



## Health Reform and the AAP: What the New Law Means for Children and Pediatricians

Throughout the health reform process, the American Academy of Pediatrics has focused on three fundamental priorities for children and pediatricians. These are as simple as “A-B-C”— **A**ccess to covered services through appropriate payment rates and workforce improvements, age-appropriate **B**enefits in a medical home and health insurance, and **C**overage for all children in the United States. In March 2010, President Obama signed into law *The Patient Protection and Affordable Care Act* (Public Law 111-148) and *The Health Care and Education Reconciliation Act* (Public Law 111-152), which are collectively known as the *Affordable Care Act*. This health reform package not only addresses the Academy’s goals, but also provides many additional benefits for children and the pediatricians who care for them.

### The Health Reform Law:

#### **Improves access to covered services:**

- Invests an unprecedented \$8.3 billion in federal funds to create a minimum of Medicare payments for certain Medicaid services provided by physicians. The increase applies to payments for evaluation and management codes recognized by Medicare starting in 2013 and running through 2014, and is available to physicians with a primary specialty designation of internal medicine, family medicine or pediatrics.
- Defines Medicaid to include the provision of health care services, not just the financing of such services. This change should have a positive impact on the ability of Medicaid-eligible children to seek court enforcement ensuring access to needed health care.
- Strengthens the pediatric primary care, subspecialty, and surgical specialty workforce through Title VII and other improvements as well as a new loan repayment program (up to \$35,000 a year for three years) for individuals who pursue full-time employment in pediatric medical subspecialties, pediatric surgical specialties, or child and adolescent mental and behavioral health care fields.
- Funds state-based health insurance exchanges, provides tax credits to small businesses, and funds state-based high risk pools, which are designed to make affordable health insurance more accessible.

#### **Provides age-appropriate benefits to children:**

- Covers all *Bright Futures* services for children with no cost-sharing.
- Provides comprehensive, essential benefits for newly-established plans in the health insurance exchanges, including rehabilitative care, pediatric services, oral and vision services. All plans will limit annual out-of-pocket expenses to \$5,000 per individual and \$10,000 per family. Exchanges must be ready to begin offering insurance by 2014, or the federal government will establish one for the state.
- Provides new funding for Medicaid medical home demonstration projects.

#### **Increases health insurance coverage for children and families:**

- Expands health insurance to cover nearly thirty-two million more children, parents, and other individuals.
- Preserves the Children's Health Insurance Program with funding through fiscal year 2015 and provides an increased federal funding commitment to states through 2019.
- Bans pre-existing condition exclusions for children, and in 2014, prevents children and adults from losing access to health insurance if they become sick.
- Eliminates annual caps over time and bans lifetime limits on health insurance coverage.
- Allows young adults to stay on their parents’ health insurance up to age 26. In 2014, the law will also require Medicaid coverage to be extended up to age 26 for foster children who have aged out of the foster care system.

## Age-Appropriate Benefits

Prevention is the heart of pediatric medicine. The mission of pediatric care is to promote and monitor the physical, mental and behavioral health of children at every stage of development. Children and adolescents need to see their doctors for a set schedule of well-child visits, during which they receive crucial immunizations and are screened for a variety of conditions to ensure that their development is proceeding appropriately. Children's health is an investment in primary prevention, addressing the development of disease at its earliest and most preventable stages.

The American Academy of Pediatrics maintains that barriers to preventive care, such as deductibles and co-payments, should be removed. The Academy is pleased that the health reform law not only acknowledges that "standard benefits" included in many private and managed-care health insurance plans do not adequately address the specific health needs of the pediatric population, but also addresses the current limitations through the inclusion of provisions to ensure that children's unique health needs are met through comprehensive, age-appropriate benefits.

### **The Health Reform Law:**

- As of Sept. 23, 2010, requires all non-grandfathered\* health insurance plans to cover all pediatric well-child visits—including a physical exam, immunizations, hearing and vision screenings, developmental and behavioral screenings, and anticipatory guidance, in accordance with the *Bright Futures* periodicity schedule—without cost-sharing. *Bright Futures* was developed by an evidence-informed collaboration led by the AAP, and is the definitive standard of pediatric well-child and preventive care. Non-grandfathered health insurance plans will be required to provide this benefit for individual policy years and group plan years beginning on or after Sept. 23, 2010. Over time, more and more insurance plans will provide this benefit.
- Beginning January 1, 2014, assures that all newly-established health insurance plans offering coverage through the health insurance exchanges provide at a minimum a package of essential health benefits:
  - While private plans offered in the exchanges may vary the form of insurance by establishing different percentages of contribution by the plan versus individuals (also known as "actuarial value"), the essential benefits of every plan offered in the exchanges must meet a minimum standard. The minimum standard will provide children with benefits, including hospitalization; ambulatory patient services; emergency services; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care.
  - The scope of benefits provided in the exchange must equal benefits provided under a "typical" employer-sponsored plan.

\* A grandfathered health plan is an existing health insurance plan already on the market when the Affordable Care Act was signed into law in March 2010. Grandfathered plans are exempt from several provisions in the law, as long as they have not made any significant changes, such as significantly raising premiums or cutting benefit categories. Insurance plans that undergo such changes and therefore forfeit their grandfather status are referred to as "new" in the context of this provision.



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## Children and the Medical Home

It is the position of the American Academy of Pediatrics that payers should be incentivized to adequately finance the medical home as the primary model of health care delivery for infants, children, adolescents and young adults. Payment and delivery systems should be reformed based on the principles of the patient-centered medical home agreed upon by physicians, family leaders, patient advocates and purchasers.

First pioneered by the Academy in the late 1960s, the medical home has become accepted by primary care medical associations, patient and family groups, and purchasers of health care as the standard for the delivery of primary health care services. A medical home is not a particular place, but an approach to providing primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.

Through successful partnerships between families and providers, medical homes can provide the best care for children, appropriately utilizing limited resources and remaining responsive to health care costs. Major demonstration projects are under way in the public and private sectors. Many state Medicaid programs are also adopting incentive structures based on the patient-centered medical home model. The new health reform law will give states the opportunity to expand upon current medical home efforts. It is critical that states create medical home programs that meet the needs of children and pediatricians, including ensuring coverage of necessary services, better coordination between state programs and pediatric primary care providers, and payment for care coordination and other services provided in a medical home.

### **The Health Reform Law:**

- Creates a Medicaid state option to provide medical assistance in a medical home (deemed “health home” in the law’s provision) to individuals with chronic conditions. An individual may select a physician, a team of health care professionals operating with a physician, or a health team as their designated health home. The payment methodology for the program can be determined by states and may be tiered to reflect the severity or number of a patient’s chronic conditions and the specific capabilities of the health home. Payment models are not limited to per-member per-month structures. Those who may enroll include individuals eligible under the state plan or waiver with (1) at least two chronic conditions, (2) one chronic condition and a risk of developing a second, or (3) one serious and persistent mental health condition. Chronic conditions include, but are not limited to, a mental health condition, a substance use disorder, asthma, diabetes, heart disease and obesity.
- Provides grants to states or state-designated entities to establish community-based interdisciplinary, inter-professional health teams to support primary care practices and provide capitated payments to primary care providers. Health teams may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians’ assistants. These planning grants will be made available to states, but the total funding for the grants will not exceed \$25,000,000.



## Pediatric Workforce

An important component of the health reform debate was the challenge of ensuring an adequate supply of health professionals to care for newly-insured patients. The health reform law, otherwise known as the Affordable Care Act, recognizes this need, and includes many important provisions to strengthen the pediatric workforce.

### The Health Reform Law:

- Authorizes a loan repayment program for pediatric subspecialists, pediatric surgical specialists and providers of mental and behavioral health services for children and adolescents. The law authorizes a combined \$50 million per year for loan repayment to individuals who commit to pursuing full-time employment in pediatric medical subspecialties, pediatric surgical specialties, or child and adolescent mental and behavioral health care fields. Participants in this new program would be eligible for up to \$35,000 per year in loan repayment funds for 3 years if they meet to-be-determined requirements.
- Increases workforce supply and aid training of health professionals through scholarships and loans. The law supports primary care training and capacity-building and also provides state grants to providers in medically underserved areas. Provisions include training and recruiting providers to serve in rural areas, establishing a public health workforce loan repayment program, and providing medical residents with training in preventive medicine and public health.
- Amends the current law for federally supported student loan funding by easing criteria for schools and students to qualify for loans, lower interest rates, shorten payback periods, and ease the non-compliance provision.
- Establishes a National Health Care Workforce Commission to make recommendations and disseminate information on workforce priorities, goals and policies, including education and training, workforce supply and demand, and retention practices.
- Reforms the Graduate Medical Education (GME) program to increase the supply, education and training of doctors, nurses and other health care workers, especially in pediatric, geriatric and primary care fields. The Affordable Care Act increases the number of GME training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios. It also increases flexibility in laws and regulations that govern GME funding to promote training in outpatient settings and ensure the availability of residency programs in rural and underserved areas.
- Establishes Teaching Health Centers, which are community-based, ambulatory patient care centers. These include federally qualified health centers and other federally funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs.
- Mandates the development of national and regional centers for health workforce analysis to collect and report data related to Title VII. The centers will collaborate with state and local agencies to collect labor and workforce statistical information and provide analysis and reports on Title VII programs to the National Health Care Workforce Commission.



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## State Roles and Partnerships

Much of the implementation and enforcement of the health reform law, also known as the Affordable Care Act, will fall to states. As a result, states have a critical role to play in the ongoing health reform effort, by acting as system innovators and implementing newly enacted federal reforms. State chapters of the American Academy of Pediatrics are important partners in these innovation and implementation efforts, and their work will help ensure that the Academy's goals of appropriate access, benefits and coverage for children will become a reality as health reform provisions are implemented.

The Academy is pleased that the Affordable Care Act strengthens and builds upon minimum standards set by the federal government by providing a structure for continued innovation and ongoing improvement of health insurance for children. This is particularly important as Medicaid, the Children's Health Insurance Program (CHIP), and the Maternal and Child Health Block Grant (Title V) are critical programs for children. The Affordable Care Act recognizes and strengthens state insurance plan requirements that protect children in the private health insurance market, and acknowledges the role states play in supplementing existing federal-state health care programs that impact children, including the financing of care provided to children through public health and human services programs.

### **At The State Level, the Health Reform Law:**

- Extends the federal funding of CHIP through fiscal year 2015 and maintains the CHIP program through 2019. As part of this maintenance of the program, the Affordable Care Act provides states with a 23 percentage point increase (up to a maximum of 100%) to their CHIP match rate beginning on October 1, 2015.
- Provides continued federal funding for Medicaid and CHIP enrollment and renewal activities, which, when added to previous funding, creates a total \$140 million for these funds through 2015.
- Requires states to maintain current Medicaid and CHIP coverage and enrollment procedures through a maintenance of effort provision.
- Establishes state-based health insurance exchanges by 2014, from which individuals and small employers can buy insurance through private insurers or through multi-state health plans. Large employers will be allowed to participate beginning in 2017.
- Provides "no wrong door" procedures for states through a streamlined application process, so that the newly eligible will be screened and referred to the appropriate program (Medicaid, CHIP, or subsidized coverage under plans offered under state exchanges).
- Requires the development of a Medicaid and CHIP enrollment website that is connected to the state-based exchange, and provide federal support to establish "navigators" (eligible entities include trade and professional organizations) to assist with public education and enrollment.
- Permits hospitals that participate in Medicaid to implement presumptive eligibility for all Medicaid populations.
- Uses existing state level high-risk pools to provide insurance to vulnerable populations who are denied other coverage.
- Requires the ongoing input of state legislators, governors, agency officials and other key state decision-makers as the regulatory framework for health reform takes shape.

## Access to Care Through Pediatric Payment Rates

Pediatricians must receive adequate payment if they are to provide comprehensive quality health services that meet the health needs of infants, children, adolescents and young adults. Ensuring health care access for children and adolescents in all communities to services provided by well-trained pediatricians, pediatric medical subspecialists, pediatric surgical specialists, and other child health professionals and specialist physicians requires a financial investment to improve Medicaid payment rates to at least equal those of Medicare.

### The Health Reform Law:

#### **Increases Medicaid Payments:**

The new law invests an unprecedented \$8.3 billion in federal funds to bring Medicaid payments to at least Medicare payment rates. This new minimum payment rate applies to some evaluation and management codes claimed by physicians with an internal medicine, family practice or pediatric primary specialty designation. While the increase applies to codes recognized by Medicare starting in 2013 and runs through 2014, states may begin increasing Medicaid payments before 2013 in order to avoid a steep rise in payment rates. The Academy will continue working with the Administration, Congress and the states to expand and extend this investment.

#### **Creates an Enforcement Mechanism for Medicaid's Equal Access Clause:**

Recent court decisions have ruled that Medicaid-eligible children do not have an enforceable right to access medically necessary health services under Medicaid even though the Medicaid statute requires states to provide medically necessary services to each Medicaid-eligible child. The Medicaid law further requires states to provide sufficient Medicaid payments to pediatricians and other health care providers to administer care and services to Medicaid beneficiaries that are at least equal to the services available to the state's privately insured population. This provision within the law is commonly called the "equal access clause." Despite these requirements, the Sixth and Tenth Circuits have ruled that Medicaid-eligible children are unable to enforce their right to receive these health care services. In light of these decisions, the Academy is pleased that the Affordable Care Act codifies Congressional intent by re-affirming that Medicaid includes the provision of health care services, not just the financing of those services. This change should help ensure that pediatricians are paid appropriately and that Medicaid-eligible children have access to needed health care services.

#### **What Does the Health Reform Law Mean for Pediatric Practices?**

These two provisions within the health reform law—the first-ever federal financial investment to increase Medicaid payment rates and the clarification that the definition of Medicaid includes health care services—have the potential to significantly improve access to care. These provisions will enable pediatric providers, many of whom have had to cap or even cut their Medicaid caseload due to low payment rates, to continue to care for children enrolled in Medicaid and the Children's Health Insurance Program.

However, more work remains to be done to ensure that the Affordable Care Act provides access to all needed health services for children enrolled in public programs. For instance, the law's Medicaid payment increase only includes evaluation and management codes that are recognized by Medicare and paid for under the Medicare program. The payment increase thus excludes procedure codes and some additional codes that children need but Medicare does not recognize. The inclusion of procedure codes is particularly important in providing access to pediatric subspecialists and pediatric surgical specialists, since these doctors often bill for services using procedure codes more frequently than evaluation and management codes. Excluded codes, such as well-child care codes that are not paid for by Medicare, could limit access to the preventive services included in the law. The Academy will be advocating for Congress and the Administration to increase federal funding to states to cover payment for all recommended and needed services. In addition, the Academy is encouraging the federal government, rather than pediatricians and the families they care for, to enforce the equal access clause and hold state governments accountable for ensuring that payment rates assure equal access.





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## Support for Small Pediatric Practices

For the first time in modern history, fewer than half of U.S. small businesses provide health insurance to their employees. Many small businesses and physicians running pediatric practices cannot afford the tremendous cost of health insurance coverage and are therefore unable to provide this benefit to employees. The Affordable Care Act was designed to alleviate some of the burden on these employers and their employees, while at the same time modifying current laws to make existing health insurance coverage more effective, affordable, and accessible.

### The Health Reform Law:

#### **Helps small businesses afford health insurance:**

The law provides a sliding-scale tax credit (retroactive to January 1, 2010) to small businesses—including many pediatric practices—that have fewer than 25 full-time equivalent employees with average annual wages of \$50,000 or less and that cover at least 50% of each employee's premium. An estimated 4 million small businesses nationwide can qualify for the tax credit, which is expected to provide a total \$40 billion in tax savings to small businesses through 2019.

For tax years beginning in 2010 through 2013, the tax credit covers up to 35% of the employer's premium cost. Small businesses can claim the credit on their annual income tax returns, starting with their 2010 return. The credit is available for a maximum of six years: 2010 through 2013 plus two consecutive years after that. Beginning in 2014, the credit increases to 50%, and the employer must purchase coverage through a specific small business exchange (known as the Small Business Health Options Program or "SHOP" Exchange) in order to claim the 50% tax credit.

Beginning in 2014, the law requires an employer with more than 50 full-time employees to offer health insurance or pay a penalty. These larger employers that do not offer coverage and have at least one full-time employee receiving premium assistance tax credits in the health insurance exchanges will pay an assessment fee of \$2,000 per full-time employee (the first 30 employees are not included as part of this calculation).

Employees who do not receive insurance through their employer and do so through the exchange will have access to sliding-scale tax credits to help them pay their premiums. Effective in 2014, for those with access to the exchange, sliding-scale tax credits will be provided to individuals as well as to families earning up to 400% of the federal poverty level (nearly \$90,000 for a family of four).

## Health Reform Implementation Timeline

In March 2010, President Obama signed into law *The Patient Protection and Affordable Care Act* (Public Law 111-148) and *The Health Care and Education Reconciliation Act* (Public Law 111-152). Together, these two laws make up the health reform package known as the *Affordable Care Act*. The package contains many strong provisions that impact children and the pediatricians who care for them. The following is a summary and timeline of such provisions:

### Currently, the Affordable Care Act:

- Bans pre-existing condition exclusions for children up to age 19 who are enrolled in non-grandfathered individual market plans and group insurance plans.
- Provides five billion dollars to fund affordable health coverage through the Pre-existing Condition Insurance Plan (PCIP) program for individuals who have been uninsured for at least six months.
- Extends coverage to young adults under a parent's health insurance plan to age 26 if the plan provided dependent coverage.
- Requires coverage of all *Bright Futures* services for children, with no cost-sharing, by non-grandfathered health plans.
- Bars all private insurance plans from rescinding coverage, except in the case of fraud or misrepresentation by the enrollee.
- Bars private insurance plans from imposing lifetime dollar limits on coverage for "essential health benefits."
- Restricts annual limits on coverage on a phased-in basis for all non-grandfathered individual market plans and all group plans.
- Allows plan enrollees in all non-grandfathered plans to choose a participating pediatrician as child's primary care provider.
- Requires that out-of-network emergency care services be covered at the same cost to enrollees as in-network emergency services.
- Requires non-grandfathered plans to establish internal appeals and external review processes for denials of coverage.
- Requires insurers to document "unreasonable" premium increases prior to implementing them.
- Requires insurers to pay out at a specific percentage of premiums on clinical care and quality improvement mechanisms (also known as "medical loss ratio"). Large group plans must pay out 85% of premiums; individual and small group plans must pay 80%.
- Provides the first phase of health care tax credits to small businesses (up to 35% of the premium cost for 2 years for small businesses with 25 full-time employees or fewer whose average income is less than \$50,000)—including private pediatric practices—to help them cover the cost of health coverage for their employees. The credits are retroactive to Jan. 1, 2010.

### Beginning in 2013, the Affordable Care Act:

- Provides federal funding of \$8.3 billion to bring Medicaid payments to at least Medicare payment rates. The increase applies to payments for evaluation and management codes recognized by Medicare starting in 2013 and runs through 2014. The investment is available to physicians with an internal medicine, family practice or pediatric primary specialty designation.

### Beginning in 2014, the Affordable Care Act:

- Funds the establishment of state-based health insurance exchanges, which are designed to make health insurance more accessible and affordable for small businesses and individuals.
- Increases the small business health care tax credit to 50% of the premium cost.
- Requires Medicaid coverage to be extended up to age 26 to foster children who have aged out of the foster care system.
- Expands income eligibility for Medicaid to all adults and children up to 133% of the federal poverty level, or \$29,327 for a family of four and \$14,404 for an individual.