Creating a Child- and Family-Friendly Health Insurance Exchange in New York

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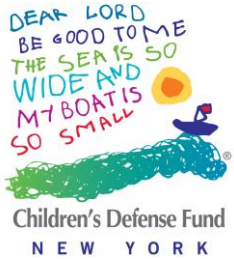

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The Affordable Care Act as it Relates to Children and Families

March 23, 2010 was a historic date in the United States. With passage of the Patient Protection and Affordable Care Act (ACA), Congress sent a strong message that all Americans should be able to access health care. It is estimated that an additional 32 million Americans will be able to acquire health insurance through the full enactment of the ACA. Provisions of this legislation include: an individual mandate for coverage, the potential for expansion of the Medicaid program, a health benefit exchange in each state, new accountability measures for managed care plans, changes to private coverage, employer requirements and cost and coverage estimates.[i]

The ACA provides abundant protections for Americans — including children and families.[ii] When we consider the needs of New York's children and families, especially those in the most vulnerable situations, it is especially noteworthy that the law allows for:

- The potential to have more children eligible for and covered by the Medicaid program;
- Employer-sponsored coverage for youth by their parents' insurance up to age 26; and
- Medicaid coverage up to age 26 for youth transitioning out of the foster care system.

The potential to successfully fulfill the reality of "universal coverage for children" in New York does exist. With the passage of the ACA, New York State has moved ahead with planning for a health insurance marketplace that is affordable, offers quality service and fosters health equity for all residents. The ACA provides New York State with a solid framework for establishing a child- and family-friendly health care system. New York needs to leverage its previous success in offering "universal eligibility" for children's health insurance coverage through the expansion of the income level for Child Health Plus program.[iii] Effective implementation of the ACA can seal the gaps in children's health care due to insurance company mishandlings, churning, discontinued coverage for foster care youth in transition and misinformation regarding eligibility criteria for immigrant families. State officials need to tap into this potential to build new enrollment infrastructure and eliminate the glitches that currently contribute to coverage lapses.

As a leader in monitoring enrollment for working families across the state, the Children's Defense Fund – New York (CDF-NY) offers the following recommendations regarding how to create a user-friendly enrollment experience for children and families through New York's Health Insurance Exchange.

Outreach and Education

New York State currently enrolls individuals and families in private health insurance through employers, insurance brokers and health plans, whereas enrollment onto public coverage takes place at county/district offices, health plans and community-based organizations. The ACA calls for enrollment onto health care coverage via telephone, an online system or in-person assistance with a Navigator which is defined as an entity that is able to conduct public education of qualified health plans; distribute impartial information concerning enrollment and cost-sharing; facilitate enrollment in qualified health plans; provide necessary referrals for consumer assistance; and provide

information that is culturally and linguistically appropriate to the needs of the population being served.[iv] More specifically, Navigators may be community- and consumer-focused nonprofit groups; trade, industry and professional associations; commercial fishing industry organizations; ranching and farming organizations; chambers of commerce; unions; partners of the Small Business Administration; licensed insurance agents and brokers; and other entities capable of carrying out the required duties.[v]

While Navigators will facilitate enrollment in exchange health plans and conduct public education and outreach about new coverage options, these programs must be entirely supported by an exchange's operating funds. Because exchanges may not have enough resources to support this operation in the beginning, the "In-person Assister" role was introduced by federal guidance and is defined as one that will mirror that of the Navigator. Specifically, In-Person Assisters will be allowed to help consumers file applications, obtain eligibility determinations, report changes in eligibility status, compare coverage options and select/enroll consumers in qualified health plans. As a prelude to the Navigator program, states can use federal grants to establish In-person Assistance programs and provide education and outreach through Assisters until September 2015, when Navigator programs will need to take over and be supported by income independent of federal establishment grants.[vi]

In New York State, it is estimated that more than 180,000 children are still uninsured despite the existence of policies that permit universal coverage for this population.[vii] Statewide data also demonstrate that the uninsured rate for children is highest among immigrant families and adolescents.[viii] Any new infrastructure designed to eliminate the uninsured rate must address these realities.

Reaching eligible but uninsured children and families, specifically in disenfranchised communities, is surely a tall order. History has shown, however, that it is one that can be satisfied with effective outreach and education. The role of In-Person Assisters will be instrumental in successfully creating awareness across New York State, particularly with hard-to-reach populations.

In keeping with the need to ensure that New York State can reach the most hard-to-reach children and families, we recommend the following:

- **The In-Person Assister program should leverage successes of the existing community-based programs that provide enrollment and consumer assistance services.**

  New York is in an advantageous position in its ability to build on thriving community-based Facilitated Enrollment (FE) and Community Health Advocate (CHA) programs. Created in 1999, the FE program serves all counties across New York through state-administered contracts with nonprofit service organizations to facilitate enrollment onto public health insurance programs. In consortium with FE services, the CHA program – formerly named the New York City Managed Care Consumer Assistance Program – also emerged in 1999 to provide enhanced support to consumers, communities and social service organizations in navigating New York's healthcare systems and services.

The community-housed model, evidenced by the FE and CHA programs, has been largely successful in New York State. Since the inception of these programs, the uninsured rate for children across the state has decreased to less than 10 percent. This existing infrastructure should be maintained to ensure that we are building upon strong inroads established in communities over the past 13 years and effectively partnering with organizations that have the knowledge and capacity to fruitfully serve these local areas.

Enrollment onto public health insurance should be accessible and user-friendly. With the establishment of a new marketplace in New York for the purchase of affordable, comprehensive health benefits, it is important that people who have been well-served through FE and CHA programs not lose the community-friendly, competent service that has been vital to their acquisition and retention of affordable health insurance. Rather, New York State should build upon what has been created in communities across the state and optimize the potential for quality services to health insurance consumers through continued collaboration with community-based providers.

- **In-Person Assisters should be geographically distributed among counties at a level proportionate to the uninsured rate among local counties.**

  Monitoring the prevalence of the uninsured in geographic regions across the state is important in determining how to eliminate the problem and guarantee coverage for all children and families. Allocating resources for outreach and enrollment according to need is the logical intervention for creating sustainable awareness and outreach systems in areas where the uninsured rate may be high.

  Optimizing enrollment capacity in areas where the rate of the uninsured is high allows for necessary support to communities that may require enhanced education and enrollment support for health insurance programs. This is a necessary step to eliminating the uninsured rate among children and families statewide.

- **In-Person Assistance and enrollment materials, including the online application, should be offered, at a minimum, in the seven most commonly utilized languages in New York State.**

  Collectively, state residents speak more than 175 languages. More than 2.4 million New Yorkers speak a language other than English at home. Of that 2.4 million, 95 percent comprise state residents who primarily speak Spanish, other Indo-European languages, Chinese and Russian.[ix] Provision of enrollment documents in the primary languages (other than English) spoken fluently by state residents promotes health literacy for children and families of diverse ethnicities and backgrounds.

  Ensuring that, at a minimum, enrollment materials are available in the seven most commonly utilized languages in New York State is vital in working toward the elimination of health coverage disparities among families whose primary household languages is one other than English.

Currently, New York City boroughs administer online renewal systems for public health insurance coverage that incorporate language options in English, Spanish, Chinese, Russian, Haitian Creole and Arabic.[x] When creating this system, population demographics informed the decision to ensure that the need for language capacity was met effectively in the online renewal tool. In transitioning the state's health insurance enrollment system to a reality in which the Health Insurance Exchange will have one entry point for all state residents, it is imperative for New York to meet language diversity on the front lines. Enrollment materials need to have the linguistic breadth to reach all New Yorkers – including those who are most often isolated because of unmet needs related to translation and the availability of culturally competent services and information. .

The Enrollment Pathway

Lessons Learned.

The advent of the Child Health Plus program in 1999 provided an alternative means for families to enroll children onto a government-sponsored health insurance program that was separate from Medicaid. This shifting reality meant that the separate enrollment pathways that existed for Medicaid and Child Health Plus were not an efficient means of administering coverage. Therefore, New York invested significant time and resources in integrating the applications for Medicaid and Child Health Plus into one comprehensive document that serves as a single entry point for public health insurance enrollment. At present, families enrolling in government-sponsored health insurance anywhere in New York State complete one application for entry into Medicaid or Child Health Plus.. Having a single entry point for enrollment onto government-sponsored health insurance will continue to be critical to providing families with one clear starting point at application.

While one gateway exists for families at the time of application initiation, the enrollment corridor for Medicaid and Child Health Plus currently diverges onto two separate pathways after submission. The Medicaid pathway leads to application processing via the Local Districts of Social Services for eligibility determination; whereas the Child Health Plus application is funneled to a health plan for processing and determination. In both scenarios the State Department of Health approves and keeps record of all application determinations. Families enrolling children onto Medicaid or Child Health Plus are not made aware of which pathway their application takes because their process at the time of application is the same, regardless of program qualification. However, at the time of renewal, these divergent pathways pose a risk to families below 250% of the Federal Poverty Level (FPL). These most at-risk familiesoften shift between Medicaid and Child Health Plus when recertifying for their children's public health insurance coverage.

Going Forward.

Having a "seamless" process for families at renewal is critical to eliminating churning. The implementation of the ACA in New York State has expanded opportunities for children's coverage because Qualified Health Plans (QHPs) with premium credits are an option for coverage. This additional option further adds to the enrollment course. Coordinating enrollment among Medicaid,

Child Health Plus and QHPs with premium credits via the Exchange will be challenging; thus, reinforcing the need for a clear, single, streamlined, user-friendly application process for families and a robust, sound infrastructure to mitigate churning at renewal is critically important.

Moreover, administering "No Wrong Door"[xi] in the statewide system at application would direct consumers to the appropriate program for coverage – Medicaid, Child Health Plus or Qualified Health Plans with premium credits – through the Exchange. This would reduce the risk of families having a fragmented enrollment experience, and in acquiring coverage gaps.

In order to eliminate opportunities for fragmented enrollment and ensure health coverage continuity for all children, CDF-NY recommends the following:

- **New York's Health Insurance Exchange should build upon the single, streamlined process for public health insurance application to ensure one entry point for application via the Exchange.**

  Having one document for all public health insurance programs has been hugely successful in New York State. Using one, consistent application eliminates confusion for families and ensures that the application serves as a reliable framework for the provision of information. Through the implementation of the ACA, New York State should keep the application for all health insurance programs constant on the front lines.

- **New York's Health Insurance Exchange should create a system that guarantees seamless transition among all health coverage programs.**

  Since household incomes below 250% FPL can fluctuate within a given year, shifting children's eligibility for coverage between Medicaid and Child Health Plus at renewal, New York State should ensure that transitions from children's Medicaid to Child Health Plus and vice versa take place without interrupted coverage. Families most vulnerable to Medicaid-Child Health Plus transitions are those with the lowest household incomes. Not having a system in place for seamless transitions for this income group creates an additional barrier for underserved families in having stable, consistent access to care. Additionally, given the added coverage option of Qualified Health Plans, New York State will host a more complex course for enrollment through its Exchange. Therefore, the infrastructure that supports program transitions for children needs to guarantee seamlessness across the board.

The Benefit Package

Provisions of the ACA state that all plans must cover the Essential Health Benefit (EHB) as of 2014. This includes non-grandfathered plans in the individual and small group markets, those inside and outside the Exchange, Medicaid benchmark and benchmark-equivalent, Child Health Plus, and Basic Health Plans. Self-insured group health plans, insurance offered in the large group market, and grandfathered health plans are not required to cover the EHB package.

Non-grandfathered plans in the individual and small group markets in the Exchange are identified as Qualified Health Plans. Provisions of the ACA organize these plans into four categories. Each category offers a package of covered services at an identified cost to the consumer. Covered services and cost-sharing features are discussed in the statute, indicating that the level of cost-sharing will determine the actuarial value of the plan. Bronze-level plans will offer 60 percent actuarial value; silver, 70 percent; gold, 80 percent; and platinum, 90 percent.[xii]

The EHB needs to include the following 10 benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

While statutory provisions allow for flexibility in the ways states will design the EHB, section 1302(b)(2) of the ACA instructs that the scope of benefits must be equal to the benefits provided under a "typical" employer plan. The definition of "typical" is not clearly identified, leaving room for New York State to exercise autonomy in making such a determination. In September 2012, New York opted for Oxford EPO as the model for the state's adopted Essential Health Benefits package.[xiii]

In order to ensure comprehensive coverage for all children and families in New York State, we propose the following:

- **The Essential Health Benefit package should offer robust specialty care coverage with quality, pediatric-specific standards.**

  While the EHB package is designed to offer services that include pediatric oral, vision and mental/behavioral health care, and rehabilitative and habilitative services, the State Department of Health should set forth additional guidelines to require that specialty care providers for all disciplines are licensed and/or certified health professionals who can meet specific criterion of care for the pediatric and adolescent population.

  As pediatric primary care is a subset of internal medicine and requires specialized training for working with children and youth, pediatric specialty care should require – across all disciplines (i.e. dental care, mental health care) – training and certification to ensure specific quality measures relevant to pediatric medicine are met.

- **The Essential Health Benefit package should include health education and counseling for children and youth as part of "wellness services and chronic disease management."**

  The prevalence of chronic disease – specifically diabetes and asthma within New York's disenfranchised and impoverished communities – is high. Overall, 17 percent of children ages 0-17 in New York City have been diagnosed with asthma at some time in their lives, compared with 13 percent of children nationwide. Further, 22 percent of New York City

children in low-income neighborhoods have been diagnosed with asthma at some time in their lives, compared to 14 percent in high-income neighborhoods.[xiv] Health education for chronic disease management is a crucial part of preventive care and wellness services.

In aspiring for a holistic benefit package that will educate and empower families about wellness and preventive health care, New York's Essential Health Benefit package should include education and counseling services for focus areas that impact the health of children and families at large across the state. Namely, education and counseling for diabetes, obesity, asthma and reproductive health should be a mandated coverage provision for all children and youth.

- **New York State should seek federal approval to use the existing Medicaid package as the Medicaid benchmark benefit required under the ACA.**

  The Medicaid expansion provision of the ACA requires that states have a Medicaid benchmark benefit. This benchmark benefit is the level of coverage states must provide for "newly eligible" Medicaid enrollees.[xv] In New York, those "newly eligible" for Medicaid coverage in 2014 include childless couples and single adults, as well as parents with incomes above the current Medicaid income levels.

  States have the option to create a single benchmark benefit for all Medicaid enrollees, or to create multiple benchmark benefit designs in a tiered approach to benefits. In addition, states can seek federal approval to use their existing Medicaid benefit as the benchmark. The option for offering multiple benchmark benefit designs will create a system fostering unequal benefit packages among the population of Medicaid beneficiaries. Such a system creates a construct that fosters inequity for coverage and care within a population that is already vulnerable to poorer health outcomes.[xvi] Moreover, it is counter-productive in simplifying and streamlining coverage and care for families.

  New York State's current Medicaid program does meet the existing Essential Health Benefit standard of the ACA, and offers a comprehensive package for its enrollees. Leveraging New York's success in offering a Medicaid plan that meets the needs of children and families, the state should strongly consider seeking federal approval to use this existing plan as the Medicaid benchmark benefit.

Conclusion

Achieving the vision of the Affordable Care Act – for all Americans to have access to affordable, quality health care – will require successfully creating a Health Insurance Exchange that is user-friendly for all individuals and families. New York State has instituted policies in the past five years that offer "universal coverage" for children statewide. To build upon New York's innovation and leadership to-date in adopting child-friendly policies for insurance eligibility, the state needs to build and effectively administer infrastructure and systems to eliminate the uninsured rate by enrolling and retaining hard-to-reach, vulnerable populations. Furthermore, the state needs to include pediatric-specific quality standards in the Essential Health Benefit package and ensure

comprehensive coverage for all Medicaid enrollees. By incorporating a gold standard of care for all children, youth, and families, the promotion of preventive care and health equity is upheld.

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CDF-NY offers a special thank you to community-based organizations that manage Facilitated Enrollment and Community Health Advocate programs. The dedication, expertise and competence these organizations have invested in serving their communities for more than a decade, in order to reach New York's most vulnerable communities, has dramatically and positively impacted the lives of countless New Yorkers — including so many children and families.

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