Affordable Care Act: States Move Forward With Health Reform

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KEY WORDS
Affordable Care Act, uninsured children, health reform, individual mandate, ACOs, PCMHs

Since the Supreme Court decision in June 2012 to uphold the provisions of the Affordable Care Act (ACA), states legislators legislators began to take a second look at the provisions in the law. Americans are already familiar with the provisions of the law that expanded health insurance benefits to youth up to 26 years of age, eliminated preexisting conditions as a barrier to health insurance coverage, and implemented health insurance coverage for preventive health care services. However, many of the provisions of the new law are to be implemented by the States in partnership with the federal government, and the impact on children and families depends on the readiness of States to embrace health care reform.

This article will (a) review the provisions of the ACA yet to be implemented and that aim to expand health care services to children and youth and (b) look at the key issues facing children and families that need to be addressed in the planning and implementation of the ACA in 2014. In addition, the opportunities for pediatric health care providers and advance practice nurses to be leaders in the implementation of the health reform provisions will be discussed.

AFFORDABLE CARE ACT

The Affordable Care Act of 2010 was created to expand access to health insurance for 32 million uninsured individuals by 2019, to institute fairer practices for individuals and families with health insurance, to stabilize the cost of health care by reducing waste and fraud, and to improve the quality of care by improving the performance of health care systems and providers. To provide broader access to health insurance, the provisions of the ACA will offer low-cost health insurance administered through State-regulated "insurance marketplaces" or "exchanges." To reduce the number of uninsured individuals nationally, the ACA requires individuals or families who are not already insured to buy health insurance in the exchanges. This provision has been referred to in the new law as the *individual mandate*.

The Supreme Court decision upheld this provision in the law requiring all citizens who are legal residents to have health insurance coverage by 2016 or pay a penalty. The legal precedent for the decision was based on the power of the Supreme Court to regulate taxation, and the provision of the *individual mandate* to have insurance was considered a tax under the law. The cost of health insurance through the exchanges will be federally subsidized for families with incomes from 133% to 400% of the Federal Poverty Level (FPL). For example, for a family of four living in California and making

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Conflicts of interest: None to report.

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J Pediatr Health Care. (2013) 27, 158-160.

0891-5245/$36.00

http://dx.doi.org/10.1016/j.pedhc.2012.12.005

$35,137 a year, thus being at 150% of the FPL, the health exchange premiums are estimated to cost approximately $117 monthly (California Healthcare Foundation, 2011). California currently has 30 private health insurance companies interested in offering health insurance and benefit packages in the proposed "insurance marketplace" poised to be implemented in 2014.

The tax penalty for uninsured individuals or families who do not purchase health insurance in the insurance marketplaces or exchanges is $695 per individual or up to three times that amount for a family, not to exceed 2.5% of household income. Exemptions to the penalty may be granted for short lapses in insurance coverage, financial hardships, and religious objections, and for undocumented immigrants. The decisions that individuals and families make regarding health insurance coverage under the new law will significantly affect the health of all children.

IMPACT ON CHILDREN

The full implementation of the ACA provides the opportunity to make substantial progress toward covering all children and youth with affordable health insurance. Overall, the number of children living in poverty has increased during the past decade, and children who are living in lower-income families, are 6 years of age or older, and who are living in rural communities are more likely to be uninsured. The majority of states (30) have seen no significant change in their rates of insurance coverage for children since 2009 (Alker, Mancini, & Heberlein, 2012). About two thirds of uninsured children who are eligible for Medicaid and the State Children's Health Insurance Program (CHIP), a public insurance program for uninsured children at or above 200 percent of the FPL, are not currently enrolled (Kaiser Commission on Medicaid and the Uninsured, 2009).

In 2011, children had health insurance coverage at the rate of 92.5% nationally. Massachusetts remains the leader in health care coverage for children, with 98.3% enrolled in some form of health insurance plan. Nevada has the highest rate of uninsured children at 16.2%. Texas and Oregon led the nation with declines of 3.1% in the rate of uninsured children, with Florida close behind at 2.9%. The majority of uninsured children live in six states: Texas, California, Florida, Georgia, Arizona, and New York. Hispanic children are disproportionately represented among uninsured children nationally. Hispanic children account for approximately 40% of the nation's uninsured children, yet they constitute only 24% of the child population in the United States. Immigrant children and youth who are undocumented are of concern because they represent a portion of the uninsured who that are not eligible for federal or state health insurance programs.

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States poised to implement health care exchanges stand to benefit the most in 2014 when the provisions of the ACA go into effect. Currently, 28 states have applied to establish health insurance exchanges. Other states are now considering the benefits of a federal/state partnership, and others have decided not to participate. Child health advocates are concerned about the developing fragmentation from state to state in the implementation of the health care exchanges and the variable benefit packages that will be available to newly insured children and families. The course of the economic recovery and state funding will contribute to state's decisions to participate and will determine the ability of states to provide quality health care services for newly insured children and families.

Enrollment in Medicaid and CHIP programs has varied across states, and marketing to families also has been implemented differently depending on state eligibility levels. In times of economic distress, states often need to reduce costs in state-subsidized programs and have minimal resources to devote to marketing and enrollment processes. Of the 5.5 million children who currently are uninsured, it is estimated that 4.7 million currently are eligible for state-subsidized programs. A provision of the new health care law offers states bonus grants to enroll and retain eligible children in each state. Under the ACA, states must maintain their current eligibility for CHIP until 2019, and funding for CHIP has been extended through 2015. Also, beginning in 2015, states will receive a 23% increase in their federal Medicaid matching rate for CHIP expenses to encourage enrollment increase retention rates from current levels. The new law expanding Medicaid coverage to eligible adults up to 138% of the FPL stipulates that a child must be covered before his or her parent can enroll in Medicaid. This provision and others in the new law will ensure that more children will gain health insurance. The increased eligibility under the ACA for youth between 19 and 21 years of age who became eligible under parental insurance already has helped to decrease the number of uninsured children. The overall number of uninsured children and youth declined to 5.5 million in 2011 (Alker et al., 2012).

COMMUNITY CLINICS AND HEALTH CENTERS

Implementation of the ACA includes expanded funding to Federally Qualified Health Centers (FQHCs) in order to meet the demands of increased access to health care services for children living in families who are currently uninsured or underinsured. Nationally, community clinics and health centers will play a pivotal role in caring for individuals and families insured through Medicaid or the health insurance exchanges. It is anticipated that community clinics and health centers will serve

44 million patients by 2015 and up to 50 million in 2019. The proportion of Medicaid patients being served by clinics will rise from 36% in 2009 to 44% by 2019 (Kaiser Commission on Medicaid and Uninsured, 2011).

The expansion in federal funding will be available through several initiatives established to create the primary care workforce and infrastructure needed to meet the increased demand of health care needs of the newly insured. The National Health Service Corps, nurse-managed health centers (NMHCs), school-based health centers, and teaching health clinics are all eligible for expanded funding under the provisions of the ACA. The National Health Service Corps will receive $11 billion over 5 years under the ACA, and the Department of Health & Human Services has begun the process of issuing block grants to eligible community clinics and health centers (Gardner, 2012). The Department of Health & Human Services received more than 700 applications for the initial block grants, and the demand exceeds the available funding. NMHCs will benefit from $50 million in grant programs through 2014 to provide funding for community-based primary care sites administered by advanced practice nurses (Gardner, 2012). NMHCs provide comprehensive primary health care and wellness services to vulnerable or underserved populations and often are sites for workforce training.

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Accountable care organizations (ACOs) and patient-centered medical or health care homes (PCMHs) account for a large part of the change in health care system design designated under the new law. It is estimated the U.S. health system could save upwards of $175 billion over 10 years if primary care providers shifted to a PCMH model (Gardner, 2012). The organization of ACOs requires interprofessional and interagency collaboration to address the need for comprehensive continuity of care for children and families with chronic health conditions.

OPPORTUNITIES FOR PEDIATRIC HEALTH CARE PROVIDERS

The implementation of the ACA will provide increased demand for pediatric health care providers and advanced practice nurses and opportunities to provide quality health care to children and families through community clinics, health centers, ACOs, and PCMHs. It is critical for advanced practice nurses to take every opportunity to actively participate in the design and implementation of the provisions of health care reform. To produce the needed change in health status for children and families requires sustained access to quality health care services and continuity of care over time. The goal is to nurture a healthier population of children so they can develop to their full potential and become healthier adults. The full implementation of the ACA provides the next best opportunity to move closer to that goal as a nation.

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