

Who Will Be Covered for What in 2015 and Beyond?

An Overview of Insurance Affordability Programs for Maternal and Child Health Populations Existing Prior to or Expanded under the Affordable Care Act

The AMCHP Role

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 promote women's health; provide and promote family-centered, community-based, coordinated care for women and children; and facilitate the development of community-based systems of services for women, children and their families.

The AMCHP 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.

Under the Affordable Care Act (ACA), the 2016 marketplace open enrollment period for health insurance will last from November 1, 2015 – January 31, 2016. The ACA expands important coverage opportunities for women, children, and families through the marketplace and Medicaid expansion. Several studies have shown that when parents have access to coverage, children are less likely to be uninsured.¹ Thus, state Title V maternal and child health (MCH) programs can play an important role in educating women, children and their families about eligibility levels for various health insurance coverage options and potential gaps they may face in gaining coverage. The importance of health reform is seen in the proposed National Performance Measures for Title V, which includes direct and indirect measures for access to healthcare services such as [percentage of children without health insurance](#). For states that need support in understanding health reform within their state, the MCH National Workforce Center has developed [a tool](#) to help states do so.

This fact sheet is designed to assist state MCH programs in understanding insurance affordability programs not including employee-sponsored coverage. Figures 1 and 2 outline the federal minimum eligibility levels for each income scenario, including identified and potential gaps in eligibility for MCH populations both with and without Medicaid expansion. Table 1 is designed to be interactive; hyperlinks direct readers to detailed resources. The table highlights the projected minimum or essential health insurance benefits for MCH populations, including children and youth with special health care needs (CYSHCN), for each of the following coverage options or scenarios: Medicaid, Children's Health Insurance Plan (CHIP), insurance purchased through the health insurance marketplace (exchange), and safety-net services for those remaining uninsured. It is important to note that eligibility for public insurance coverage is limited to those who live in the United States, have satisfactory immigration status, and are not incarcerated.^{2,3}

These charts provide an overview of federal benefit and coverage requirements under the ACA. However, the actual benefits package, cost-sharing and affordability for families will vary widely depending on the state. These charts will be updated as needed in response to any funding or policy changes as the ACA is implemented.



Federal Eligibility Requirements for Adults and Children*

Figure 1. Affordable Insurance Programs with Medicaid Expansion

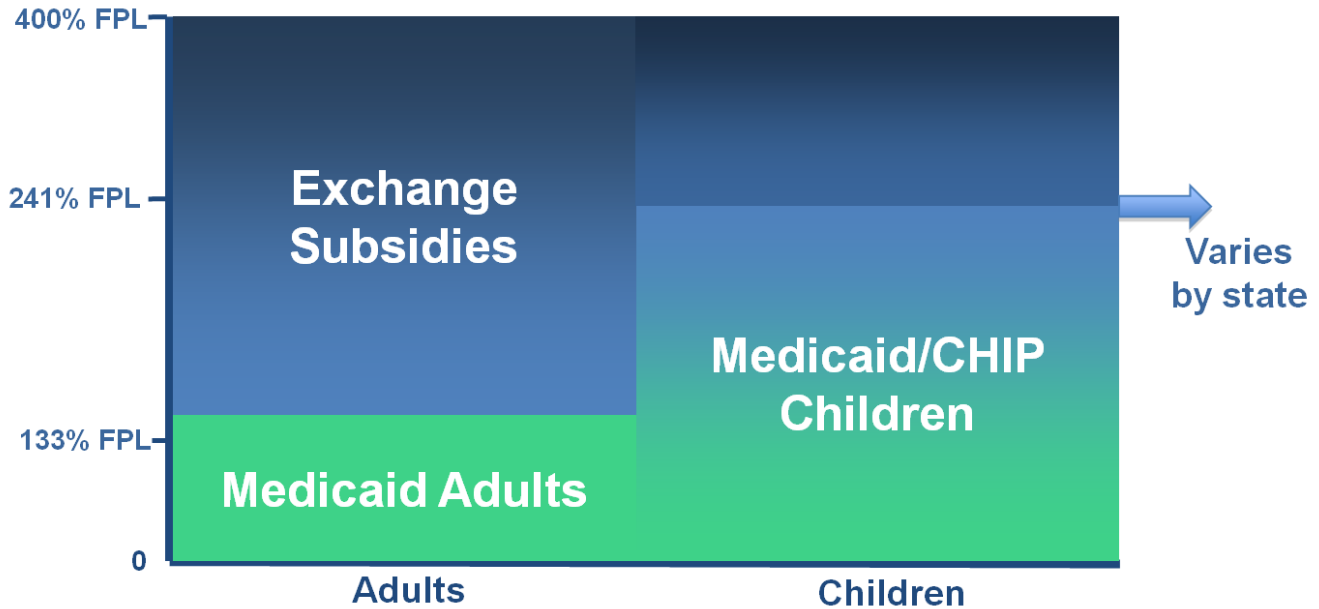
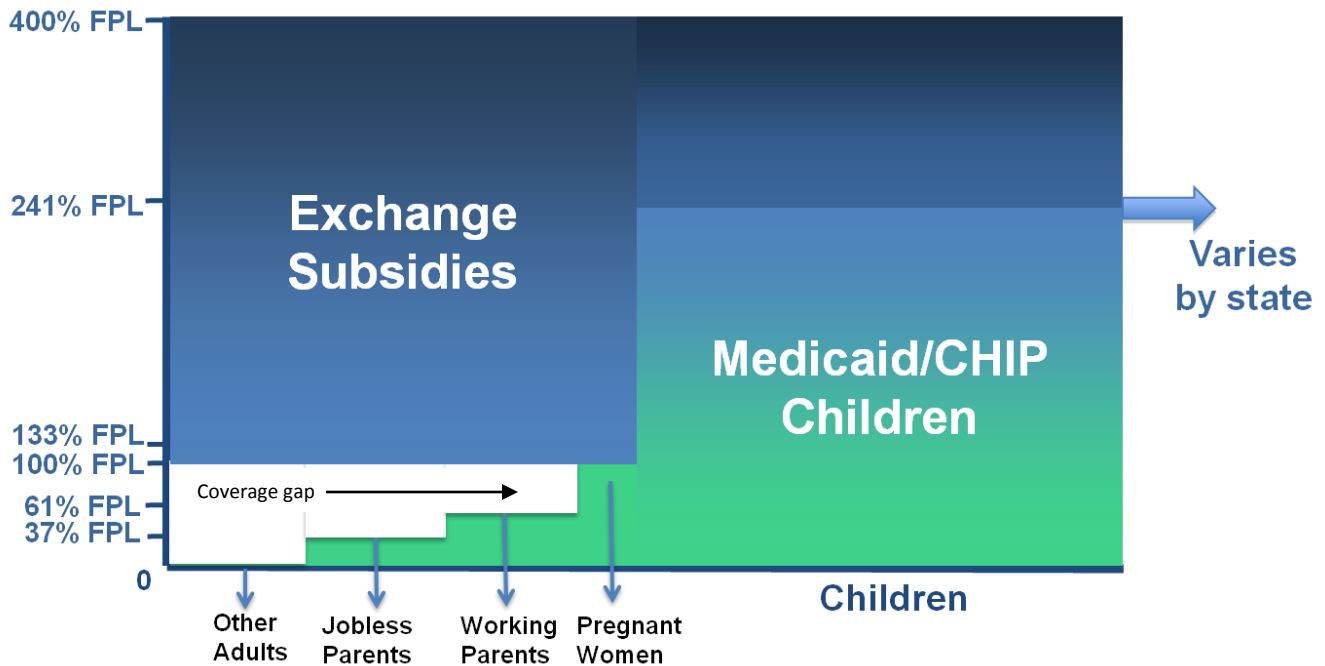


Figure 2. Affordable Insurance Programs Without Medicaid Expansion*

Non-Elderly, Non-Disabled Individuals, Based on Median State Eligibility



Source: Cindy Mann, J.D., Director, Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services (CMS/HHS), Washington, D.C. Presented at the 2012 Legislative Summit Health Sessions, National Conference of State Health Legislators

*Federal law requires that states provide Medicaid coverage to pregnant women whose household income is the higher of (1) 133 percent of the FPL or (2) the income standard, up to 185 percent of the FPL, that the state had established as of December 19, 1989 for determining eligibility for pregnant women, or, as of Jul. 1, 1989, had authorizing legislation to do so. 42 C.F.R. § 435.116. This means that while no state can reduce eligibility levels below 133 percent of the FPL, some states cannot reduce eligibility levels below 185 percent of the FPL.



Table 1: Summary of Federally Required Health Insurance Benefits and Potential Gaps, by Coverage Type Beginning Jan. 1, 2014

	Children, including those with special health care needs	Adult women (<65 years old)	Pregnant women	Potential gaps in benefits
Medicaid	<p>Early and Periodic Screening, Diagnosis & Treatment (EPSDT), for those up to age 21</p> <p>States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of the following screening, diagnostic and treatment services:</p> <ul style="list-style-type: none"> • Screening services • Comprehensive health and developmental history • Comprehensive unclothed physical exam • Appropriate immunizations (according to the Advisory Committee on Immunization Practices) • Laboratory tests (including lead toxicity screening) • Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention) • Vision services • Dental services • Hearing services • Other necessary health care services • Diagnostic services • Treatment 	<p>Full mandatory Medicaid benefit package plus any optional services covered by the state (Medicaid and CHIP eligibility levels for children and non-disabled adults).</p> <p>In states that elect to provide Medicaid eligibility to adolescents up to age 21, benefit package also includes EPSDT services.</p>	<p>Pregnant women receive care related to pregnancy, labor and delivery, and any conditions that might complicate the pregnancy, as well as perinatal care until the end of the month in which the 60th day postpartum falls (Medicaid eligibility for pregnant women).</p> <ul style="list-style-type: none"> • States should provide pregnant women comprehensive coverage, however, if a state denies coverage for a service to pregnant women who is provided to other adults, the state must first provide an explanation for this decision in a state plan amendment and obtain approval from the secretary of HHS. 	<p>For states that do not expand Medicaid, women under 133 percent of the federal poverty level (FPL) who are not otherwise eligible, would likely not be insured until becoming pregnant, leaving them otherwise uninsured.</p> <p>In states that do not provide full scope Medicaid benefits for women who qualify for Medicaid based on pregnancy status, there may be gaps in services provided.</p> <p>Women may face enrollment churn in the postpartum period, especially those who received coverage based solely on pregnancy status</p>
CHIP	<p>If the state has a separate CHIP program, benefits vary by state. States may choose either:</p> <ul style="list-style-type: none"> • Benchmark coverage • Benchmark-equivalent coverage • Secretary-approved coverage 	<p>Women only up to age 21 receive CHIP benefits</p>	<p>State determined, benefits vary, may include (CMS letter to state health officials):</p> <ul style="list-style-type: none"> • Full pregnancy coverage and 60 days postpartum through CHIP coverage of the unborn child. • Cannot exceed Medicaid benefits 	<p>States have the flexibility to offer coverage that meets the requirements of section 2103 of the CHIP statute under the new CHIP option for pregnant women, including in most cases, benefits during a 60-day postpartum period.</p>

	Children ages 0-18 including those with special health care needs	Adult women (<65 years old)	Pregnant women	Potential gaps in benefits
<p>The Health Insurance Marketplace (AKA health insurance exchanges)</p>	<p>10 Essential Health Benefits, states select benchmark plan</p> <ul style="list-style-type: none"> • Ambulatory patient services • Emergency services • Hospitalization • 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 and chronic disease management • Pediatric services, including oral and vision care 	<p>10 Essential Health Benefits, states select benchmark plan</p> <p>Preventive Services for Adults and Preventive Services for Women covered without cost sharing (applicable to all non-grandfathered plans inside and outside the marketplace).</p>	<p>10 Essential Health Benefits, states select benchmark plan</p> <p>Preventive Services for Adults and Preventive Services for Women</p> <p>Maternity and newborn care (care before and after the baby is born)</p> <p>Prenatal care as a preventive service must be provided without cost sharing</p> <p>Women who become pregnant while enrolled in QHP and become eligible for Medicaid pregnancy-related coverage, may now have the option to remain in the QHP with federal subsidies or switch to Medicaid</p> <p>If a state's Medicaid program offers pregnancy-only coverage that is not minimum essential coverage (MEC), women may be eligible for subsidies on the Marketplace. If the state's Medicaid pregnancy-only coverage is deemed MEC, the woman is not eligible for subsidies</p>	<p>The actual benefits package cost sharing, and affordability for families will vary widely depending on the state and the plan the individual or family selects.</p> <p>Prior to ACA, many states did not define or cover habilitative services in the State Benchmark Plan. For plan years 2014/15, if those services were missing, states were required to submit a plan to supplement coverage. For states that did not establish a marketplace, the federal government made the decision. In states that established their marketplace, the state or insurer could define habilitative services. For Medicaid alternative benefit plans (ABPs) the state must define. The extent that habilitative services will be sufficient to meet the needs of CYSHCN is unknown. Similar concerns remain for children's oral health services.</p> <p>For 2016 and beyond, CMS has proposed to adopt a uniform definition of habilitative services to ensure adequate coverage. CMS is also proposing to disallow insurers the option to define those services.</p>

	Children ages 0-18, including those with special health care needs	Adult women (<65 years old)	Pregnant women	Potential gaps in benefits
Remaining Uninsured	<p>Community health centers (authorizing legislation) serve a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing services, either through the staff and supporting resources of the center or through contracts or cooperative arrangements.</p> <p>A full list of required primary health benefits can be found in the authorizing legislation. Those relating to MCH populations:</p> <ul style="list-style-type: none"> • Health services related to family medicine, internal medicine, pediatrics, obstetrics or gynecology that are furnished by physicians • Preventive health services, including: <ul style="list-style-type: none"> ○ Prenatal and perinatal services ○ Well-child services ○ Immunizations against vaccine-preventable diseases ○ Screenings for elevated blood lead levels, communicable diseases and cholesterol ○ Pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care ○ Voluntary family planning services ○ Preventive dental services • emergency medical services • pharmaceutical services <p>Hospitals: <i>Emergency Medical Treatment & Labor Act</i> (EMTALA legislation) Requires hospitals with emergency departments to screen and stabilize individuals who come to the emergency department and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. This includes active labor and delivery regardless of an individual's ability to pay.</p> <p>Some local health departments provide health care services to women, children and their families. The extent and scope of services varies by jurisdiction and is determined by local needs, capacity and resources. These services are funded by a range of funding sources including the Title V MCH Services Block Grant in some states.</p>	<p>Community Health Centers (authorizing legislation)</p> <p>Hospitals: <i>Emergency Medical Treatment & Labor Act</i> (EMTALA legislation)</p> <p>Public Health Clinics (percentage of local health departments that provided maternal and child health services in 2013)</p>	<p>Community Health Centers (authorizing legislation)</p> <p>Hospitals: <i>Emergency Medical Treatment & Labor Act</i> (EMTALA legislation)</p> <p>Public Health Clinics (percentage of local health departments that provided maternal and child health services in 2013)</p> <p>Emergency Medicaid: Emergency Medicaid may be used to pay for labor and delivery if a woman meets the criteria established by the state Immigrants (documented or undocumented) may qualify for federal public benefit to treatment for an emergency medical condition (with the exception of organ transplant procedures)</p>	

Selected Resources for Further Information:

Catalyst Center: [*Public Insurance Programs and Children with Special Health Care Needs*](#)

Catalyst Center: [*The Affordable Care Act: A Side-by-Side Comparison of Major Provisions and the Implications for Children and Youth with Special Health Care Needs*](#)

Commonwealth Fund: [*Map of Medicaid Expansion*](#)

Health Resources and Services Administration, Maternal and Child Health Bureau: [*EPSDT Toolkit*](#)

Kaiser Family Foundation: [*Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults*](#) (Updated April 2015)

Kaiser Family Foundation: [*Medicaid Moving Forward*](#)

Kaiser Family Foundation: [*Health Reform: Implications for Women's Access to Coverage and Care*](#)

National MCH Workforce Development Center: [*The Affordable Care Act: A Working Guide for MCH Professionals*](#)

Robert Wood Johnson Foundation and Urban Institute: [*What is the Result of States Not Expanding Medicaid?*](#)

Robert Wood Johnson Foundation and Urban Institute: [*In States That Don't Expand Medicaid, Who Gets New Coverage Assistance under the ACA and Who Doesn't?*](#)

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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. AMCHP staff can be reached by phone at: (202) 775-0436.

¹ Center for Budget and Policy Priorities and Georgetown University Center for Children and Families: Expanding Coverage for Children Helps Parents, <http://www.cbpp.org/sites/default/files/atoms/files/expanding-coverage-for-parents-helps-children7-13.pdf>. Sep. 16, 2015

² U.S. Department of Health and Human Services. Who's eligible? <https://www.healthcare.gov/quick-guide/eligibility/>. Accessed Sep. 16, 2015

³ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Eligibility. <http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-eligibility-levels/medicaid-chip-eligibility-levels.html>. Accessed Sep. 16, 2015