

A State Child Health Official's Walk Through Health Care Reform

Section	Provision	Effective Date
Individual and Group Market Reforms		
1201, PHSA 2702	<i>Guaranteed availability of coverage</i> requires health insurers to accept every employer and individual in the State that applies for coverage, permitting annual and open enrollment periods. Secretary to promulgate regulations on enrollment periods.	Plan years beginning on/after 1/01/14
1001, PHSA 2703	<i>Guaranteed renewability</i> required, regardless of health status, utilization of services or any other related factor.	Plan years beginning on/after 1/01/14
1001, PHSA 2707	<i>Comprehensive health insurance coverage</i> requires health insurers in the individual and small group market to ensure that coverage includes a benefit package that includes essential health benefits required under § 1302(a) of PPACA and provides cost sharing protections.	Plan years beginning on/after 1/01/14
1001, PHSA 2711	<i>No lifetime or annual limits</i> by a group health plan and a health insurer offering group or individual health coverage. These limits cannot be placed for any beneficiary or participant on the monetary value of the benefits. This restriction is limited to "essential health benefits".	Plan years beginning on/after 9/23/10
1001, PHSA 2713	<i>Coverage of preventive health services</i> at no cost, including items rated A or B by US Preventive Services Task Force, immunizations, preventive care and screenings provided for in the comprehensive guidelines supported by HRSA (Bright Futures).	Plan years beginning on/after 9/23/10
1001, PHSA 2714	<i>Coverage of dependent children</i> required by a group health plan or health insurance issuer offering group or individual health coverage that provides dependent coverage to extend that coverage until the dependent turns 26 years old.	Plan years beginning on/after 9/23/10
1001, PHSA 2717	<i>Ensuring quality of care</i> requires the Secretary to develop guidelines for use by group health plans and health insurers to report on initiatives and programs that include improving health outcomes, implementing wellness activities, improving patient safety, and reducing hospital readmissions.	Secretary to develop by 3/23/12. Once developed, annual reports required by plan/issuer to Secretary
1001, PHSA 2715	<i>Development and utilization of uniform explanation of coverage documents and definitions</i> for group and individual coverage that must provide an accurate summary of benefits, cost sharing, exceptions and limitations on coverage that must be provided to applicants, enrollees, and policy holders. Standards will be developed by the Secretary.	Standards must be developed by 3/23/11. Health insurers must comply by 3/23/12
1201, PHSA 2704	<i>Prohibition of pre-existing condition exclusions</i> or other discrimination based on health status.	Plan years beginning on/after 9/23/10
1201, PHSA 2701	<i>Premium differentials</i> establishes that premiums in the individual and group market may vary only by family structure, geography, the actuarial value of the benefit, age (limited to a 3/1 ratio) and tobacco use (limited to a ratio of 1.5 to 1)	Plan years beginning on/after 1/01/14

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1103	<i>Immediate information that allows consumers to identify affordable coverage options</i> requires the Secretary, in consultation with states, to establish an internet website through which a resident of and, or small business in, any State may identify affordable health coverage options.	7/01/10
1001, PHSA 2719	<i>Effective appeals processes</i> must be implemented in group or individual health coverage for appeals of coverage determinations and claims.	Plan years beginning on/after 1/01/14
1001, PHSA 2719A	<i>Choice of health care professional</i> provides that if a group health plan or health plan issuer offering group or individual coverage requires designation by the enrollee of a participating primary care provider, the plan shall permit each enrollee to make that designation who is available to accept that person. In the case of a child, the plan or issuer shall permit the designation of a physician who specializes in pediatrics as the child's primary care provider, if such a provider participates in the plan's provider network.	Plan years beginning on/after 9/23/10
1003, PHSA 2794	<i>Ensuring consumers get value for their dollars</i> requires the Secretary, in conjunction with states to establish a process for an annual review, beginning with the 2010 plan year, of unreasonable increases in premiums for health insurance coverage.	3/23/10
2707	<i>Comprehensive health insurance coverage</i> requires that a health issuer that provides health insurance coverage in the individual or small group market shall ensure that the essential health benefits package required under section 1302(a) of PPACA shall be provided. And, if a health insurance issuer offers health insurance coverage in any level of coverage specified in section 1302(d) of PPACA, the insurer shall offer this coverage in child-only plans (up to age 21).	Plan years beginning on/after 1/01/14
1251	<i>Preservation of right to maintain existing health insurance coverage</i> in which an individual was enrolled on the date of enactment of PPACA. Family members of individuals enrolled in these health plans are also permitted to enroll, if the plan is accepting the enrollment of family members.	3/23/10
Exchanges		
1411	<i>Procedures for determining eligibility for exchange participation and premium tax credits.</i> Tax credits for individuals not eligible for public programs with income below 400% of the FPL.	
1402	<i>Reduced cost-sharing</i> for individuals enrolling in a qualified health plan in the silver level of coverage in the Exchange. Limited out-of-pocket for those with income between 100 and 400 percent of the FPL and reduction in cost sharing for individuals with household incomes between 100 and 250 percent of the FPL.	
State Exchange Option		
1321	<i>State flexibility in operation and enforcement of Exchanges and related requirements</i> includes that States must choose whether they will establish and operate an Exchange by January 1, 2013.	

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1312	<i>Qualified individuals and qualified employers</i> are defined. Exchange at inception for small employers; States may allow large employers to qualify beginning 2017. Allows lawfully residing immigrants not eligible for Medicaid or CHIP due to immigration status/5 year bar, to be eligible for exchange subsidies/tax credits.	
1311	<i>Certification</i> provides criteria for Exchanges to certify qualified health plans and provides flexibility in allowing regional or interstate Exchanges, if the State agrees to, and approves, such Exchanges. Exchanges must be self-sustaining by 2015.	
1311	<i>Assistance to States to establish American Health Benefit Exchanges.</i> Grants are available until 2015 for states to plan and establish American Health Benefit Exchanges, including Small Business Health Options Program (SHOP) within 1 year of enactment.	Awards to be made, no later than 3/23/11
1331	<i>Coordination</i> required with state administered programs, including Medicaid and CHIP.	
2101, 10203(c)(2)(C)	<i>Certification of comparability of pediatric coverage</i> offered by qualified health plans requires the Secretary to review the benefits and cost sharing for children by plans in a State Exchange and certify that they are at least comparable to benefits and cost sharing in CHIP.	Beginning 4/01/15
1311	<i>Offering of stand-alone dental benefits</i> requires each Exchange within a State to allow an issuer of a plan that only provides limited scope dental benefits meeting certain requirements to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b).	
1311, 10104(e)(1)	<i>States may require additional benefits</i> to required essential benefits, but the State must defray and assume costs.	
Essential Benefits for Plans in Exchanges		
1302	<p><i>Essential benefits</i>-There will be further elaboration of essential benefits by the Secretary. Minimum benefits:</p> <ul style="list-style-type: none"> • Rehabilitative and habilitative services and devices • Preventive and wellness services and chronic disease management. • Pediatric services, including oral and vision care • New health plans effective after September 23, 2010, must provide free Bright Futures preventive care and screenings. • Mental health and substance abuse disorder services, including behavioral health • Maternal services and newborn care. 	
Child Only Plans		
1302(f)	<i>Child only plans</i> will be available through Exchanges and shall be treated as a qualified health plan.	

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Public Options		
High Risk Pool (HRP)		
1101	<i>Immediate access to insurance for uninsured individuals with a pre-existing condition. HHS to establish temporary HRP program until Exchanges go into effect (1/1/14). \$5 billion to enter into contracts with states and non-profit organizations to pay claims for HRP enrollees. MOE on the annual funding amount expended for the operation of one or more state HRPs during the year prior to when a state enters into a contract to operate a temporary HRP.</i>	By 90 days after date of enactment
Basic Health Plan		
1331, as revised by 10104(o)(2)	<i>State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid. Option for states, using federal funding that would have been used for premium subsidies (95%) to negotiate coverage with health plans for eligible individuals above 133% and at or below 200% of the FPL. These eligible individuals would not be eligible for coverage under the Exchange.</i>	
Waivers		
1332	<i>Waiver for state innovation. States may apply for waivers to establish own HCR program comparable to national reform program. Coverage must be at least as comprehensive as provided by qualified health plans and cost-sharing must be at least as affordable. Waivers must be budget neutral and the Secretary will make a determination on granting the waiver within 180 days of application.</i>	Beginning in January 2017
Medicaid and CHIP		
Medicaid Eligibility		
2001, as amended by Section 10201	<i>Medicaid coverage for the lowest income populations creates mandatory Medicaid eligibility for adults who are below the age of 65, not pregnant, not entitled to or enrolled in benefits under Medicare Part A, not enrolled in Medicare Part B, not enrolled in any of the previously existing mandatory categorically needy groups in section 1396(a) (10) (A)(i) and have income that does not exceed 133% of the FPL . A conforming amendment also sets the Medicaid eligibility threshold level for children at 133 % of the FPL, including children now eligible for coverage under a separate CHIP program, beginning 1/01/14.</i>	State option beginning 4/1/10 to expand eligibility before 2014 through State plan amendment and may phase in eligibility.
2001	<i>State option for coverage for individuals with income that exceeds 133% of the FPL. State option to cover as an optional categorically needy group an expansion to all non-elderly, non-pregnant individuals with family income above 133% of the FPL. The State must first cover lower income individuals and Medicaid eligible children must be enrolled in Medicaid or in other coverage in order to cover parents/caretaker relatives.</i>	1/01/14
2001,2101	<i>Maintenance of Income Eligibility requires maintenance of effort (MOE) for Medicaid adults until December 31, 2014 and for children in Medicaid and CHIP through September 30, 2019.</i>	3/23/10

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2001, Recon 1201	<i>Increased FMAP</i> temporarily increases federal matching during which the Federal government will pay 100% of the cost of covering "newly eligible" individuals.	FY 2014 through 2016
2002, 1004	<i>Conversion to income eligibility using Modified Adjusted Gross Income (MAGI)</i> Income eligibility will be established using a modified adjusted gross income, with exceptions for certain groups (e.g., aged, blind and disabled individuals receiving SSI, children receiving federal adoption or foster care assistance, and individuals receiving assistance for Medicare premiums and cost sharing. Also included is an across-the-board 5% income disregard, effectively bringing income level up to 138% of the FPL, but no other income disregards will be permitted.	
2004, 10201	<i>Medicaid coverage for former foster care children</i> establishes eligibility for former foster care children through age 25, including EPSDT. Makes the State option to cover former foster children in Medicaid mandatory, and limits it to only those children who have aged out of the foster care system as of the date of enactment. See also §2955 on information to be provided to individuals aging out of foster care and independent living.	
2303	<i>State eligibility option for Family planning services</i> allows coverage as an optional categorically needy group for individuals under the state plan. Presumptive eligibility may be provided for this group.	3/23/10
2202	<i>Permitting hospitals to make presumptive eligibility for all Medicaid eligible populations</i> allows hospitals that participate in Medicaid to make PE determinations.	
2003, 10203	<i>Premium assistance for employer-sponsored insurance</i> extends the state option to provide premium assistance to all Medicaid beneficiaries and their families.	
Medicaid Benefits		
2001	<i>Provision of at least minimum essential coverage</i> of newly eligible, non-elderly, non-pregnant individuals shall be benchmark or equivalent consistent with §1937, including essential exchange benefits, Rx and mental health at actuarial equivalence.	
4107	<i>Coverage of comprehensive tobacco cessation services for pregnant women</i> Medicaid requires states to cover counseling and pharmacotherapy for tobacco-cessation of pregnant women without cost sharing.	10/01/10
2301	<i>Coverage for freestanding birth center services</i> requires Medicaid coverage of freestanding birth center services and other ambulatory services provided by free-standing birth centers.	3/23/10
2302	<i>Concurrent care for children</i> provides that a voluntary election for hospice care for a child does not constitute a waiver of that child's rights to be provided with, or have payment made, for services related to the treatment of that medical condition under Medicaid and CHIP.	3/23/10
2304	<i>Clarification of definition of medical assistance</i> redefines medical assistance to include services, not just the payment.	3/23/10

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4106	<i>Improving access to preventive services for eligible adults in Medicaid</i> expands current option to provide other diagnostic, preventive and rehab services to include any clinical preventive services recommended with a grad of A or B by the US Preventive Services Task Force for eligible adults in Medicaid. States electing to cover, may not charge cost-sharing for services and vaccines, and would receive an increased FMAP of one percentage points for these services.	1/01/13
Medicaid Access and Quality		
Recon 1202	<i>Enhanced Medicaid payment rates for primary care services</i> provided by a physician with a primary specialty designation of family, general internal or pediatric medicine must be no less than 100% Medicare rate in 2013 and 2014; 100% federal funding for incremental costs to states. Note that there is no express provision for reimbursement rates in subsequent years.	1/01/13
2701	<i>Adult quality measures</i> extends CHIPRA quality measures process to adults.	Recommended initial core measures to be published for comment by 1/01/11, with core set published by 1/01/12
2703	<i>State option to provide health homes for enrollees with chronic conditions</i> provides a new state plan option for Medicaid beneficiaries with chronic conditions to designate a health home. Provides 90% FMAP for provider reimbursement for medical home provider for 8 quarters. Beneficiaries with 2 chronic conditions or 1 chronic condition plus at risk of 2 nd qualify. Medicaid beneficiaries with one serious and persistent mental health condition also qualify. States can receive planning grant up to \$25M in federal matching funds, but states must contribute state share.	1/01/11
CHIP		
2101	<i>Maintenance of Effort (MOE)</i> requires the maintenance of income eligibility standards, methodologies or procedures for CHIP until October 1, 2019.	3/23/10
2201	<i>Assurance of Exchange coverage for CHIP children</i> if enrollment in the state's program is closed due to exhausted federal allotment. Otherwise eligible children will be eligible for tax credits in State Exchange.	
2101, as revised by 1004(b)(2)(A)	<i>Income eligibility determined using modified adjusted gross income (MAGI).</i>	
2101	<i>CHIP eligibility will be provided for children ineligible for Medicaid as a result of elimination of disregards (MAGI).</i> These children will be considered targeted low-income children.	
10203	<i>Exceptions to exclusion of children of employees of a state</i> provides the state option of eligibility for some children of public employees with access to coverage under state health plan, based upon the level of agency contribution for family coverage or hardship.	3/23/10

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Coordination of Enrollment Between Medicaid, CHIP and Exchanges		
1413	<i>Streamlining procedures for enrollment</i> requires the Secretary to establish a system for residents of each state to apply for/continue enrollment in state health subsidy programs, including subsidy for exchange, Medicaid and CHIP. HHS to create single form for all; states can use or develop own single, streamlined form.	
2201	<i>Enrollment simplification and coordination with State Health Insurance Exchanges</i> provides that as a condition of federal Medicaid matching funds, states must ensure that individuals are able to apply for coverage in Medicaid, CHIP or Exchange plan through state-run website and that enrollment procedures for coverage under any of these is be coordinated and seamless.	
State Financing		
10203	<i>Extension of CHIP funding</i> provides funding through September 30, 2015.	Effective as if included in the enactment of CHIPRA
2101	<i>Additional Federal Financial Participation (FFP) for CHIP</i> provides a 23% bump in FMAP.	Begins for FY starting on 10/01/15 and ending on 9/30/19
2010	<i>No enrollment bonus payments for children enrolled after fiscal year 2013</i> , ends performance bonuses for states.	
2001	<i>Increased FMAP for Newly Eligible mandatory individuals.</i>	
2005	<i>Payments to Territories</i> increases spending caps by 30% and the applicable FMAP by 5 percentage points to 55%.	7/01/11
2006	<i>Special adjustment to FMAP determination for certain States recovering from a major disaster.</i>	1/01/11
Data Collection and Reporting		
4302	<i>Understanding health disparities</i> addresses health disparities data collection and analysis in titles XIX and XXI, requires HHS to develop national standardized data collection requirements. Also required is an evaluation by HHS of approaches for data collection in Medicaid and CHIP along with existing data requirements. CHIP programs required to collect data that includes the primary language of children, parents and legal guardians.	No later than 3/23/12
6504	<i>Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.</i>	1/01/10
1115 Waivers		
10201(i)	<i>Amendments to section 1115 of the SSA</i> provides new requirements for section 1115 demonstrations involving eligibility, enrollment, benefits, cost sharing or financing; increases transparency of the Medicaid and CHIP section 1115 demonstration development and approval process.	Promulgation of regulations required not later than 180 days after enactment

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Program Integrity		
6401	<i>Provider screening and other enrollment requirements under Medicare, Medicaid and CHIP</i> requires the CMS Administrator to establish a process for informing the agency administering Medicaid or CHIP the identifying information for any provider or supplier that has been terminated under Medicare or CHIP, within 30 days of the termination.	90 days from enactment
6402	<i>Enhanced Medicare and Medicaid program integrity provisions</i> requires CMS to include in the integrated data repository (IDR) claims and payment data from Medicare, Medicaid and CHIP, health related programs administered by the VA, DOD, SSA and HIS. This section also authorizes the Secretary to withhold FFP to States for medical assistance expenditures when the State does not report encounter data in a timely manner in the State's MMIS.	3/23/10
Medicaid Long Term Care		
2401	<i>Community First Choice Option</i> through which states could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require an institutional level of care, including an intermediate care facility for the mentally retarded.	10/01/11
2402	<i>Removal of barriers to providing home and community based services</i> provides a state plan option to provide home and community based services to individuals with incomes up to 300% of the FPL.	4/01/10
10202	<i>Incentives for states to offer home and community based services as a long-term care alternative to nursing homes.</i> States receive a balancing incentive payment but must meet maintenance of eligibility requirement.	State balancing incentive period is from 10/01/11 to 9/30/15
National Strategy to Improve Health Care Quality		
3011, 10302	<i>National Strategy for quality improvement in health care</i> amends Title III of PHSA to charge Secretary with establishing national priorities for improving delivery of health care services and development of strategic plan to achieve. Requires coordination and collaboration with state Medicaid and CHIP agencies. Among other requirements, strategic plan must address agency-specific plans to achieve priorities, establish annual benchmarks and reporting process for affected agencies, include strategies to align public and private payers with regard to quality and patient safety efforts and incorporate QI and measurement in the HIT strategic plan required by ARRA.	Must be submitted to Congress no later than 1/01/11 with annual updates
3012	<i>Interagency Working Group on Health Care Quality</i> is limited to a broad range of federal agencies.	Report to Congress due no later than 12/31/10 and annually thereafter
3013	<i>Quality Measure Development</i> will fill gaps in existing standards for measuring performance and improvement of population health or of health plans, providers and other clinicians in the delivery of health care services. Provides for grants and contracts for needed quality measure development. States not expressly included as potential grantees, but should be consulted by grant entities as a payer who will use the measures developed. \$75M appropriated.	Appropriations for FY 2010 through 2014

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3015	<i>Collection and analysis of data for quality and resource use measures</i> amends Title III of PHSA to require Secretary (1) to collect and aggregate consistent data necessary to implement to public reporting on performance information described in §3011 and (2) to post on the Internet, performance measurement information on quality measures, including, where possible, provider-specific information on clinical conditions. Permits Secretary to award grants or contracts for support new or improve existing data collection efforts. Authorizes appropriations of necessary sums.	Authorizes appropriations for FY 2010 through 2014
10203	<i>Qualified Plan certification</i> requires reporting of pediatric quality measures by plans seeking certification for the Exchange.	
Public Health		
Prevention		
4001	<i>National Prevention, Health Promotion and Public Health Council</i> will be established to develop a national prevention, health promotion and public health strategy.	National strategy to be developed and made public by 3/23/11. Report to the President and Congress on activities and progress due not later than 7/01/10 and annually thereafter
4002	<i>Prevention and Public Health Fund</i> provides for expanded national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health sector costs. This will provide a stable funding stream for prevention, wellness and public health activities.	Authorizes appropriations in FY 2010 of \$500,000,000, with an increase each fiscal year until 2015 when it is \$ 1,500,000,000 that each and each year thereafter.
4003	<i>Clinical and Community Preventive Services Task Forces</i> replaces existing statutory language governing the Preventive Services Task Force provided for in §915 of the Public Health Services Act (PHSA) with new language which bolsters and broadens the scope of the Task Force. Requires coordination with a newly created Community Preventive Services Task Force (to be convened by CDC), the Advisory Committee on Immunization Practices, and the U.S. Preventive Services Task Force. All are Federal and develop recommendations for stakeholders, including state agencies.	3/23/10
4004, 1004(c)	<i>National education and outreach campaign regarding preventive benefits.</i> To be developed by the Secretary as a public-private partnership for a national campaign to raise public awareness of health improvement across the life span. It will include a media campaign, website that includes a personalized prevention plan tool relating to the top 5 diseases in the US, dissemination of information through providers who participate in Federal programs, and an internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.	Media campaign to be implemented no later than 3/23/11.

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4004	<i>Public Awareness of Preventive and Obesity-Related Services.</i> The Secretary shall provide guidance and relevant information to states and providers on the preventive and obesity-related services available to Medicaid enrollees. Each state shall design a public awareness campaign to educate enrollees about the availability of these services.	Report to Congress due no later than 1/01/11 and every 3 years thereafter until 2017
Oral Health		
4102	<i>Oral healthcare prevention campaign</i> requires the Secretary to establish a 5-year national prevention and education campaign, including prevention of oral disease such as early childhood and other caries, periodontal disease and oral cancer.	No later than 3/23/12
4102	<i>Updating National Oral Healthcare Surveillance Activities.</i> HHS to update Pregnancy Risk Monitoring System (PRAMS) as it relates to oral healthcare. States to be required to report to HHS on activities conducted by the State under PRAMS, including mandatory use of healthcare measurements. The Secretary will develop oral healthcare components, including tooth-level surveillance (i.e. clinical exam of all teeth) for inclusion in National Health and Nutrition Examination Survey; requires Secretary to ensure that this System includes the measurement of early childhood caries.	No later than 3/23/15 and every 5 years thereafter
New Mothers		
2952	<i>Support, education and research for postpartum depression</i> provides for research to expand the understanding of causes and treatment for postpartum conditions; may include a national coordinated education campaign.	Report due to Congress no later than 3/23/15 and periodically thereafter
4207	<i>Reasonable break time for nursing mothers</i> provides accommodations for nursing mothers in workplace settings and is a requirement for employers, although those with less than 50 employees are exempt if it would cause hardship.	3/23/10
Indian Health Care (title III)		
10221	<i>Indian health care improvement</i> authorizes appropriations for the Indian Health Care Improvement Act, including programs to increase the Indian health care, new programs for innovative delivery models, behavioral health care, new services for health promotion and disease prevention, efforts to improve access to health care services, an Indian youth suicide prevention program and construction of Indian health facilities.	