AMCHP supports state maternal and child health (MCH) programs and provides national leadership on issues affecting women and children. We work with partners at the national, state and local levels to expand medical homes; provide and promote family-centered, community-based, coordinated care for children with special health care needs; and facilitate the development of community-based systems of services for children and their families.

AMCHP’s National Center for Health Reform Implementation provides state MCH leaders and their partners with the information, tools and resources to optimize the opportunities presented by the Patient Protection and Affordable Care Act (ACA) for improving services, systems and health outcomes for MCH populations.

Background

On July 11, 2011, the U.S. Department of Health and Human Services (HHS) released a proposed rule on the Establishment of Exchanges and Qualified Health Plans. The rule provides a suggested framework from which states can begin to develop Health Insurance Exchanges (Exchanges). It is important to note that this is a proposed rule and HHS is seeking comments on a number of provisions. Comments to HHS are due Oct. 31, 2011.

The Association of Maternal & Child Health Programs (AMCHP) is working with members and a broad coalition of MCH groups to develop comments about this regulation. This Issue Brief highlights some of the key considerations for state MCH programs and partners in developing their Exchanges and provides key leaders with some ideas to ensure that the unique needs of women, children and families are addressed in state Exchange planning. For states that will not develop their own Exchanges, AMCHP will submit comments to HHS to help assure these key issues are considered during the development of the federal Exchange.

State Health Insurance Exchanges

The Patient Protection and Affordable Care Act (ACA) created a new mechanism for purchasing health insurance coverage called “Exchanges” which are entities that will be set up in states to create an organized and competitive market for health insurance. Exchanges are expected to offer consumers a choice of health plans and establish common rules regarding the offering and pricing of insurance and provide information to help consumers better understand the options available to them. States must establish Exchanges by Jan. 1, 2014. If the secretary of HHS determines that a state will not have an Exchange operational by 2014, the secretary must establish and operate the exchange in that state. According to the Kaiser Family Foundation, by July 2011 more than one third of states had begun laying the foundations for Exchanges that meet the requirements outlined by the ACA.
The Congressional Budget Office estimated in 2019 that approximately 24 million people would purchase their own coverage through the Exchanges, plus an additional 5 million people whose employers allow all their workers to choose among the plans in the Exchanges.

It is important to note that some issues AMCHP is tracking were not addressed in the proposed Exchange rule, including the coordination of eligibility and enrollment with Medicaid and Children’s Health Insurance Program (CHIP) and definition of the essential benefits package. While several parts of the rule are relevant to children and youth with special health care needs, the rule does not specifically address this group.

States have flexibility regarding the structure and governance of an Exchange. They may establish an Exchange as a state agency, a nonprofit organization or choose to contract with other eligible entities. A state may also choose to partner with other eligible entities to form regional or other subsidiary Exchanges within the state. Additionally, on Sept. 19, 2011 the Administration unveiled a “partnership options” initiative where states may choose to perform some functions of the exchange and let the federal government perform other functions for them. These options include either the state taking the lead on working with health plans and/or a state conducting outreach, education and in person consumer support.

Exchange Implementation and Operations:
States can begin operations by Oct. 1, 2013 to support the initial enrollment period. Exchanges need to be assessed by HHS to evaluate their operational readiness. Statute requires HHS to approve state Exchanges by Jan. 1, 2013 for an operational date of Jan. 1, 2014.

Conditional Approval: HHS may issue a conditional approval if they presume the state Exchange will be fully operational by Jan. 1, 2014, even if it cannot demonstrate complete readiness on Jan. 1, 2013.

Review Process: HHS proposes a review process to approve Exchange plans similar to Medicaid and CHIP. Specifically, 90 days to review for approval, denial or request for comment. An Exchange must also notify and obtain approval by HHS before implementing significant changes. HHS proposes using the state plan amendment process in place for Medicaid and CHIP.

After 2014: A state must have an approved or conditionally approved Exchange plan at least 12 months prior to the first date of affected coverage and work with HHS to develop a plan to transition from a federally facilitated Exchange to a state Exchange.

Federal Exchange: If a state elects not to establish an Exchange directly or with a nonprofit entity, or if the state Exchange is not approved by HHS, the federal government must establish and operate an Exchange in this state. Generally, all the requirements included in the regulation apply to a federally-facilitated Exchange except for Exchange-approval requirements and other specific state Exchange requirements.

Key Considerations for State MCH Programs

The proposed rule includes a number of items for consideration by state MCH programs and their partners. Specific recommendations for state Title V leaders are included below.

Exchange Governing Boards: Boards governing state Exchanges must be comprised of voting members who have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health or health-policy issues. Boards may not consist primarily of health insurance issuers, agents or brokers.

RECOMMENDATION: MCH leaders are encouraged to work with their state health officials and other policymakers to suggest that state Title V MCH programs and other key MCH stakeholders (e.g., family groups representing children with special health care needs) be appointed members of the Exchange Governing Board.

Stakeholder Consultation: Exchanges are required to consult with stakeholders as they establish their programs and throughout ongoing operations. Including:

- Educated health care consumers
- Individuals and entities with experience in facilitating enrollment in health coverage
- Advocates for enrolling heard to reach populations including advocates for individuals with disabilities
- Small businesses and self-employed individuals
• State Medicaid and CHIP agencies
• Federally recognized tribes
• Public health experts
• Health care providers
• Large employers
• Health insurance issuers
• Agents and brokers

RECOMMENDATION: MCH leaders should encourage policymakers to assure that consultation with “public health experts” includes state MCH programs and that Exchanges also be encouraged to consult with state and local MCH organizations, representatives of families of children with special health care needs and other entities that specialize in the care of children with disabilities.

Enrollment: Exchanges will play a central role in the process of determining an individual’s eligibility for enrollment in a qualified health plan, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP and basic health plans (BHP). The ACA requires the establishment of a single streamlined and coordinated eligibility and enrollment system through which an individual may apply for enrollment in a qualified health plan (QHP), advance payments of the premium tax credit, cost sharing reductions, Medicaid and CHIP and receive a determination of eligibility for any such program. The rule proposed that eligibility and enrollment function should be consumer oriented, minimizing administrative hurdles and necessary paperwork for applicants.

RECOMMENDATION: MCH leaders can advocate for Exchanges to actively engage state Title V MCH programs in providing guidance on the development and strengthening of outreach and enrollment processes to assure that the unique needs of MCH populations are considered in the development of a single streamlined and coordinated eligibility, enrollment process, and that, where relevant, eligibility for other public health programs [e.g., CSHCN programs, high risk prenatal care coordination, Early Intervention (Part C of IDEA), WIC child nutrition programs, Family Planning, etc] is considered and integrated into these systems.

Required Consumer Assistance Tools: The regulation codifies the requirement for the Exchange to establish a website and call center. HHS encourages Exchanges to use these call centers as conduits to these and other state consumer programs where appropriate.

RECOMMENDATION: MCH leaders can advocate for Exchanges to work with state Title V MCH programs to assure that websites and call centers are linked to statewide 1-800 help and hotline numbers required by Title V programs. These Title V funded numbers are designed to link women, children and their families to programs and services and offer a prime opportunity to closely coordinate with other state programs.

Education and Outreach: The proposed rule specifies that Exchanges should aim to maximize enrollment of eligible individuals into QHP to increase participation. Exchanges should conduct outreach broadly and target hard-to-reach populations. These activities are separate from the navigator activities also included in the rule.

RECOMMENDATION: MCH leaders should advocate that Exchanges draw on state Title V MCH programs expertise and experience in developing and implementing outreach and enrollment programs for women, children and their families, particularly those who are hard-to-reach.

Navigator: Codifies the requirement for Exchanges to award grant funds to public or private entities to serve as Navigators. Navigator duties include maintaining expertise in eligibility, enrollment and program specifications and conducting public education activities to raise awareness of the availability of QHPs. Navigators also facilitate enrollment in a QHP and provide referrals to any applicable office of the health insurance consumer assistance or health insurance ombudsman. Navigators must demonstrate they have existing relationships or could develop relationships with employers and employees, consumers or self employed individuals. States can choose to permit or require Navigator activities and may also address Medicaid and CHIP administrative functions.

HHS proposes that the Exchanges include at least two of the types of entities listed below to receive a Navigator grant:
• Community and consumer focused nonprofit groups
• Trade, industry and professional associations
• Commercial fishing industry organizations, ranching and farming organizations
• Chambers of commerce
• Unions
• Resource partners of the Small Business Administration
• Licensed agents and brokers
• Other public or private entities

RECOMMENDATION: MCH leaders should advocate that Exchanges work with state Title V MCH programs to assure that the unique needs of MCH populations are considered in the development and selection of Navigators, and in the development and design of public education activities to raise awareness of QHPs. Additionally, Exchanges should assure that families of CSHCN are engaged in the development and selection of Navigators. In addition, AMCHP encourages HHS to suggest that state Exchanges award grants to Family to Family Information Centers to serve as Navigators.

Treatment of a Direct Primary Care Medical Home: The proposed rule codifies the requirement for a QHP issuer “to provide coverage through a direct primary care medical home that meets the requirements established by HHS.” HHS is seeking comments on what standards should be established. The regulation does not allow an individual to purchase a direct primary care medical home plan and separately acquire wrap-around coverage.

RECOMMENDATION: AMCHP encourages HHS to adopt the universal definition of “patient centered medical home” and incorporate other organizations criteria to the definition of medical home, in partnership with the American Academy of Pediatrics and other related groups/organizations.

Establishment of Exchange Network Adequacy Standards: Exchanges will make health insurance available to a variety of consumers, including those who reside or work in rural or urban areas where it may be challenging to access health care providers. The proposed rule specifies that Exchanges should ensure that enrollees of QHPs have a sufficient choice of providers. HHS solicits comments on additional minimum qualitative or quantitative standards for the Exchange to use in evaluating whether the QHP provider networks provide sufficient access to care. HHS also solicits comments on a standard so that the Exchange ensures the QHPs’ provider networks provide sufficient access to care for all enrollees, including those in medically underserved areas.

Essential Community Providers: The proposed regulation codifies a requirement that a health plan’s network include a “sufficient” number of essential community providers who provide care to predominantly low-income and medically underserved populations to be certified as a QHP. HHS defines essential community providers as those defined in section 340B(a)(4) of the Public Health Service Act which include the following:
• Federally-qualified health centers (FQHCs)
• FQHC look-alikes
• Migrant Health Centers
• HIV/AIDS clinics
• Women’s Health Centers (receiving grants under Title X)
• Native Hawaiian Health Centers
• Urban Indian Organizations;
• Public hospitals and other hospitals meeting a certain percentage of disproportionate share payments

HHS is soliciting comments on the extent to which the above definition should include other types of providers that serve predominantly low-income, medically underserved populations. AMCHP will work with partners to develop comments for this section on behalf of state MCH programs.

Other Provisions Relevant to Maternal and Child Health

In addition to the areas described above, there are several other provisions that have specific implications for the work of state MCH programs.

Enrollment Periods: Upon qualifying for a special enrollment period, the Exchange may only allow an existing enrollee of a QHP to change plans within levels of coverage. HHS recognizes that limiting enrollees to a specific level during a special enrollment period would pose a challenge for an enrollee in a catastrophic plan that becomes pregnant. HHS requests comments as to whether they should provide an exception for such circumstances. AMCHP will work with other MCH groups to develop comments urging HHS to provide an exception for pregnant women to ensure their unique needs are addressed during the prenatal period.
Pediatric Dental Benefit: HHS codifies the requirement that an Exchange allow limited-scope, stand-alone dental plans to be offered provided that the plan furnishes at least the pediatric essential dental benefit. AMCHP is working with partners to identify a shared recommendation on this topic.

Qualified Health Plan Minimum Certification Standards: Each Exchange will be responsible for determining whether a health plan seeking to participate meets the minimum requirements to be a QHP. The standards for QHPs do not supersede existing state laws or regulations applicable to health insurance issuers. Each QHP the Exchange offers must comply with the benefit design standards, adhere to cost-sharing limits and meet the leverage of coverage, will be the subject of future rulemaking.

Child Only Health Plan: Any QHP issuer offering a non-catastrophic health plan in the Exchange must offer the identical plan as a “child only plan” available only to individuals under the age of 21.

Conclusion

A significant number of women, children and families are likely to gain insurance coverage starting in 2014. Accordingly, there are a number of issues that policymakers should be aware of that uniquely impact women, children and children with special health care needs. AMCHP will continue to share the recommendations and comments it develops for HHS on these issues with state MCH leaders.

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Sources and Selected Resources for Additional Information:

- **Association of Maternal & Child Health Programs**: Additional information covering key aspects of ACA that pertain to MCH populations is available at: [http://www.amchp.org/Advocacy/health-reform/Pages/default.aspx](http://www.amchp.org/Advocacy/health-reform/Pages/default.aspx)

AMCHP Staff Contact Information

This fact sheet is part of an AMCHP series of tools, documents and resources on implementation of the ACA and its impact on maternal and child health populations. For more information, please visit the AMCHP website at: [amchp.org](http://amchp.org) and/or contact the AMCHP staff listed below. All AMCHP staff can be reached by phone at: (202) 775-0436.

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