered in a stand-alone dental plan will meet the EHB requirement for pediatric dental services, but families purchasing this stand-alone dental coverage may not benefit from the cost protections that apply to all other marketplace QHPs. Federal guidance establishes an annual out-of-pocket cost-sharing limit for QHPs, but allows stand-alone dental plans to have a separate additional annual limit.[100] This could mean that families with members enrolled in stand-alone dental plans could be responsible for more cost sharing out of pocket per child than families enrolled in QHPs that offer dental benefits. State-based marketplaces are responsible for determining a reasonable annual cost-sharing limit for their states' stand-alone dental plans.[101] Federal guidance released on plans offered in the federally-facilitated marketplace set this annual limit at $700 for one child enrollee and $1400 for two or more child enrollees for plan years beginning in 2014. This guidance also states that cost-sharing reductions cannot be applied to pediatric dental services offered in a stand-alone dental plan,[102] though some questions have been raised about this policy.[103] Furthermore, CMS has stated that there is no federal requirement that families purchase stand-alone dental plans for children enrolled in QHPs that do not offer these services.[104]

Advance premium tax credits (APTCs) in the marketplace will first be applied to a family's medical QHP and any remaining tax credit amount will then be applied to a stand-alone pediatric dental plan.[105] Some concerns have been raised about whether families will have enough of their APTC left over to cover the cost of a pediatric stand-alone dental plan. Premium tax credits for most families will be based on the cost of the second-lowest cost silver plan in an exchange. Because dental benefits can be offered through stand-alone dental plans in the marketplace, the second-lowest cost QHP may not include dental benefits and therefore the cost of these benefits would not be included in the APTC calculation. In a letter sent to the Treasury Department on May 9, 2013, 46 state and national children's and oral health advocacy organizations, dental provider organizations, and others asked for clarification that the cost of stand-alone pediatric dental coverage be included in the APTC calculation.[106]

Taken together, these policies for stand-alone dental coverage could result in some families foregoing dental coverage for their children because of the additional cost.

Family Affordability Test

According to the Treasury Department's final regulations on health insurance advance premium tax credits released on February 1, 2013, a family will not qualify for an APTC in the marketplace if they have access to affordable employer-sponsored insurance (ESI). The regulations state that ESI is considered affordable if the employee's contribution for *self-only* coverage is less than 9.5 percent of the family's income, regardless of the cost of *family* coverage.[107] This "family affordability glitch" means that families are ineligible for subsidized marketplace coverage even when their contribution for employer-based family

coverage exceeds the 9.5 percent level, potentially leaving families with unaffordable coverage even after health care reform. In a June 2012 report, the Government Accountability Office (GAO) reported that approximately 460,000 children, and potentially more, could be adversely affected by this affordability standard. Although these children would not necessarily be automatically eligible for premium tax credits if the affordability test were changed, the GAO analysis suggests that some of these uninsured children's families could become eligible for an APTC if the affordability test was based on family coverage.[108]

Premium Stacking

Families with some members enrolled in different coverage programs, including Medicaid and CHIP with premiums, could be responsible for those programs' costs in addition to the premium costs for coverage in a marketplace. The calculation for the APTC in the marketplace is based on the percentage of household income a family is required to contribute out-of-pocket to a premium in the marketplace, up to a maximum of 9.5 percent. The calculation does not take into account whether a family also pays a premium for Medicaid or CHIP coverage. This could negatively affect families in the five states that charge Medicaid premiums for children's coverage and the 30 states that charge CHIP premiums.[109] Families facing "premium stacking," could be required to pay up to five percent of their income toward the Medicaid or CHIP program and up to the 9.5 percent of their income required for marketplace premiums, effectively putting them above the affordable coverage limit.

While it is unclear how many families would face premium stacking, a 2012 Urban Institute estimate projected that 75 percent of parents eligible for marketplace coverage will have at least one child eligible for Medicaid or CHIP.[110] Despite public comments on the premium stacking issue, final Treasury Department regulations stated that premium tax credits offered through the marketplace could not be increased to cover premiums associated with other minimum essential coverage, such as CHIP.[111]

Families who will experience greater premium costs because of premium stacking also could experience confusion if they have to make premium payments on behalf of family members to different programs or agencies. Families that may have a hard time keeping track of multiple payments due to different agencies could be at risk of missing premium payments for their children and possibly losing their coverage.

Options and Strategies for Addressing Potential Affordability Issues

Addressing affordability issues in health coverage programs can be difficult, particularly given federal rules and state budget constraints. The financing and structure of coverage programs may affect whether the following options for addressing affordability issues are applicable to any particular state.

Enact Policies to Make Marketplace Coverage More Affordable for Lower-Income Marketplace Enrollees

For families purchasing marketplace coverage, especially those with lower incomes, cost sharing, including premiums, may be difficult to afford. In addition to the federal subsidies that will be available to qualified individuals in the marketplace, states could consider further subsidizing coverage for some of their lower-income QHP-enrolled residents.[112] For example, in his proclamation to convene a special session of the state legislature related to implementation of the ACA, California Governor Jerry Brown declared that California should explore options for helping individuals with incomes at or below 200 percent FPL to afford coverage in the marketplace.[113] Vermont Governor Peter Shumlin's 2014 fiscal year budget included $10.5 million in state funds to further subsidize marketplace coverage for low- and middle-income Vermonters.[114] Massachusetts is planning to create "wrap plans" in its marketplace that provide state financial assistance on top of federal subsidies to certain individuals—citizens earning between 139

percent and 300 percent FPL and legal immigrants earning up to 300 percent FPL—enrolled in a subset of QHPs. Massachusetts is seeking federal support through a section 1115 demonstration waiver,[115] and as of January 2013, the state reports that CMS has indicated it will provide 50 percent federal match for individuals, excluding immigrants, in wrap plans.[116]

Consider Eliminating or Waiving CHIP or Medicaid Premiums for Families Facing Premium Stacking

Eliminating or waiving premiums for families facing premiums in multiple coverage programs are options states could consider to help reduce the cost of health coverage for those families beginning in 2014. In final regulations released in March 2012, CMS reminded states they have the flexibility to eliminate or waive premiums for families enrolling in subsidized coverage through the marketplace if states are concerned about affordability.[117] Research has shown that premiums, even for a nominal amount, can decrease enrollment in CHIP and Medicaid and cause some enrollees to lose coverage.[118] In states that rely on premiums as a way to support the cost of their CHIP or Medicaid programs, waiving premiums may be less feasible. However, states that charge only nominal amounts in these programs may find that the cost of administering premiums is more than the premiums themselves. Arizona estimated implementing a cost-sharing administrative infrastructure could cost the state $16 million but that it would only collect $6 million in potential premiums and copayments. When Virginia implemented a $15 per month premium for CHIP families between 150 and 200 percent FPL, administrative costs were estimated to be $1.39 for every $1 collected.[119]

Help Families Get through the Confusion of "Premium Stacking"

Having families pay multiple premiums to multiple programs could mean that coverage becomes unaffordable for some families. It could also create confusion, possibly leading to missed payments and loss of coverage. In circumstances where states are unable to waive premiums, ensuring that families understand the premium responsibilities associated with their coverage and simplifying payment options may be good ways to help all family members remain covered. For instance, states could provide one combined health coverage statement, which would include in the total the cost for the parents' coverage in the marketplace, minus any APTC, and the cost of a premium for a child in CHIP or Medicaid. The total owed by the family could then be paid to one entity to cover the cost of enrolling in all coverage programs. On September 13, 2012, Nevada's marketplace board adopted a policy that would require its vendor to conduct a streamlined billing process on behalf of the marketplace for individuals and families enrolled in QHPs, Medicaid, CHIP, and any ancillary products. Families will therefore have one place where they can handle all insurance premium transactions.[120]

Access to Providers Appropriate for Children and Youth

Adequate and appropriate provider networks are essential for meeting consumers' health care needs, in particular, those of children and youth. However, the combination of the expected enrollment growth in health coverage programs—an estimated 16 million people in 2014[121]—and an anticipated, ongoing shortage of certain providers makes the work of creating, maintaining, or improving provider networks that meet children's needs all the more important.[122]

Reimbursement and Network Adequacy in Medicaid and CHIP

In tough budget times, states have looked to lowering Medicaid and CHIP provider reimbursement rates to find cost savings. Low reimbursement rates in Medicaid and, to a lesser extent, in CHIP have already made

provider capacity a concern.[123] The Medicaid expansion could further exacerbate current access issues. A 2010 estimate based on provisions in the ACA projected that by 2015 there will be a shortage of nearly 30,000 primary care physicians, including pediatricians, and by 2025, the shortage will grow to over 65,000.[124] Because of federal Medicaid and CHIP requirements on cost sharing and benefit packages, and the ACA's maintenance of effort (MOE) requirement to maintain March 2010 CHIP and Medicaid eligibility levels for children through 2019, states have limited ability to find cost savings in program areas other than provider reimbursement rates.

The ACA established a temporary Medicaid primary care rate bump, which many hope will encourage greater primary care provider participation in Medicaid. In 2013 and 2014, Medicaid will reimburse at the generally higher Medicare levels certain primary care providers—including pediatric providers and nurse practitioners and physician assistants under physician supervision—for primary care. States will receive 100 percent federal funding for any rate increase above the Medicaid reimbursement rate in place in their states on July 1, 2009. Thus, states that have decreased Medicaid provider rates to below their July 2009 levels must restore them to those levels in order to secure the 100 percent federal funding for the primary care rate bump. The cost associated with restoring reimbursement rates to the July 2009 levels will be reimbursed at the state's normal federal Medicaid matching rate, on average 58 percent in 2013.[125] Whether this temporary primary care rate bump will increase provider participation in Medicaid remains to be seen, and state S-CHIP programs do not qualify for the provider rate increase.[126]

Network Adequacy in QHPs

States have a great deal of flexibility in establishing QHP provider network requirements. The ACA requires that the networks be "…sufficient in number and types of providers, including providers that specialize in mental health and substance abuse"[127] but does not include similar or otherwise more specific requirements for pediatric providers. Children and youth have developmental and physical needs different from adults.[128] These differences are particularly important for children with special health care needs who may require care from pediatric subspecialists. Additionally, children, especially lower-income children, and their families benefit from having their care coordinated not only among physical, mental, and dental care providers, but also with other child- and family-service providers such as daycare providers and schools.[129]

Although the nearly four million children who will qualify for marketplace coverage in 2014[130] may be a relatively small proportion of marketplace enrollees—due to the availability of CHIP and Medicaid and the family affordability issues noted above—if CHIP is not extended past 2015, marketplace coverage may become the only coverage option for children in families with incomes above 133 percent FPL without affordable ESI. As states are addressing QHP network requirements, considering the specific types of providers children need and are accustomed to seeing will benefit children who will obtain coverage through the marketplace.

Provider Continuity

As discussed earlier in this paper, churning between programs is a significant issue. It can lead to disruptions in care for children, as well as disruptions in their relationships with providers. To help children who churn between Medicaid and CHIP programs stay within the care of providers with whom they have established relationships, some states have implemented strategies to maintain consistent CHIP and Medicaid provider networks. The addition of marketplaces as a potential coverage source for at least some children and the fact that marketplaces will contract with multiple QHPs introduces further risks for churning and discontinuity of care. Without consistent provider networks among plans in CHIP, Medicaid, and QHPs, children may face disruptions in primary and specialty care when they churn between coverage

programs. Research has shown that monitoring the quality of care is more difficult when individuals churn between public programs, and providers report challenges in managing care even with short gaps in coverage.[131] This could be a particular issue for children with special health care needs who may have complex treatment plans involving multiple providers.

Options and Strategies for Addressing Potential Provider Access Issues

While children are not the largest group likely to gain coverage through QHPs in the marketplace, they are a unique population whose specific needs should influence the development of provider networks. States and, in most cases, their contracted managed care plans have worked to build and strengthen pediatric-provider networks serving children in Medicaid and CHIP. States may be able to look to these programs to help ensure that children and youth have consistent access to appropriate providers.

Align Providers Across Health Coverage Programs

States could require or incentivize QHPs to contract with some or all providers participating in Medicaid and CHIP or with entire provider networks of Medicaid and CHIP programs. This would help ensure that children have access to appropriate providers and would help children keep their providers if they switch between programs. For instance, some states have required that both Medicaid and CHIP health plans contract with certain community providers, such as Federally Qualified Health Centers (FQHCs).[132] Similar incentives or requirements could be extended to QHPs and could also help QHPs meet network requirements relating to essential community providers (ECPs).

The ACA requires that QHPs contract with ECPs, which are providers that serve predominantly low-income individuals, including providers that qualify for 340B drug discounts. States have much flexibility for meeting the ECP requirement[133] and could consider requiring or incentivizing QHPs to contract with child-specific providers that could be considered ECPs, such as children's hospitals and school-based health centers (SBHCs). As mentioned earlier, some state Medicaid and CHIP programs already require that their plans contract with FQHCs. Like children's hospitals and SBHCs, FQHCs serve a high proportion of children, tend to participate in Medicaid and CHIP, and would qualify as ECPs. Incentivizing QHPs to contract with community providers that also participate in Medicaid and CHIP health plans not only helps to align provider networks across programs for children, but also has the added benefit of helping QHPs to meet the ACA's essential community provider requirement.

Alignment of providers in Medicaid and CHIP may be especially helpful in states that will be moving six- to 19-year-olds with incomes between 100 and 133 percent FPL from CHIP into Medicaid. Encouraging CHIP providers to accept Medicaid patients may help with the transition of these children and youth and guard against possible disruptions in care by allowing them to stay with their current providers.

Align Plans Across Health Coverage Programs

States can require or incentivize health plans to provide coverage under Medicaid, CHIP, and in the marketplace. This would help provide continuity to children and families moving between the programs by allowing them to stay in the same plan and likely with the same providers after transitioning to a different coverage program. It would also allow families to enroll in a single health plan even if different family members are covered under different coverage programs. This continuity could be especially helpful for the projected 75 percent of parents who will obtain marketplace coverage and who will have at least one child eligible for Medicaid or CHIP.[134] Some states already have looked to aligning plans across health

coverage programs to promote continuity of care. For example, New Jersey currently maintains the same HMO plans in both its CHIP and Medicaid programs. In implementing its 2006 health care reform law, Massachusetts originally allowed only Medicaid managed care plans to offer plans in Commonwealth Care, the state's subsidized insurance program for individuals who have incomes under 300 percent FPL but who do not qualify for Medicaid. In more recent years, the state has added a for-profit plan to Commonwealth Care.[135]

Another alternative is to offer a bridge plan—a Medicaid managed care plan certified as a QHP in the marketplace—to individuals who recently moved from Medicaid coverage or who have family members still in Medicaid or CHIP. This bridge option, originally developed by Tennessee, would keep family members and those transitioning between coverage options in one plan with one provider network, regardless of whether the family members were eligible for Medicaid or marketplace coverage.[136, 137] CMS has approved states to use this option and stated that state-based marketplaces will be best positioned to implement a Medicaid bridge plan.[138] In early March 2013, California's marketplace board approved the development of a bridge plan option, which will also provide further reduced-cost plans to individuals transitioning from Medicaid into marketplace coverage.[139]

Permit Children Transitioning to QHPs to Temporarily See Non-Network Providers

States could consider a policy to temporarily allow children, particularly children with special health care needs or those undergoing a course of treatment, to see their current provider even if that provider is not part of the family's new QHP provider network. This would ease the transition of children who will move between Medicaid or CHIP and the marketplaces, minimize any potential gaps in coverage, and ensure continuity of care. To preserve certain existing enrollee-provider relationships, New York implemented a similar policy for Medicaid and Family Health Plus (the state's subsidized coverage for limited-income 19- to 64-year-olds who do not qualify for Medicaid) enrollees receiving an ongoing course of treatment. During the time these individuals are transitioning to managed care, they may continue to receive services from their existing non-participating provider for 60 days from the time of enrollment.[140] Adapting this type of policy for children transitioning in to marketplace coverage could help families by giving them time to identify new providers and adjust to a different type of coverage, especially if they previously were not enrolled in managed care.

States also could consider policies to permit standing referrals to out-of-network pediatric providers, such as specialists, if those providers are not available in-network. In early guidance on the use of managed care for children with special health care needs, CMS suggested that states could consider such policies to ensure access to needed specialists.[141,142]

Access to Appropriate Benefits

Ensuring the availability of age-appropriate services that account for the health and developmental needs of children and youth is important to addressing the unique needs of this age group.[143, 144] How benefits are defined under health care reform and how marketplace coverage compares to benefits available to children under CHIP and Medicaid will be important considerations for states.

Defining Coverage to Meet the Unique Needs of Children

Under the ACA, states must design their EHB package to encompass 10 categories of benefits, including pediatric and habilitative services.[145] In order to create their EHBs—the minimum coverage that all private health plans both inside and outside of the marketplace and Medicaid benchmark and benchmark-

equivalent plans are required to provide—states could choose from four types of benchmark plans: the largest federal employee, state employee, small group, or commercial non-Medicaid HMO products. As of March 18, 2013, most states (43, including DC) had chosen or defaulted to the largest small group plan,[146] which tends to be the least generous for children of all the benchmark options.[147]

Appropriate benefits will be important to all children in the marketplace, particularly low-income children who are more likely to have poorer health and have a higher prevalence of special health care needs than other children.[148] While states are required to include habilitative and pediatric services in their EHBs, federal guidance gives states much flexibility in defining these categories of services.[149] Questions remain about what the amount, duration, and scope of services—which are of key importance to children and youth—will look like. In addition to defining coverage for children who will enroll in family policies in the marketplace, the EHB will also make up the benefit package of child-only plans offered in the marketplace.[150] Although it is a small market (estimated at about eight percent of all individual policies),[151] child-only insurance policies are an important coverage option for children ineligible for Medicaid or CHIP and who: have no offer of ESI; live with grandparents who get insurance through Medicare; or have special health care needs and parents who cannot afford coverage for all family members. It is also an important coverage option for some immigrant populations who do not qualify for public coverage, including children who are legal immigrants and do not qualify for Medicaid or CHIP as a result of the five-year ban.

Unlike individual and group market plans, CHIP and Medicaid plans are created with children in mind, ensuring that benefits and services suited to children and youth are available. A July 2012 analysis of benefits in five states' large federal-employee, state-employee, and small-group health insurance plans concluded that coverage of the 10 EHB categories available under Medicaid and CHIP plans was far more generous for children than the analyzed QHP benchmarks. Even though the report did not analyze the largest commercial HMO products in the five states, previous research found that private insurance generally provides less comprehensive benefits than public insurance programs for children.[152] The July 2012 analysis and the December 2011 federal EHB Bulletin noted that coverage for pediatric services, including oral and vision care, would likely need to be supplemented because coverage for such services is not commonly included in the available benchmark plans.[153,154] In addition, interim final federal rules on EHB design recognized that state benchmark plans may not include habilitative services, which can be very important for children with complex conditions.[155]

Continuity of Benefits

As states finalize their benefit packages for the marketplace, it will also be important to consider how differences in covered services may affect families and children moving between programs. For children who move between Medicaid, CHIP, or the marketplace, differences in covered benefits could affect their ability to access needed services and may lead to disruptions in their care. Some families may incur out-of-pocket costs when obtaining needed but uncovered services. States may find aligning benefit packages across programs helps improve continuity of care and thereby promotes better quality care.[156]

States may also want to consider how marketplace benefit packages designed now will compare to CHIP, given a provision calling for secretary certification of plans by 2015. Under the ACA, federal CHIP funding continues through September 2015. If federal funding is not extended, or if a state's CHIP allotment runs out, a state must establish procedures to enroll CHIP-eligible children into the marketplace. Before this transition takes place and no later than April 2015, the Secretary of the U.S. Department of Health and Human Services (HHS) is required to certify which plans in the marketplace offer benefits and cost-sharing provisions comparable to CHIP.[157] Although uncertified plans will still be offered in marketplaces,

the certification will provide families with important information about the children's benefits available, and families may perceive secretarial certification as a positive plan attribute. As of April 2013, no federal guidance delineating the requirements for secretary certification had been released.

Pediatric Dental Benefits

The ACA specifies that pediatric oral heath care services must be covered as part of EHBs, but questions remain about how the oral health benefit will work with QHPs in the marketplace. Potential concerns include the lack of an appropriate private-market benchmark that includes a comprehensive pediatric dental benefit and the higher rate of dental expenditures paid out of pocket than medical expenditures for people insured in the private market.[158]

If a state chooses an EHB benchmark that does not include coverage for dental services for children, the state must supplement the benchmark plan by adding pediatric dental benefits from either the federal employees supplemental dental plan (FEDVIP) or from the state's S-CHIP program.[159] States were required to submit their EHB benchmark selections to HHS by December 26, 2012. As of March 18, 2013, 31 states had chosen or defaulted to the FEDVIP dental benchmark, while only 19 states chose to use the state's S-CHIP dental benefit.[160]

Insurers in the marketplace have the option of offering a comprehensive QHP, which includes pediatric dental benefits, or to offer a stand-alone dental plan that provides EHB-required pediatric dental services. If at least one stand-alone dental plan is offered in the marketplace, medical QHPs will not be required to also offer dental benefits bundled with medical benefits.[161] As stated earlier, while pediatric dental services will technically be available to families in the marketplace, there is no federal requirement that a family purchase a stand-alone dental plan for a child enrolled in a QHP that does not offer these services bundled with medical services.[162] Because of the affordability issues discussed earlier in this paper, this may mean that a child will go without access to important and necessary dental services, even after 2014.

Options and Strategies for Addressing Potential Benefit Design Issues

Providing children and youth with health insurance will not be enough if they do not also have access to the appropriate benefits for their age-specific needs. How states and insurers design benefit packages with respect to services important for supporting children's health and development could determine how well coverage works for children in the future.

Use CHIP or Medicaid Benefits to Guide QHP Benefit Design

Given that federal EHB guidance does not clearly define pediatric and habilitative services, states could model benefits after CHIP and the Medicaid EPSDT program, which are designed specifically for children.[163] S-CHIP programs often include habilitative services, an important benefit for children with special health care needs,[164] and under EPSDT, states' Medicaid programs cover all otherwise-optional Medicaid services that are necessary for children's health. CMS recognized CHIP as a potential model when it named CHIP dental benefits as one of the potential EHB pediatric dental benchmarks.[165] Of the 28 states that selected an EHB benchmark, 19 chose their CHIP dental benefit as the pediatric dental benchmark.[166]

Align Benefit Packages Across Health Coverage Programs

Aligning QHP benefit packages with CHIP or Medicaid programs, where possible, could also help ease coverage transitions for children moving between programs and help ensure continuity of care. Eleven states have already aligned their S-CHIP programs with Medicaid by offering Medicaid benefits, although

possibly without full EPSDT protections.[167] Alignment of pediatric benefits, to the extent possible, with plans offered in marketplaces could potentially reduce issues in transitioning between programs, especially for children or youth that need ongoing care for their conditions. Aligning benefits across the marketplace and CHIP now may also position plans well for QHP certification as comparable to CHIP in 2015,[168] possibly making certain QHPs more attractive for families.

Encourage or Require Families to Purchase Stand-Alone Dental Plans if Services are Not Covered through a Medical QHP

When faced with unaffordable coverage in the marketplace, families may choose to forego stand-alone pediatric dental plans that will add additional costs to their families' coverage.[169] Since no federal requirement exists for purchasing this coverage,[170] states may want to explore the value of a state mandate requiring that families enroll children and youth in dental coverage in the marketplace, whether through a comprehensive QHP or a stand-alone dental plan. This may be easier on families if states also offer state-based subsidies to purchase a stand-alone dental plan. Some states may find it more feasible to encourage families to purchase stand-alone dental plans through the use of educational materials highlighting the importance of dental care for children, especially very young children. Stand-alone dental plans are required to be offered on marketplace enrollment portals along with all other QHPs.[171] Therefore, states may also consider designing a virtual prompt on their enrollment portal that encourages a family to purchase a stand-alone dental plan if they are enrolling a child into a QHP that does not include dental benefits.

Conclusion

States have made important gains in children's health coverage, especially over the 15 years since CHIP was enacted. The program drove improvements in children's coverage through both Medicaid and CHIP. State and federal efforts in children's coverage have focused on targeted outreach, streamlined enrollment and retention strategies, and enhanced program eligibility levels for children. Although children currently have relatively high rates of health insurance coverage, five million children and youth remain uninsured but currently eligible for Medicaid or CHIP.[172] States face a considerable amount of work to implement health care reform, but it is nonetheless important to pay attention to how children and their coverage will fare in 2014 and beyond. With health reform implementation, states have opportunities to create and coordinate systems of coverage that meet the needs of many populations, including entire families and their children. By pinpointing potential challenges with children's and families' coverage, and seizing opportunities under the ACA to bolster coverage for these populations, states can maintain and even improve upon past gains in children's coverage.

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