Leveraging Affordable Care Act Opportunities to Improve Childhood Asthma Outcomes

How advocacy organizations can mobilize around ACA provisions to improve health outcomes for millions of children most at risk for asthma

ENSURING STABLE AND CONTINUOUS HEALTH INSURANCE COVERAGE FOR CHILDREN WITH ASTHMA

The 2010 *Changing pO$_2$licy* report describes several essential elements that are critical to ensuring that comprehensive asthma treatment and management reach children in need. According to the report, access to stable, continuous health insurance coverage forms the foundation of comprehensive asthma care. Ensuring uninterrupted access to health insurance for all low-income children can be achieved by expanding, improving and streamlining Medicaid and CHIP enrollment.

The following chart describes several *Affordable Care Act* (ACA) provisions and implementation activities that target the stability and continuity of health insurance for children. Regardless of whether a provision has been fully implemented or is still in progress, each presents a unique opportunity for policy and advocacy efforts to improve access to health insurance for children with asthma.

This review includes descriptions and implementation timelines of several ACA programs and initiatives, including:

- ***Health insurance coverage of preventive health services***
- ***Development of an essential health benefit for all individuals securing insurance through state health insurance exchanges***
- ***Streamlining enrollment procedures under Medicaid, CHIP and state exchanges***
- ***Expanding Medicaid to cover individuals up to 133 percent of the federal poverty line***
- ***Enhanced Medicaid payments to primary care physicians***

Following descriptions of each ACA provision and related implementation activities, the chart describes potential areas for asthma stakeholder engagement, policy research and development, and advocacy action at the national, state and local levels.

About This Series

In February 2010, the George Washington University School of Public Health and Health Services, Department of Health Policy released *Changing pO$_2$licy: The Elements for Improving Childhood Asthma Outcomes*. The report provided a comprehensive look at childhood asthma prevalence, risk factors and disparities; described best practices for clinical care and disease management; and, outlined evidence-based policy recommendations to improve the prevention, diagnosis, treatment, and long-term management of childhood asthma.

The report identified five essential elements for improving asthma outcomes in children:

(1) Stable and continuous health insurance
(2) High-quality clinical care, case management and asthma education available for all children
(3) The ability to continuously exchange information and monitor progress, using health information technology
(4) Reducing asthma triggers in homes and communities
(5) Learning what works and increasing knowledge

Following the release of these recommendations, Congress passed the *Affordable Care Act* (ACA), emphasizing expanding access to private health insurance and Medicaid and reforming the healthcare delivery system to improve quality. The ACA includes provisions to eliminate health care disparities, strengthen public health programs and access to preventive services, invest in expanding and improving the health care workforce, and encourage care coordination and disease management.

Many ACA provisions correspond to recommendations in the *Changing pO$_2$licy* report and have the potential to profoundly impact the prevention and treatment of childhood asthma.

This paper focuses on one of the five essential elements for improving asthma outcomes in children: ***stable and continuous health insurance***. The accompanying chart describes ACA provisions and implementation activities that could be activated to help millions of children most at risk for asthma.

Childhood Asthma Leadership Coalition

DESCRIPTION OF PROVISION	RECENT IMPLEMENTATION ACTIVITIES	OPPORTUNITIES FOR CHILDHOOD ASTHMA POLICY/ADVOCACY
COVERAGE OF PREVENTIVE HEALTH SERVICES (Section 1001)		
For plan years beginning on or after September 23, 2010, all group and health insurance issuers offering group or individual health insurance to provide, without cost-sharing, a minimum level of preventive health services, in accordance with the following: (1) Evidence-based items and services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Service Task Force (USPSTF); (2) Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); (3) Evidence-informed preventive care and screenings for infants, children, adolescents, and women, as presented in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and (4) The current recommendations from the USPSTF on breast cancer screening and mammography.	• February 15, 2012: The Departments of HHS, Treasury, and Labor issued final regulations on preventive health services, including an exemption for religious employers from having to cover certain women's preventive services. • February 15, 2012: HHS issued an issue brief estimating that 54 million Americans had received preventive benefits without cost-sharing due to the ACA. • March 21, 2012: CMS issued an Advance Notice of Proposed Rulemaking, proposing amendments to establish alternative ways to fulfill the requirements of the ACA's preventive health services provisions when health coverage is sponsored or arranged by a religious organization. The comment period closed June 19, 2012. • August 1, 2012: For plan years beginning on or after August 1, 2012, non-grandfathered plans and issuers are required to provide preventive coverage without cost sharing consistent with HRSA guidelines on women's preventive services.	• USPSTF: USPSTF recommends certain preventive services that may impact asthma, including: (i) tobacco counseling for pregnant women (exposure to tobacco *in utero* increases the likelihood that a child will develop asthma); and (ii) obesity screening and counseling for children (studies suggest that asthma in overweight children is more likely to be uncontrolled). USPSTF has not evaluated clinical preventive health care services (such as screening, counseling, and preventive medications) related to childhood asthma, and has not developed recommendations. The National Asthma Education and Prevention Program (NAEPP) has found insufficient evidence to recommend any specific clinical strategies to prevent the development of asthma, however research is ongoing. • ACIP: NAEPP states that influenza and pneumococcal immunizations are important means of preventing and controlling asthma in children (respiratory infections can exacerbate asthma and children with asthma are at an increased risk for complications from influenza and pneumococcus; in addition, clinicians often mis-diagnose asthma, labeling it as a respiratory infection and preventing children from getting appropriate therapy to address asthma symptoms). ACIP recommends yearly influenza immunizations for all children over 6 months of age, and pneumococcal vaccines for: (1) all children under 5 years; and (2) children 6-18 years with certain underlying medical conditions that increase their risk for pneumococcal disease or complications (asthma is not considered among this list of underlying conditions). • HRSA Guidelines for Children: Guidelines for infants, children, and adolescents supported by HRSA appear in two charts: (i) the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care; and (ii) the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. Asthma is not among the preventive screenings supported by HRSA guidelines. • HRSA Guidelines for Women: HRSA guidelines for women include preventive health services that may impact childhood asthma prevention. The guidelines include annual well-woman visits that include the set of preventive services recommended by USPSTF (including tobacco counseling for pregnant women). • ***Potential Policy Action: USPSTF, ACIP and HRSA recommendations are likely to become the cornerstone of what preventive services will be covered by group and individual health insurance – both inside and outside of the state Exchanges. Encouraging these entities to evaluate pediatric asthma and issue recommendations for asthma prevention will be important means of ensuring that children with asthma have continuous access to these benefits.***
ESSENTIAL HEALTH BENEFITS PACKAGE (SECTION 1302)		
All health insurance plans sold in the individual and small group (100 employees or fewer)	• FAQs; February 17, 2012: In response to questions raised by stakeholders about	State Mandated Benefits: The HHS Bulletin suggests that states will have the discretion whether to include state-mandated benefits within the EHB for in-state health insurance plans. The FAQ document clarifies that if

DESCRIPTION OF PROVISION	RECENT IMPLEMENTATION ACTIVITIES	OPPORTUNITIES FOR CHILDHOOD ASTHMA POLICY/ADVOCACY
markets – whether sold outside or inside state insurance Exchanges – must cover certain "essential health benefits" (EHBs). The HHS Secretary will define the EHB package, which, at a minimum, must include the following general categories of benefits: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) maternity and newborn care; (v) mental health and substance abuse services, including behavioral health treatment; (vi) prescription drugs; (vii) rehabilitative and habilitative services; (viii) laboratory services; (ix) *preventive and wellness services and chronic disease management*; and (x) *pediatric services* (including oral and vision care). • The law requires the Secretary to take certain "elements for consideration" into account in developing the EHB package, including "the *health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups*." • Overall, the scope of the EHB will be equal to the scope of benefits provided under a "typical employer plan." • The EHB definition also applies to Medicaid benchmark and benchmark equivalent plans which cover newly eligible Medicaid beneficiaries under the Medicaid expansion (see below).	how states should develop their essential benefit packages, HHS published a "Frequently Asked Questions" document providing additional guidance on HHS's intended approach to defining EHB. • July 18, 2012: HHS issued a final rule outlining what data will be collected from health insurance plans regarding essential health benefits. The rule requires each of the three largest small group health insurance plans in each state to report covered benefits and other data to HHS. Information reported by health plans will be used by states and health plan issuers to define and evaluate EHBs. • November 20, 2012: HHS released a proposed rule detailing coverage of essential health benefits. The proposed rule requires all non-grandfathered group and individual plans to offer preventive health services that include the USPSTF, ACIP and HRSA preventive benefits (described in detail in the preceding provision), and the rule defines standards for plans to supplement an EHB with additional benefits. This rule does not address essential health benefits for the Medicaid expansion.	a state were to select an EHB benchmark plan that does not include all state-mandated benefits, the state must defray the cost of any additional mandated benefits outside of the chosen benchmark. In addition, any state-mandated benefits enacted after December 31, 2011 cannot be part of the essential health benefit in 2014 or 2015, unless the chosen EHB benchmark plan already included that benefit regardless of the mandate. • ***Potential Policy Action: Advocates could consider identifying existing state mandates important to childhood asthma prevention and treatment, and advocating for states to select an EHB benchmark plan that includes those benefits.*** Definition of Medical Services: The IOM Report concludes that benefits under the EHB should be only for medical services/items, "*not serving primarily a social or educational function*." • ***Potential Policy Action: As many services important to childhood asthma prevention and treatment are community support and educational services, there is a potential need to advocate for states to include these services within the EHB.*** EPSDT: The HHS Bulletin indicates that HHS will allow states to offer benefits equivalent to four benchmark plans. The Bulletin does not explain how the EHB provisions will be adjusted to reflect Medicaid's EPSDT requirements. • ***Potential Policy Action: Advocates could consider asking HHS to include the EPSDT benefit for expansion eligibles.*** Data Collection: According to the final rule on EHB data collection, the information to be reported includes information regarding health benefits in the plan, treatment limitations, drug coverage, and enrollment. • ***Potential Policy Action: Advocacy may be needed at the state and federal levels to ensure that health plans collect asthma-relevant data to help bolster coverage of asthma-related items and services in future iterations of EHB rulemaking. Advocates may want to push for plans to report on additional elements of plan design, such as provider network characteristics.*** Future EHB Regulations: According to the February FAQ, HHS's EHB guidance thus far represents a two-year transitional policy approach; the Agency intends to revisit the EHB benchmark plan selection approach – including policies on the treatment of state benefit mandates – in 2016. • ***Potential Policy Action: In advance of potential regulatory changes in 2016, advocates could focus on researching/scoring benchmark plans to determine their adequacy in providing appropriate services to children with asthma.***

STREAMLINING ENROLLMENT – EXCHANGES, MEDICAID AND CHIP (SECTION 1413)		
Under the law, the HHS Secretary is required to establish a streamlined system for enrollment in the Exchange. Under this system, any individual applying to the state Exchange who is found eligible for health subsidy programs (including premium credits for purchasing health plans in the Exchange, Medicaid and CHIP) must be automatically enrolled in the appropriate program.	March 27, 2012: HHS published a final rule that provides the framework for states to follow when setting up Exchanges. The final rule establishes a streamlined, coordinated, and web-based system through which an individual may apply for and receive a determination of eligibility for enrollment in a qualified health plan through the Exchange and for insurance affordability programs (premium tax credits, Medicaid, CHIP and the Basic Health Plan). The final rule provides two ways for Exchanges to interact with Medicaid agencies when making eligibility determinations: (i) Exchanges, following state-established Medicaid rules, can conduct eligibility determinations for Medicaid and for advance payment of premium tax credits; or (ii) the Exchange will make the preliminary eligibility assessment and turn it over to the state Medicaid agency, if applicable, for final determination.	The streamlined, web-based system established under the final Exchange rule is intended to ensure that no matter how an enrollment application is submitted or which program receives the application, an individual will use the same application and receive a consistent eligibility determination, without the need to submit information to multiple programs. Once implemented, this system should greatly assist low-income children with asthma to enroll in coverage through Medicaid and the Exchange. However, the Exchange rule gives states substantial flexibility in determining how to build their Exchange and how to conduct enrollment. The rule does not address many concerns about enrollment continuity over time. Today, many children are eligible but remain unenrolled in Medicaid and CHIP. A similar trend is likely to continue for the Exchanges and the Medicaid expansion (see below). Furthermore, there will be new challenges for children to maintain coverage when their family income levels inevitably fluctuate between traditional Medicaid/CHIP, the Medicaid expansion and the state Exchange. • ***Potential Policy Action: Advocates could work to ensure that state Exchange and Medicaid eligibility determinations and enrollment procedures are streamlined, coordinated and family-friendly. Leverage points may include input on the Federal model application, states' on-line enrollment applications, and states' automated eligibility processes.***
MEDICAID EXPANSION (SECTION 2001 ET. SEQ., 2201, 2202)		
• Medicaid Expansion: Beginning January 1, 2014, the law extends and simplifies Medicaid eligibility. The law replaces Medicaid's previous, multiple categorical groupings and limitations with one simplified overarching rule: all individuals under age 65 with incomes under 133 percent FPL, who meet citizenship/lawful U.S. status and state residency requirements, are entitled to medical assistance. In addition, use of an asset test is eliminated.	• March 16, 2012: CMS released a final rule implementing the ACA's Medicaid eligibility expansions as well as its simplified enrollment and retention procedures. The final rule makes it easier for eligible individuals and families to enroll in Medicaid and CHIP by simplifying financial eligibility determinations for most Medicaid and CHIP enrollees (children and non-disabled adults under age 65) and by consolidating eligibility categories into	Medicaid Expansion: As a result of the June 2012 Supreme Court decision, some states have stated that they will not expand their Medicaid programs in 2014. Other states may seek to expand Medicaid only for certain populations or up to an income level below 133%. • ***Potential Policy Action: State level advocacy may be needed encourage states to expand Medicaid to cover individuals, including low-income children, who will face difficulty obtaining coverage in state Exchanges.*** Enrollment and Continuous Coverage: Ensuring the continuity and stability of health insurance enrollment was cited in the *Changing pO$_2$licy* report as a major element for improving asthma outcomes in children. However, many children today are eligible but remain unenrolled in Medicaid and CHIP, and a similar trend is likely to continue under the Medicaid expansion.

• Income Eligibility: Replaces the current standards and methods for evaluating income eligibility for purposes of Medicaid and CHIP with a "modified adjusted gross income" test (MAGI), the same income methodology used to determine eligibility for premium tax credits and cost sharing assistance in insurance Exchanges. Thus, the ACA financially aligns both the Medicaid and Exchange markets in order to enable prompt enrollment. • Enrollment Simplification: Requires alignment of eligibility determination and enrollment between Medicaid and the Exchange. • Benchmark Coverage: New Medicaid enrollees who qualify for Medicaid under the expansion are entitled to "benchmark" or "benchmark-equivalent" coverage. Benchmark plans offered to individuals who are eligible under the Medicaid expansion must provide all essential health benefits (EHBs) as defined for the state Exchange. • Hospital Presumptive Eligibility: Beginning January 1, 2014, allows all hospitals participating in Medicaid to make presumptive eligibility determinations for all Medicaid-eligible populations.	four main groups – adults, children, parents and pregnant women. The regulations also coordinate Medicaid/CHIP enrollment with state Exchange enrollment. This final rule and the recently issued Exchange final rule (see above) are intended to work together to build a seamless system of coverage so that in 2014, Medicaid, CHIP and the state Exchanges will work together to efficiently enroll consumers in the appropriate program. • June 2012: In *NIFB v* Sebelius, the Supreme Court upheld the constitutionality of the ACA in general. However, the decision modifies implementation of the Medicaid expansion provisions. The Court found that the law as written (which would have effectively required states to expand their Medicaid rolls up to 133% FPL or risk losing federal funding for their current Medicaid program) is unconstitutionally coercive to states. The Court decision essentially alters the Medicaid expansion mandate into a state Medicaid option: a state can elect to expand Medicaid, but will no longer lose funding for their current program if they do not.	• ***Potential Policy Action: The Changing pO$_2$licy report recommends working to encourage states to adopt Medicaid and CHIP enrollment reforms, including making enrollment possible through community health care providers, schools and other locations. The ACA and subsequent implementing regulations appear to address some enrollment issues (e.g. creating new enrollment opportunities through the state Exchange), but advocates could consider continuing to push for enrollment reforms.*** Benchmark Coverage; EPSDT: Benchmark plans offered to individuals who are eligible under the Medicaid expansion must provide all essential health benefits as defined for the state Exchange. The HHS Bulletin & FAQs describe broadly the approach that HHS intends to take in defining EHBs (described in further detail in essential health benefits section), but the Bulletin/FAQ does not explain how the EHB provisions will be adjusted to reflect Medicaid's EPSDT requirements for children who fall into the Medicaid expansion population (e.g., 6-19 year olds between 100 and 133 percent FPL). HHS intends to offer additional guidance on the interaction between EHB and Medicaid. • ***Potential Policy Action: The private insurance market has not historically provided benefits sufficient to meet children's health needs, and typically does not provide benefits up to the level of EPSDT. Advocates could encourage HHS to maintain the EPSDT benefit for children eligible for the expansion.***
PAYMENTS TO PRIMARY CARE PHYSICIANS (SECTION 1202 OF THE RECONCILIATION ACT)		
• Increases Medicaid payments for certain primary care services provided to Medicaid beneficiaries in 2013 and 2014. During these years, state Medicaid programs are required to reimburse family medicine, general	The provision is effective January 1, 2013 through December 31, 2014.	• ***Potential Policy Action: This provision will help ensure greater access to primary care providers among Medicaid recipients, which will be important during the first year of the Medicaid expansion. As evaluation, management and immunization services are central to asthma treatment and prevention, advocacy may be needed to ensure that Medicaid programs appropriately reimburse for these services.***

internal medicine, and pediatric medicine physicians who furnish certain evaluation, management and immunization services at 100% of the Medicare payment rate. • The provision provides for an increased federal medical assistance percentage ("FMAP") to states to reimburse all additional costs to state Medicaid programs for reimbursing these Medicaid services at the Medicare rate.		
EXPANDED PARTICIPATION IN 340B PROGRAM (SECTION 7101)		
This provision extends participation in the 340B program to children's hospitals excluded from the Medicare prospective payment system, free-standing cancer hospitals excluded from the Medicare prospective payment system, critical access hospitals, sole community hospitals, and rural referral centers.	These amendments apply to drugs purchased on or after January 1, 2010.	• ***Potential Policy Action: Extension of the 340B program to these hospitals will make treating asthma more affordable in the hospital setting and may increase low-income patient access to quality asthma care. Advocacy may be required to ensure that patients are receiving access to discounted drugs.***