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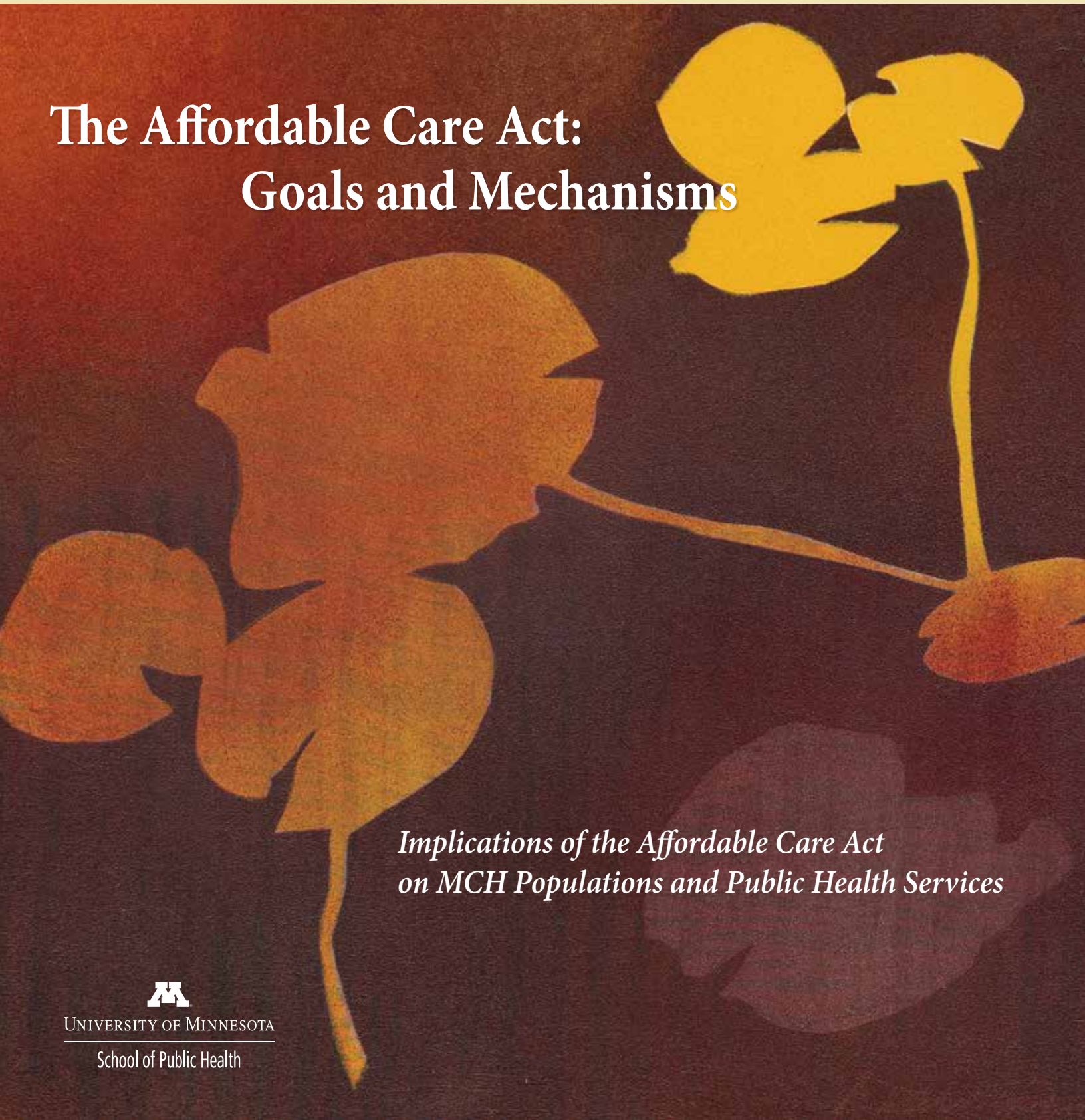
The Affordable Care Act: Goals and Mechanisms



Implications of the Affordable Care Act on MCH Populations and Public Health Services

University of Minnesota
School of Public Health

The Affordable Care Act

Fall 2013

IN THIS ISSUE

The ACA Basics

Implications of the ACA for MCH Populations and Public Health Services

LETTER FROM THE EDITORS

In October 2013, health insurance marketplaces ("exchanges") began online open insurance enrollment in response to the Affordable Care Act (ACA) and many states expanded Medicaid eligibility. Since the inception of the ACA in 2010, we have been inundated with information (true and false) from opponents and advocates of this historic shift in how we pay for medical care in the United States. Some of us have been more confused than enlightened by news media, advocacy organizations, and politicians. Should we doubt whether we have the infrastructure to administer the ACA? Should we fear dire, unintended consequences? Should we interpret the July 2013 decision to delay employer participation until 2015 as second-guessing by ACA architects? Despite concerns, many of us are betting on this horse: it may be slow out of the gate, but waiting at the finish line is expanded health benefits for our most vulnerable citizens, a focus on primary prevention, and health system reforms. As a nation, we are taking this major step into one of the most far-reaching health policies in our country's history with both hope and uncertainty.

With this volume, we hope to clarify some aspects of the ACA and its potential to improve the health of families, children, youth, and women. *Healthy Generations* has tackled tough subjects in the past (e.g., war and public health, early childhood mental health), but this has been the toughest. As we go to press, there are more than 250 bills pending in Congress to repeal or modify the ACA. In late August 2013, conservative legislators called for a government shutdown to prevent funding for the ACA. Our leap of faith in producing this volume—full of information that could potentially change—is rooted in our commitment to the promise of the ACA. This is, by far, the most interesting, controversial, and important topic in our 10-year publication history.

—Wendy L. Hellerstedt, MPH, PhD, and Charles N. Oberg, MD, MPH

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The Affordable Care Act:

What Are Its Goals and Do We Need It?

by Wendy L. Hellerstedt, MPH, PhD

"The cost of our health care is a threat to our economy. It's an escalating burden on our families and businesses. It's a ticking time bomb for the federal budget. And it is unsustainable for the United States of America…health care is the single most important thing we can do for America's long-term fiscal health. That is a fact."

—President Barack Obama, Annual Conference of the American Medical Association, June 2009

75% of our health care dollars are spent on treating preventable conditions while 3% of our health care dollars are spent on disease prevention

President Obama signed the Patient Protection and Affordable Care Act (ACA) into law on March 23, 2010. Since then, we have been inundated with news reports and political speeches about the ACA—the most expansive health care policy in recent history. According to the Democratic platform, "…health reform will eliminate all discrimination for pre-existing conditions, start the process of expanding health insurance coverage for an additional 32 million Americans, and provide the largest middle-class tax cut for health care in history. The Affordable Care Act has already begun to end the worst insurance company abuses."[1] According to the Republican platform, "The Patient Protection and Affordable Care Act—Obamacare—was never really about health care, though its impact upon the nation's health is disastrous." The 2012 GOP platform also states that the law should be repealed as it represents "an attack on our Constitution."[2]

Information overload, the biased nature of many news reports, and the complexity of the law have left many of us confused. The following provides a simple description of the three major goals of the ACA, as described by the American Public Health Association in 2013.[3]

1. Expand Health Insurance Coverage

Many people in the US are uninsured or under-insured and it appears that health care access is getting worse. According to a 2012 national report on health care quality and access indicators, ***quality*** is improving, but remains suboptimal, especially for minority and low-income groups. ***Access*** indicators are getting worse and race and income disparities are not changing.[4] It is likely that these social disparities contribute to the poor ranking of the US compared to other industrialized countries for several health indicators, including infant mortality[5] and life expectancy.[6]

As of May 2013, about 49 million US citizens did not have health insurance,[7] putting them at risk for poor health care access and quality.[4] It is expected that by 2016, the implementation of ACA provisions will result in that number dropping to 26-27 million.[7]

2. Shift the Focus of the Health Care Delivery System from Treatment to Prevention

Health care has traditionally focused on treatment rather than prevention. The American Public Health Association estimated that 75% of our health care dollars are spent on treating preventable conditions while 3% of our health care dollars are spent on disease prevention.[3] The ACA expands incentives for providing preventive care and provides funds to communities and public health agencies for primary prevention programs (e.g., Community Transformation Grants, **see page 16**).

3. Reduce the Costs and Improve the Efficiency of Health Care

Health care delivery and payment in the US are inefficient and, ultimately, unsustainable. Health care costs in the US are significantly higher than those of similar countries, but higher costs do not always translate into better health care delivery or outcomes.[8] A comparative report of 2011 health care costs and outcomes in 34 countries, including the US, showed that:[9]

- The US spent more on health care per capita ($8,608) and more on health care as a percentage of its gross national product (17.9%) than any other country;
- The US was one of the few countries in which less than 50% of health care costs were publicly financed. Nonetheless, health care spending was so high in the US that US ***public*** funds, as well as private funds, for health care were among the highest of the 34 countries;
- Despite its high health care costs, the US had 2.5 practicing physicians per 1000 population, below the average for all 34 countries of 3.2/1000. The US, however, had a higher level of nurses/1000 population than the combined average for the 34 countries (11.1/1000 vs. 8.7/1000); and
- The US had fewer hospital beds than the average for the combined 34 countries (3.1 beds/1000 population vs. 4.8 beds/1000), but ranked higher than average in availability of medical technology (e.g., computed tomography).

The ACA mandates some reductions in out-of-pocket costs and in health care delivery reforms, but it is possible that the greatest long-term cost savings may come from its encouragement of primary prevention services and programs. According to 2002 data from the US Medical Expenditure Panel Survey, 5% of the population accounted for 49% of total health care expenses. Individuals with multiple chronic conditions (some of which may be preventable) accounted for 44% of total health care expenses.[10]

Conclusion

The intent of the ACA is to reform how insurance and health systems work to ultimately improve health care access, quality, and individual and public cost. If successful, the ACA has the potential to improve individual health and, ultimately, population health. Compared with other countries, the US has a much stronger focus on diagnostic and treatment-related technology than on primary prevention.[8,9] Many believe that this focus has translated into our high rates of potentially preventable causes of morbidity and mortality, such as obesity,[7] and explains our poor international ranking in infant survival5 and in life expectancy.[6] We also have deep social disparities in health outcomes.[4] Such disparities have complex etiologies that may not be completely addressed by medical care. The ACA's strong endorsement of primary prevention may have the long-term effect of reducing disparate health outcomes among economically and socially vulnerable citizens.

ACRONYMS OFTEN USED IN THIS VOLUME

ACA	Affordable Care Act
AMCHP	Association of Maternal and Child Health Programs
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CYSHCN	Children and Youth with Special Health Care Needs
EHB	Essential Health Benefit
EPSDT	Early Periodic Screening, Diagnosis and Treatment Program
FPL	Federal Poverty Level
IOM	Institute of Medicine
HRSA	Health Resources and Services Administration
MCHB	Maternal and Child Health Bureau
MOE	Maintenance of Effort
MCE	Medicaid Coverage Expansion
PCIP	Pre-existing Condition Insurance Plan
PPACA	Patient Protection and Affordable Care Act

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SOME PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA), BY YEAR

2010

Portions of the ACA into effect, prohibiting insurance companies from denying coverage to children with pre-existing conditions, rescinding coverage, and setting lifetime limits on insurance coverage.

Young adults were allowed to remain on parents' health insurance plan until they turn 26.

Payments for rural health care providers increased, Community Health Centers were better funded, and a $15 billion Prevention and Public Health Fund was established (to fund community programs through entities like the Community Transformation Grants).

2011

Improvements to Medicare coverage implemented, including better prescription drug coverage, free preventive care for seniors, and systems to coordinate care for Medicare recipients.

80/20 Rule: insurers must spend 80% of premium dollars on health care services and quality improvement rather than administrative costs (85% for large employer plans).

2012

Physicians may form Accountable Care Organizations to improve quality and prevent unnecessary hospital admissions.

Value-Based Purchasing and electronic health records went into effect to improve care and lower costs.

2013

New funding for some state Medicaid programs and increased Medicaid payments for preventive care.

Open enrollment in the health insurance marketplace began October 1, 2013.

2014

Discrimination because of pre-existing conditions or sex will be prohibited, insurance tax credits will be available, Medicaid expansion in some states, and the individual mandate to purchase insurance coverage will be implemented. Open enrollment ends in March 2014.

Note: This timeline identifies just a few elements of the ACA. For more information go to https://www.healthcare.gov/timeline-of-the-health-care-law/#part=1

How Will the Affordable Care Act Accomplish Its Goals?

Part I. Insurance Reforms

by Wendy Hellerstedt, MPH, PhD

"My view is that health care reform should be guided by a simple principle: fix what's broken and build on what works. And that's what we intend to do."

— President Barack Obama, Annual Conference of the American Medical Association, June 2009

The Affordable Care Act (ACA) is intended to reform both insurance and health care systems.[1] Insurance reform will improve health insurance coverage and lower individual costs. They are intended to achieve three main goals:

- Expand insurance coverage to more people;
- Provide insured people with more benefits and protections; and
- Lower consumer and government costs of providing health care.[1]

The following are some of the mechanisms through which insurance reforms will be realized.

More Preventive Service Coverage

The ACA ensures that most insurance plans (the "non-grandfathered" plans) provide coverage and eliminate cost-sharing for certain recommended preventive health services, beginning on or after September 23, 2010. Services include colonoscopies, Pap smears, mammograms, well-child visits, and flu shots for children and adults. While some plans covered these services before the ACA, millions of Americans had insurance plans that did not. According to the Kaiser Family Foundation's Employer Health Benefits Survey and Census data, an estimated 71 million more Americans received expanded coverage of one or more preventive services because of the ACA in 2011 and 2012 (Figure 1).[2] The ACA also requires that all insurance plans include the "essential health benefits" (see page 5) that cover a wide array of preventive services.

An estimated 71 million more Americans received expanded coverage of one or more preventive services because of the ACA in 2011 and 2012

Medicaid Expansion

The ACA will widen the safety net for economically vulnerable individuals by expanding Medicaid's eligibility **floor** to 133% of the Federal Poverty Level (FPL) (e.g., $30,675 for a family of four) for Americans who are younger than 65 years in states that presently fall below this threshold.[3] The law also allows for a calculation of 138% of the FPL for eligibility.[3] In 2009, Medicaid eligibility for parents was at or below 50% FPL in 17 states (e.g., $11,525 for a family of four).[4]

For the first time, adults without children will be eligible for Medicaid. In 2009, only two states allowed such adults to enroll in Medicaid, irrespective of income, and another 14 states offered limited benefits to them.[4] Also new with the ACA: parents with children will be guaranteed coverage at a uniform level across states (e.g., eligibility will be tied to the Modified Gross Income tax rules). Prior to the ACA, in more than 30 states low-income parents did not qualify for Medicaid even if their children did.[4] It is hoped that both eligibility determination

THE AFFORDABLE CARE ACT: ESSENTIAL HEALTH BENEFITS

Starting January 1, 2014, the ACA requires individual and small group plans to include all "essential health benefits" (EHBs), limit consumers' out-of-pocket costs, and meet the Bronze, Silver, Gold and Platinum coverage level standards. "Grandfathered plans" (for people who want to keep their pre-ACA insurance) and self-insured plans will be exempt.

What Are the Essential Health Benefits (EHBs)?

- Acute inpatient services
- Ambulatory patient services
- Emergency services
- Maternity and newborn care
- Mental health and substance abuse
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services (chronic disease management)
- Pediatric (i.e., < 19 years-old) services (including oral and vision care)

What Are State "Benchmark Plans"?

All states must select a "benchmark plan" type among the following 10 plans operating in their state: the three largest small group plans, the three largest state employee health plans, the three largest federal employee health plans, or the largest health maintenance organization (HMO) in the state. These four types of plans are approved by the Department of Health and Human Services (DHHS). A state's benchmark plan must include the EHBs **and** whatever state benefit mandates the state had prior to December 31, 2011. For example, if the state mandated that all bariatric surgeries be covered by insurance prior to December 31, 2011, that benefit must be included in its benchmark plan. If the plan type selected by a state (e.g., a small-group employer plan) lacks one of the EHBs, the state has to supplement its benchmark plan type with a category from another DHHS-approved plan type (e.g., an HMO plan). Thus, for example, if a state's benchmark plan is a small-group employer plan (an HHS-approved type) and it lacks pediatric vision care (an EHB), it has to supplement the pediatric services category with one from another DHHS-approved plan (e.g., Medicaid).

Controversies

The EHBs are controversial for several reasons, including:

- States may impose benefits mandates beyond those in the EHB list which could cause disparities in health coverage among states;
- Some definitions are not clear. For example, breastfeeding support by a "skilled" professional is provided without a co-pay, but "skilled" is not defined;
- Some provisions are not specific. For example, insurers have to pay for breastfeeding supplies, but quality requirements are not specified. It is thus possible that plans will not pay for $300-400 double-electric pumps (known to be effective) and instead pay for inexpensive pumps that may remove milk poorly;
- The federal government is obliged to pay part of the costs of state-determined essential services, which is politically challenging, as some state-mandated services may be expensive and/or not universally accepted as an "essential need" (e.g., infertility services, bariatric surgery);
- Insurers and others believe that covering the EHBs will make health insurance more expensive and premiums will be higher for people who bought private insurance prior to the ACA; and
- Some important services are not in the federal benefits list (although states may add them), like dental care for adults.
- Every benefit is complex. "Pediatric services," especially as it relates to oral health, provides an example of the conditional and variable way in which this benefit may be realized, as well as the potential for each benefit to be influenced by political forces. As a result of heavy lobbying efforts, pediatric dental care does not have to be embedded in a medical plan. It can be covered through a stand-alone dental plan (pre-ACA, 98% of dental plans in the US were stand-alone). It is possible that dental coverage embedded in medical plans may not be adequate. It is also possible that the cost of the alternative (stand-alone) plans may be high. There is a further potential restriction to access: if states offer stand-alone dental plans through exchanges, individuals and employers are not required to purchase them by federal law (i.e., it is feasible that youth will not be covered for dental care). States have the option to override federal law and require such purchases (leading to state disparities in required health coverage).

The guarantee that individuals will have access to the EHBs is an important one. With time, we will know how smoothly and uniformly such coverage can be provided.

For More Information

A description of preventive care benefits is at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

The Federal Register (November 26, 2012) about the EHBs is at: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf

State-specific EHB benchmark plans are at: http://www.cms.gov/cciio/resources/data-resources/ehb.html#

Information on the four coverage levels is at: http://101.communitycatalyst.org/aca_provisions/coverage_tiers#bronzesilvergold

and enrollment in Medicaid and the Children's Health Insurance Program (CHIP) will be simpler and more efficient under the ACA.

A June 2012 Supreme Court ruling determined that decisions about Medicaid expansion could be left to the States. That decision also prohibited the federal government from punishing states that did not comply, so state Medicaid expansion is optional. States can decide about expansion at any time. According to the Henry J. Kaiser Family Foundation, as of September 2013, 25 states were moving forward with Medicaid expansion efforts, 22 were not moving forward (but could do so in the future), and four legislatures were debating the issue. Governors in 16 states had voiced opposition to the Medicaid expansion and had thus chosen to reject federal funds.[5]

For states that will accept federal funds, the federal government will finance much of the cost of state Medicaid expansion. For those newly eligible for Medicaid under the ACA, states will receive 100% funding for their costs from 2014-2016 and 90% of their costs onward.[4] States will continue to receive federal funds for individuals who were eligible prior to the ACA. This amount varies by state, but is usually less than 60% of costs.[4]

The Rand Corporation studied the first 14 states that opted out of Medicaid expansion and estimated that they would lose a total of $8.4 billion a year in federal payments in 2016.[6] The economics of expansion are complex: many states argue that they will have to spend millions to expand Medicaid. This is especially true after 2016 when the federal contribution is set to decrease substantially. However, subsequent analyses of programmatic costs should include the additional jobs and greater tax revenues that will come from higher federal funding. More important than leaving billions of federal dollars unspent is the fact that an estimated 11.5 million poor Americans in those 14 states will remain uninsured.[6]

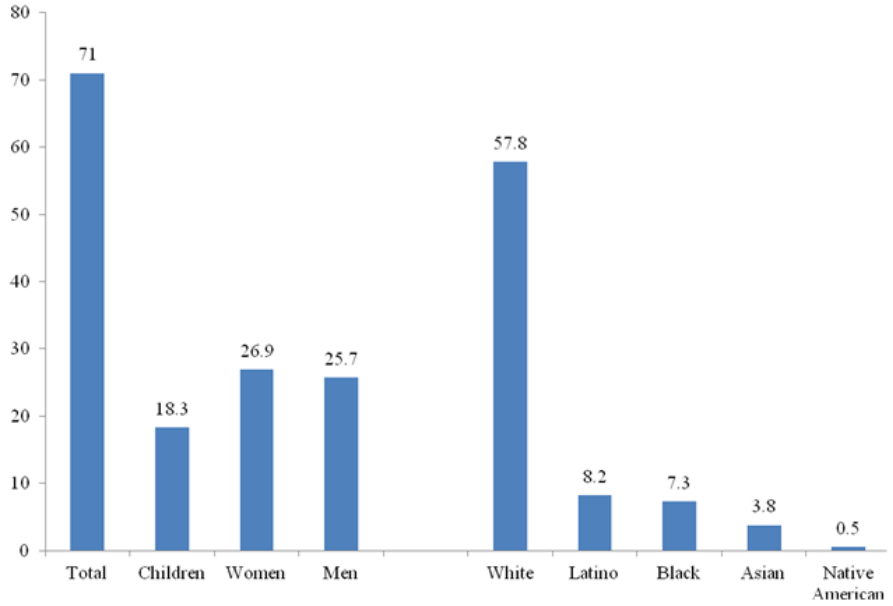

Figure 1. Number of Americans estimated to have received expanded preventive services coverage under the Affordable Care Act from 2011-2012. Data from US Census. Source: Skopec & Summers, 2013.[2]

Insurance Marketplaces (Exchanges)

Insurance marketplaces/exchanges are clearinghouses for individuals who do not have insurance through an employer, Medicaid, Medicare, or the military. They provide information about health coverage options; compare health insurance plans based on costs, benefits, and other important features; and help individuals choose and enroll in a plan. Open enrollment began on October 1, 2013 and plans will begin providing benefits on January 1, 2014. There are three models: state-run, state-federal partnership, or federal-run exchanges. As of August 2013, 16 states (and Washington D.C.) planned state-run health insurance exchanges for individuals and small businesses and six states planned state-federal partnerships. Twenty-seven states declined the opportunity to run a state-run or state-federal partnership marketplace and opted for the federal exchange; of those 27, eight states will assist in some management functions.[7]

Health Insurance Provisions

The ACA has two kinds of health insurance subsidies for individuals with incomes less than 400% of the FPL (e.g., about $94,000 for a family of four):

MOVING TO HIGH QUALITY, ADEQUATE COVERAGE: STATE IMPLEMENTATION OF NEW ESSENTIAL HEALTH BENEFITS REQUIREMENTS

In May 2011, the Urban Institute began documenting the experiences of 10 states (including Minnesota) in the implementation of various components of the Affordable Care Act (ACA). Their efforts have resulted in several reports and briefs, which can be found by searching on its health policy page, http://www.urban.org/health_policy/index.cfm. In August 2013, one of the reports about the 10 states documented the challenges faced by insurance companies and states in the development and oversight of new plans that meet the "essential health benefits" (EHBs) requirement of the ACA. The EHBs attempt to improve the adequacy of health insurance by establishing a minimum standard for health benefits. As described by the Urban Institute, "…most people will see little change in the number of benefits covered by plans, but some will gain benefits, such as maternity care, mental health, and prescription drugs, that have often not been covered. The study also finds that insurers are taking limited advantage of their flexibility to add and subtract benefits through substitution." Available from: http://www.urban.org/UploadedPDF/412882-Moving-to-High-Quality-Adequate-Coverage-State-Implementation-of-New-Essential-Health-Benefits-Requirements.pdf

- A monthly premium assistance tax credit to lower the premium amount; and
- Cost-sharing assistance to limit maximum out-of-pocket health care costs, and, for some, reduce other cost-sharing requirements (e.g., deductibles, co-insurance, co-payments).

Individuals who get insurance through their employer can also get subsidized coverage in an exchange if: (1) their premiums are unaffordable (i.e., more than 9.5% of their household income for those at 300-400% FPL and no more than 2% for those <133% FPL); or (2) their plan is inadequate (i.e., pays less than 60% of the cost of covered benefits).

Coverage without cost-sharing for many preventive services (e.g., immunizations, health screenings) is mandatory for private plans. Medicaid administrators receive incentives for providing such services. There are caps on annual out-of-pocket costs (e.g., in 2014, $12,500 for a family) and an elimination of lifetime coverage limits. Medicare beneficiaries have also realized savings for preventive services like mammograms, heart disease risk screenings, cancer screenings, and annual wellness visits. The ACA made them available without co-insurance or a deductible. It is estimated that in 2011 alone, more than 32.5 million seniors received at least one free preventive service because of the ACA.[8]

Consumers will be offered four tiers of coverage (i.e., Bronze, Silver, Gold and Platinum), which vary in terms of percent coverage (e.g., Bronze will pay 60% of health care costs and Platinum will pay 90%), although all provide coverage of "essential health benefits."

Conclusion

There remain many questions about how effective and efficient the health insurance provisions of the ACA will be. And, as exemplified by at least 16 states (as of September 2013) who have rejected federal funds for Medicaid expansion, there is significant opposition and doubt about the success of the ACA on the part of Republican governors and legislatures. However, there is already evidence of a marked increase in preventive services since the 2010 ACA mandate about preventive service coverage.[2,8] If the health exchanges operate smoothly (as they did in Massachusetts) and more people have access

KEY INSURANCE MARKET REFORMS OF THE AFFORDABLE CARE ACT

The following are some insurance provisions of the Affordable Care Act (ACA) that will be effective on January 1, 2014. These provisions are applicable to all group plans and new plans on the individual health market.

Insurers May Not:

- **Deny coverage because of a pre-existing illness ("guaranteed issue").** In the small group market (i.e., employers with 2 to 50 employees), the Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that individuals with pre-existing conditions be eligible for insurance. However, prior to the ACA, most states allowed other insurers to deny coverage based on prior illnesses—some states had lists of more than 400 conditions for which coverage could be denied. States varied in their definitions of who could be denied coverage and in the availability of safety nets for those affected.
- **Set lifetime or yearly limits on essential health benefits (EHB) services.**
- **Cancel insurance if an individual makes an honest mistake or left out information on an insurance form that is not directly related to health (i.e., no more frivolous cancellations).**

Insurers May:

- **Implement risk ratings** (i.e., community ratings) but are limited to considering age (limited to 3:1 ratio), geography, family composition, and tobacco use (1.5:1 ratio). Women may no longer be charged higher premiums than men.

Insurers Must:

- **Cover all "essential health benefits"** (see page 5).
- **Cover preventive services free, with no co-pays or deductibles.** Such benefits include substance abuse counseling, cardiovascular disease risk screenings, colorectal cancer screenings, depression screening, sexually transmitted infections and HIV screenings, dietary counseling, and immunizations (adults and children).
- **Account for health care costs through rate review and the "80/20 Rule" (the Medical Loss Ratio).** Insurers must publicly justify any increase of 10% or more to a premium. The 80/20 Rule means insurers must spend at least 80% (85% for insurers selling to large groups) of what they receive in premiums on health care and quality improvement instead of administrative, overhead, and marketing costs. If an insurer doesn't meet the 80/20 Rule, insured individuals will have some of their premium dollars returned to them (e.g., a rebate check, reduction in future premium).

Grandfathered Plans Are Exempt from ACA Provisions.
"Grandfathered" plans—plans that were in existence as of the date the ACA was enacted (March 23, 2010)—are exempt from most (not all) of the ACA's insurance provisions. A health plan must disclose in its plan materials if it considers itself "grandfathered."

Individuals Must Be Insured.
Individuals will have to pay a fine—as low as $95 the first year—if they do not choose their employers' insurance, Medicaid, or what is offered through the exchanges. There are exceptions for financial hardship and religious objections. The federal government will subsidize premium costs for those below 400% of the federal poverty level (about $46,000 for an individual and $94,000 for a family of four).

For More Information

"How does the health care law protect me?" at: https://www.healthcare.gov/how-does-the-health-care-law-protect-me/

"Federal subsidies: helping people afford health care" at: http://101.communitycatalyst.org/aca_provisions/subsidies

For individuals and families who want to enroll, go to https://www.healthcare.gov/families/ for information (including links to specific state exchanges).

to essential benefits, the insurance provisions of the ACA have great potential to improve individual and population-level health.

For More Information

The Henry J. Kaiser Family Foundation website offers **up-to-date information on the status of State Decisions about Medicaid expansion** (http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/), state health insurance exchange information (http://kff.org/state-health-exchange-profiles/), and **a subsidy calculator to determine premium assistance for coverage in exchanges** (http://kff.org/interactive/subsidy-calculator/).

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TOP 10 REASONS TO EARN AN MPH DEGREE IN MATERNAL AND CHILD HEALTH AT THE UNIVERSITY OF MINNESOTA

Opportunities in the Field of MCH

1. **MCH MPH graduates often work with—or on behalf of—socially and economically vulnerable populations** that include women, children, youth, and family members (broadly defined to include fathers, grandparents, etc.).
2. **MCH is one of the oldest—and one of the most varied—areas in national health promotion and assurance in the US.** In the US there is a national agency dedicated to MCH work, the Maternal and Child Health Bureau, which oversees public health programs that address a wide range of topics, including reproductive and prenatal health care access, newborn screening, family home visiting, care of children with special health care needs, and autism research. All of these initiatives require MCH professionals at national and local levels (see http://www.hrsa.gov/about/organization/bureaus/mchb/).
3. **MCH MPH graduates develop public health programs and policies** that focus on health promotion, health care equity, disease prevention, and primary care services. Their work is conducted in non-profit organizations, government agencies, universities, school districts, advocacy organizations, health clinics, and research/academic institutions.
4. **Every state—and many cities and counties—have departments specifically dedicated to MCH public health** advocacy, assessment, and program development. In Minnesota, see http://www.health.state.mn.us/divs/fh/mch/ for a description of the many focal areas in the State's MCH Section.
5. **MCH MPH-level epidemiologists** participate in research teams to conduct needs assessments, evaluate programs, and identify and promote social and environmental conditions that contribute to the health of women, children, youth, and families. MCH professionals with epidemiologic skills are especially in demand in city, county, and state health departments. Because MCH epidemiology training is so important, the Centers for Disease Control and Prevention sponsors MCH epidemiology training and internships (see http://www.cdc.gov/reproductivehealth/mchepi/index.htm).
6. **MCH professionals are in heavy demand internationally**. Most of the eight United Nations' Millennium Development Goals focus on MCH areas, including eradicating poverty, reducing child mortality, empowering women/promoting gender equity, improving maternal health, and reducing the risk of HIV/AIDS and other diseases that affect vulnerable populations (see http://www.who.int/topics/millennium_development_goals/en/).
7. **MCH professionals have organizations that help them network and that provide them with opportunities for continuing education**: the Association of Teachers of Maternal and Child Health (ATMCH; www.atmch.org) and the Association of Maternal and Child Health Programs (AMCHP; www.amchp.org).

Quality of the University of Minnesota MCH MPH Program

8. **The University of Minnesota has one of the most respected MCH programs in the world.** We have had more than 1000 graduates, many of whom have become leaders in MCH research, program development, and policymaking.
9. **The University of Minnesota's MCH program has about 40 regular or adjunct faculty members**, representing a variety of disciplines (e.g., pediatrics, nursing epidemiology, sociology, public health, psychology, anthropology) and community and academic work settings.
10. **To prepare our students for leadership positions,** they undertake field experiences with MCH leaders to enhance their research, program development, and policy making skills.

How Will the Affordable Care Act Accomplish Its Goals?

Part II. Health Systems Reforms

by Wendy Hellerstedt, MPH, PhD

"Our health care system lags in its ability to adapt, affordably meet patients' needs, and consistently achieve better outcomes."

— Mark Smith, President and CEO of the California HealthCare Foundation, Chair, 2012 Institute of Medicine Committee to address the quality of the US health care system

The ACA's Prevention and Public Health Fund represents the first time the US had a mandatory funding stream for improving public health

Recently, the Institute of Medicine (IOM) convened a committee to explore health care challenges and recommend ways to address them. Its September 2012 report concluded that the US health system is, bluntly, a mess. The committee concluded that, "The entrenched challenges of the US health care system demand a transformed approach. Left unchanged, health care will continue to underperform; cause unnecessary harm; and strain national, state, and family budgets. The actions required to reverse this trend will be notable, substantial, sometimes disruptive—and absolutely necessary."[1]

Are the health systems reforms of the Affordable Care Act (ACA) sufficiently comprehensive—and will they be funded adequately enough—to address the substantive problems in US health care?

As described by the American Public Health Association, the ACA's health systems reform has three main goals:

- Improve the quality and efficiency of health care services and delivery;
- Create a stronger workforce and community infrastructure; and
- Create a strong focus on public health and primary prevention.[2]

Improve Health Care Services and Delivery

The ACA has many provisions and models that will hold health systems accountable for some quality of care standards. Among the many ACA initiatives intended to serve as industry "watchdogs" are:

- **Accountable Care Organizations (ACOs)** made up of health care providers who voluntarily coordinate the care of Medicare recipients to reduce duplicative services and medical errors.[3] ACOs receive Medicare bonuses for achieving quality and cost targets. They could also receive penalties for poor performance. There are about 400 ACOs in the US (e.g., Medicare Shared Savings Program, Medicare Pioneer Program, private ACO contracts).
- **Patient-centered Medical Homes (PCMH)** is not a new concept, but the ACA provides incentives and provider payment for its various models.[4] PCMH refers to physician-directed coordinated care delivery involving a "whole person orientation" to ensure streamlined and comprehensive patient care. States can determine patient eligibility by chronic condition or geography; generally eligible patients must have one chronic condition or be at risk for one.
- **Pay for performance.** This is an umbrella term for a variety of performance-based incentives in the ACA. For example, Medicare physician payments are based on quality measures, not on numbers of patients served. Presently, Medicare reimburses hospitals through a capitated payment system for specific health conditions by Diagnostic Related Groups

(DRGs). Starting in 2015, hospitals will get paid less when patients have hospital-acquired infections, bedsores, and excessive re-admissions. The penalty will begin with a 1% cut in service payment and could increase with time. **Value-based purchasing** is another such incentive: A hospital will be financially rewarded based on how well it performs relative to quality measures and how much improvement it achieves relative to a baseline.[5]

- **State Innovation Models Initiatives.** About $300 million was granted to some states by the Centers for Medicare & Medicaid Services to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation. The aim is to improve health system performance for residents of participating states. The projects are broad-based and focus on people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP). Six states have model-testing awards, including a $45 million grant to Minnesota (see http://mn.gov/health-reform/health-reform-in-Minnesota/). Sixteen states have model-design awards, including Iowa (see http://www.ime.state.ia.us/state-innovation-models.html).

Strengthen Health Care Workforce and Community Infrastructure Supports

The ACA has dozens of provisions to strengthen community- and school-based health centers and to improve the training and supply of public health and clinical professionals. The ACA has re-authorized existing programs—and created new initiatives—to incentivize public health and medical care providers in a variety of ways, including:

- Increasing Medicaid provider payments to the level of Medicare payments;
- Providing bonus payments for primary care and surgical providers in communities of need; and
- Permanently authorizing (and increasing funding for) the National Health Services Corp program that oversees training of loan re-payments for those who work with communities in need.

Addressing Public Health Workforce Needs

As described by the IOM, public health professionals are those who "improve health through a population focus."[6] These professionals come from many disciplines and perform a diverse set of tasks to serve public health needs. There is great concern about the near-term and future quality and supply of the public health workforce. A 2012 survey of 663 local health departments in 47 states showed that 39,600 positions were lost (related to layoffs and attrition) between 2008-2011. In 2011, 57% of the local health departments reduced or eliminated services in at least one program area during that time period, affecting an estimated 65% of the US population.[7] A 2008 report by the Association of Schools of Public Health stated that public health workforce shortages will continue to increase: it estimated that, by 2020, the US will face a shortage of 250,000 public health workers.[8]

One example of the many ACA workforce development initiatives are the 19 health workforce provisions to address training, recruitment, and retention of clinical and public health workers, as described in detail by the American Public Health Association.[9] For example, through the Health Resources and Services Administration (HRSA), the ACA funds 37 Public Health Training Centers (PHTCs) in various public health and related academic institutions in the US.[10]

Some of the initiatives to address workforce needs have not yet been realized, either because they have not been funded or they have been legislatively and/or politically blocked. For example, in 2010 a 15-member National Health Care Workforce Commission was appointed to evaluate worker supply and demand. Three years after their appointment, members have not yet met. They are legally prohibited from convening or communicating with one another about Commission work because Congress has not released the $2 million required for Commission work.

Community Health Centers

About 1,200 health centers operate in 9,000 service locations to provide care to 21 million people in the US.[11] These centers offer many services, including physical and mental health services, as well as behavioral interventions. They often provide care for individuals who have no insurance or resources for care elsewhere. Since 2009, such centers have increased the number of people they serve by about four million annually.[11] About 148,000 individuals were employed by these centers in 2012.[11] The ACA established the Community Health Center Fund that provides $11 billion over a 5-year period for the operation, expansion, and construction of these health centers throughout the US. In May 2013, an additional $150 million was added to the fund to help uninsured individuals connect to the ACA health insurance marketplaces.

School-based Health Centers (SBHCs)

SBHCs are operated by hospitals, public health departments, community health centers, educational or nonprofit health agencies. They are also operated by the Indian Health Service, Bureau of Indian Affairs, or by a tribe or a tribal organization. They provide a full-range of health care, ranging from screenings (e.g., hearing, vision), dental care, mental/behavioral care, substance use counseling, nutrition education, and primary medical care.[12] They treat students who have acute (e.g., flu) and chronic (e.g., diabetes) conditions.[12] There are nearly 2,000 SBHCs in the US and most of them are open every day that school is in session.[12] The ACA provided $200 million in fiscal years 2010-2013 for School-Based Health Center Capital Program grants (administered by HRSA).[13] The intent of these grants is to foster development of new SBHC sites in medically underserved areas and to expand preventive and primary health care services at existing sites. To date, $95 million has been awarded to 278 SBHCs, allowing them to serve an additional 440,000 youth.[12] It is estimated that SHBCs served 790,000 youth in 2013 and that ACA funding will ultimately allow them to serve as many as 875,000 youth a year (representing a 50% increase in service delivery compared to 2009).[12]

Workplace Wellness

As part of the ACA, federal workplace wellness laws were amended (see http://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinalrule.pdf). Important components of this amendment include: (1) non-discrimination. Any employee who participates in a worksite

wellness program is entitled to receive incentives or rewards, irrespective of health status; (2) categorization of worksite wellness programs into activity-only and wellness-based programs; and (3) increasing the allowable employee incentive for meeting a health-related goal to 30% of the cost of employee-only coverage. Starting in 2014, employers can expand their wellness programs, offering discounts on premiums, cash rewards, gym memberships and other incentives for those who lose weight, take part in diabetes control programs, or similar plans to improve their health. ACA funding to promote worksite wellness programs were reduced in 2012, so it is difficult to know how much material support the ACA will provide to such initiatives.

Focus on Public Health and Primary Prevention

The ACA's Prevention and Public Health Fund represents the first time the US has had a mandatory funding stream for improving public health. It is intended to supplement existing public health funding (not supplant it). There are four major priorities for this Fund:[14]

- **Clinical prevention.** Enhance awareness of ACA prevention services and benefits. Support immunization, prevention, and behavioral change programs;
- **Community prevention.** This work will be realized by Community Transformation Grants (see page 16), overseen by the Centers for Disease Control and Prevention (CDC);
- **Strengthen workforce and infrastructure.** This work is largely done through the CDC's National Public Health Improvement Initiative through accelerating public health readiness activities, implementing performance and improvement management practices and systems, and implementing and sharing best practices;[15] and
- **Promote research and tracking** through funding initiatives like 37 Prevention Research Centers and Elder Abuse Prevention programs to states and tribes.

The Prevention Fund has been cut by more than half by Congress, sequestration, and various fund diversions (e.g., to other ACA activities, like the health marketplace).[16] The Fund allocated $949 million in fiscal year 2013 to various governmental agencies to address a diversity of health issues (e.g., Alzheimer's, health surveillance, heart disease prevention, immunization, tobacco use prevention, nutrition and physical activity education and programs, environmental health surveillance, breastfeeding promotion).[16]

Also related to prevention efforts is the National Prevention Council,[17] established by the ACA. The Council is chaired by Acting US Surgeon General, Boris Lushniak. Its members represent senior governmental officials from 20 federal agencies and offices. Among its duties are the coordination of prevention activities to achieve the goals of the National Prevention Strategy.[17] The Prevention Fund and the Strategy align with a range of Healthy People 2020 objectives.

Conclusion

The goals of the ACA are true health service delivery reform and enhancement of primary prevention efforts. If its ambitious aims are met, the US will be a healthier nation with fewer premature illnesses and deaths. And, when individuals need health care, it will be efficiently delivered in terms of cost, error risk, and coordination. While funding is a major challenge for the ACA, a key concern is whether the nation will have the necessary patience for long-term evaluation of its many components. The ACA is a multi-mode initiative that aims to prevent or reduce the incidence of many health outcomes. A proper evaluation may require decades.

For More Information

1. The Centers for Medicare & Medicaid Services has information about all aspects of Medicare and Medicaid, including Affordable Care Organizations. The Centers' home page is http://www.cms.gov/

2. HRSA has a website to help public health professionals find trainings sponsored by Public Health Training Centers, http://bhpr.hrsa.gov/grants/publichealth/trainingcenters/index.html

3. Of the 37 Public Health Training Centers, there are six in Great Plains and Midwestern states: Illinois (http://www.midamericacphp.com/maphtc/), Indiana (http://www.pbhealth.iupui.edu/index.php/iphtc/), Iowa (http://www.public-health.uiowa.edu/umphtc/), Minnesota (http://www.sph.umn.edu/ce/mclph/), Nebraska (http://www.unmc.edu/publichealth/Great-Plains-PHTC.htm), and Wisconsin (http://wicphet.org).

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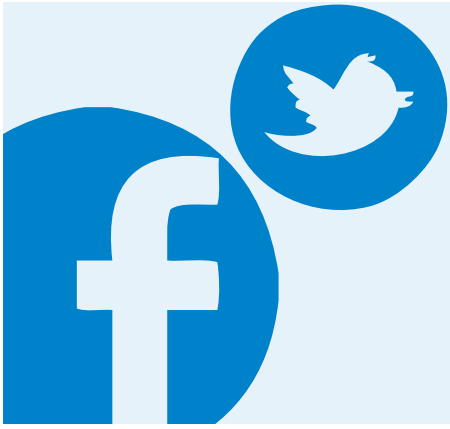
MEDICAL DEVICE MAKERS AND PHARMACEUTICAL COMPANIES: A NEW ERA OF DISCLOSURE

The Affordable Care Act (ACA) contains many health care reforms. Among them is the Physicians Payment Sunshine Act, implemented on August 1, 2013, that requires physicians, researchers, and teaching hospitals to disclose their financial relationships with pharmaceutical and medical manufacturers (http://www.policymed.com/physician-payment-sunshine-act/). This federal law requires disclosure of all industry payments to hospitals, clinics, and physicians that exceed $10 or payments less than $10 that exceed $100/year to a single person or organization. Reportable payments include cash payments for consulting, research support, or services and reimbursements for things like travel, entertainment, etc. Manufacturers will submit the reports to the Centers for Medicare & Medicaid Services annually. Most of the information they report will be available on a public, searchable website, so consumers will understand what relationships their providers have with industry. Physicians have the right to review their reports and challenge reports that are false, inaccurate or misleading. It is hoped that this law will improve transparency, allowing consumers to assess medical prescriptions relative to their providers' financial relationships, and ultimately restore consumer confidence about their interactions with providers.

Facebook and Twitter Pages for Maternal and Child Health at the University of Minnesota



Please visit our Facebook page at http://www.facebook.com/pages/Maternal-and-Child-Health-University-of-Minnesota/103274476412772?ref=hl and our Twitter page at https://twitter.com/UMN_MCH

We post news about public health research, programs, policies, and events related to women's health, reproductive health, infant and child health, adolescent health, and the health of vulnerable populations. Our site may be of most interest to public health practitioners, policymakers, researchers, students and graduates of our MCH program, but our intention is have a vital and interesting site for anyone who is interested in MCH public health and in networking with like-minded people.

Subscribe to Healthy Generations Listserv

Our Healthy Generations Listserv shares resources and enhances networks among multidisciplinary professionals who work to improve the health and well-being of children, adolescents, families, and communities. To sign up send a message to: listserv@lists.umn.edu. Leave the subject line blank. In the body of the text write:
Sub cyfhealth YOUR FIRST AND LAST NAME (example: sub cyfhealth Mary Jones). You will receive an email asking you to confirm your request.

An Interview with Health Policy Expert Lynn Blewett

The Employer Mandate Delay, the Medicaid Opt-Out, Evaluation, and Congressional Dissent

As we prepared this volume of *Healthy Generations* in September 2013, we had many questions. We contacted a University of Minnesota expert in health care policy for her perspective: Dr. Lynn Blewett is a Professor in the Division of Health Policy and Management, School of Public Health, University of Minnesota (http://sph.umn.edu/faculty1/hpm/name/lynn-blewett/). Blewett directs the State Health Access Data Assistance Center (SHADAC; http://www.shadac.org/). SHADAC supports states in monitoring and evaluating programs to increase health care access and coverage. Also, as part of the State Health Reform Assistance Network (http://www.statenetwork.org/), Blewett directs a project that provides technical assistance to 11 states (AL, CO, IL, MD, MI, MN, NM, NY, OR, RI, VA) as they implement the Affordable Care Act (ACA). The following are Blewett's responses to our questions about the complex—and evolving—Affordable Care Act.

Healthy Generations (HG): On July 2, 2013, the Department of the Treasury announced that it was delaying the ACA employer "pay-or-play" mandate and accompanying employer reporting requirements by one year. Why did this delay occur?

Lynn Blewett (LB): Under the ACA employer mandate, employers with 50 or more full-time employees (i.e., those working an average of 30 hours per week or more) must offer all employees health care coverage with "minimum value" or pay penalties for not doing so. This mandate was delayed by one year and will thus be implemented in 2015.

Most US citizens get their health insurance coverage through their employer—the national average of coverage through Employer-Sponsored Insurance (ESI) is 60%, ranging from 48% in New Mexico to 74% in New Hampshire. Our colleagues at SHADAC prepared a report in April 2013 that describes state-by-state trends in ESI that may be of interest to your readers (http://www.shadac.org/files/shadac/publications/ESI_Report_2013.pdf). They may be especially interested in knowing what states have the most and the fewest percent of residents who receive ESI (Table 1).

There are a lot of different pieces of health care reform being implemented over the next few years. I think the administration was concerned that if the employer tax were implemented, it might provide an incentive for some employers to stop providing coverage.

HG: Another complex implementation issue relates to the Medicaid expansion. What does it mean to residents of a state if their state does not participate in Medicaid expansion **(see article that describes expansion on page 4)?**

LB: States have always been able to do more than what the federal government requires them to do under Medicaid. There have been expansion activities in many states, mostly authorized through 1115 demonstration waivers but also through other vehicles. For example, nine states provided coverage for childless adults prior to the ACA (which will allow this in 2014) and received federal matching payments for providing the full range of Medicaid benefits. However, it is important to note that most states provide

EMPLOYER SPONSORED HEALTH INSURANCE: OVERALL PERCENTAGES, TOP AND BOTTOM STATES, 2010-2011

TOP FIVE STATES

New Hampshire	73.8%
Massachusetts	72.9%
Utah	71.7%
Minnesota	71.4%
Connecticut	70.9%

BOTTOM FIVE STATES

New Mexico	48.0%
Louisiana	49.9%
Texas	52.0%
Mississippi	52.1%
Arkansas	52.9%

Source: State Health Access Data Assistance Center. State-level trends in employer-sponsored health insurance. SHADAC Report. Minneapolis, MN: University of Minnesota. April 2013.
Available from: http://www.shadac.org/files/shadac/publications/ESI_Report_2013.pdf

no coverage for childless adults because there is no federal Medicaid requirement to do this. Pre-ACA, states are required to cover pregnant women and children (under age 6) at 133% of the Federal Poverty Level (FPL). If states choose to expand Medicaid under the ACA, all people will be covered at 138% of FPL regardless of sex, age, pregnancy status, or health status. States that do not expand can still use waiver authority to do other things, including some expansion with limited benefit sets. The Henry J. Kaiser Family Foundation provides very good information about the status of states and Medicaid expansion (e.g., http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/).

HG: How will the success of the ACA be measured?

LB: We spend a lot of time thinking about this question and have projects working with states and the federal government about how to evaluate the impact of the ACA. Given that the Supreme Court ruling in June 2012 allowed states to "opt out" of the Medicaid expansion, the story of implementation will certainly vary for states who chose to expand Medicaid and those who chose not to expand.

In addition to variation in Medicaid expansion, states can either do their own state-based health insurance exchange or participate in federally facilitated exchanges. So the national story of success will be complex because individual states will have such different experiences. The bottom line measures will be: how many more people will gain health insurance coverage under the ACA and how many will remain uninsured and why.

HG: Many bills have been introduced in Congress to modify, cripple, or repeal the ACA. What affect have they had—or will have?

LB: Personally, I am amazed that many provisions of the ACA have already been passed and implemented without much fanfare. Among them are provisions that allow parents to keep their children on their health plans up to age 26; the $250 rebate to Medicare beneficiaries who reached the Part D coverage gap in 2010; new requirements for insurers to make sure they pay at least 80% of the money they take in as premiums on actual medical care services; and new rules that require health plans to provide recommended prevention and disease screening care with no co-pays. These are just a few of the many provisions that have either been implemented or will be implemented.

I am most familiar with the ACA access expansions that are targeted to people who currently face significant barriers in receiving affordable health care coverage: the very poor (under 138% of FPL, which is about $13,800 a year for one person); those who do not have access to affordable employer-based coverage (they tend be self-employed or working in firms with 50 or fewer employees); and those who are denied health care coverage in the private market because of a pre-existing condition. We are talking about 10-15% of the US population.

National Listserv for MCH Students & Grads

A listserv for current and past Maternal and Child Health (MCH) students (from all disciplines) was made available by the Maternal and Child Health Bureau through the Association of University Centers on Disabilities. This listserv will allow MCH graduates and students to continue the strong connections they have made during their graduate programs and connect with MCH-ers from other disciplines and programs. This listserv is a great opportunity for members to collaborate on research, to network, and to share practices and questions with peers. The listserv subscription form and more information is at: http://www.aucd.org/resources/alltrainee_subscription.cfm

A BRIEF INTERVIEW WITH GLENDEAN SISK, RN, CRADC, MPH

Glendean Sisk is the Acting Associate Director of Family Wellness and Chief of the Bureau of Maternal & Child Health, at the Illinois Department of Human Services (http://www.dhs.state.il.us/page.aspx?item=32011).

We asked her a few questions to get her perspective, as an MCH leader, about the Affordable Care Act (ACA):

Healthy Generations (HG): How might the ACA affect specialty care services like mental health, substance use, oral health, or services to children and youth with special health care needs?

Glendean Sisk (GS): It is critical that specialty care services position themselves for inclusion, that they explore partnerships with other types of providers, and that they evaluate and explore opportunities for filling gaps in the continuum of care. Primary prevention and health/wellness promotion are reimbursable services and specialty care can—and should—incorporate these concepts into their package of services. Substance abuse and mental health can lead to chronic disease, as well as exacerbate chronic disease, and it is important that providers align with a disease management model.

HG: Does the ACA offer the potential for new (or more) MCH positions?

GS: Yes. There will be a need for care coordinators, case managers, health educators, etc.

HG: How might the ACA affect systems of care (e.g., medical home, home visiting, coordination of care)?

GS: Currently most operate as individual and distinct entities. It will become necessary to work in a coordinated and cohesive fashion.

HG: What is one important message you would like to convey to public health professionals about the ACA and its potential impact on MCH programs, services, or health indicators?

GS: Think outside your current comfort range. What services can you add to align yourself more closely with new expanded models of care? Be ready to demonstrate outcomes of what you do—current and expected. Ready your staff for the credentialing that will be required in contracting. Know what it costs to deliver your services. Know what your competitors are offering and doing.

The ACA Invests in Community Health:

The Community Transformation Grant Program

by Deborah Hennrikus, PhD

The Affordable Care Act (ACA) isn't just about health insurance. The ACA also funds programs and strategies to create healthier communities through the Community Transformation Grant (CTG) program administered by the Centers for Disease Control and Prevention (CDC). CTG funds may be awarded to state and local government agencies, tribes and territories, and nonprofit organizations. CTG funds are for:

- **Implementation** of evidence-based programs to address major causes of chronic disease, such as heart disease, diabetes and cancer in communities;
- **Capacity-building** for organizations that eventually want to conduct prevention activities; and
- **Small communities'** prevention activities in areas (e.g., counties, towns, school districts) that have fewer than 500,000 people.

The CTG-funded programs may be implemented in a variety of sectors, such as health care, education, transportation and business.

Community Transformation Grants Focus on Chronic Disease Risk Factors

The CDC estimates that chronic diseases are responsible for 75% of US health care costs (about $2.5 trillion/year) and 70% of all deaths. The CTG program is designed to address the behavioral, physical, social, and environmental risk factors associated with chronic diseases, such as tobacco use and exposure to secondhand smoke, poor screening systems for disease risks, and lack of access to healthy food and safe environments for physical activity. CTG grants thus fund programs that promote:

- Tobacco-free living;
- Physical activity;
- Healthy eating;
- Services to prevent and control high blood pressure and high cholesterol;
- Social and emotional wellness; and
- Healthy and safe environments.

Ultimately, the CTG program is expected to affect 40% of the US population—about 130 million Americans

The Cost and Impact of Community Transformation Grants

Ultimately, the CTG program is expected to affect 40% of the US population—about 130 million Americans. As described by the CDC, "In 2011, CDC awarded $103 million to 61 state and local government agencies, tribes and territories, and nonprofit organizations in 36 states." These included 5-year awards to 35 communities to implement evidence-based programs and awards to 26 communities to build

capacity for health promotion and disease prevention efforts. An additional $4 million was awarded to six national networks of community-based organizations to engage community members to support and disseminate proven CTG strategies nationally. Communities funded in 2011 are comprised of about 120 million individuals.

In 2012, the CTG program was expanded to provide funding for broadly defined areas (e.g., school districts, counties, towns) with fewer than 500,000 people. That year, $70 million was awarded to 40 communities. It is estimated that these "small communities" grants will have a direct impact on about 9.2 million Americans.

Diversity of Community Transformation Grants

The CTG programs across the nation, while focused on chronic disease risk factor reduction and/or building capacity to conduct prevention activities, are as diverse as the communities in which they are being implemented. Trust for America's Health provides a map of where Community Transformation Grants are located in the US, state-specific media coverage, and other information about CTGs at http://healthyamericans.org/health-issues/category/implementation-of-the-affordable-care-act/community-transformation-grants.

The information for this article was primarily from the CDC Community Transformation Grant site at http://www.cdc.gov/communitytransformation/.

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COMMUNITY TRANSFORMATION GRANTS IN MIDWESTERN AND GREAT PLAINS STATES

The Centers for Disease Control and Prevention (CDC) provided two kinds of Community Transformation Grant (CTG) funds in 2011: (1) for **implementation** of evidence-based programs at the community level (as of 2013, there are 35 recipients); and (2) for **capacity building** (as of 2013, there are 35 recipients). In 2012, it awarded 40 **small communities** grants to support efforts in areas with fewer than 500,000 people. A list of implementation, capacity-building, and small communities recipients is at http://www.cdc.gov/communitytransformation/funds/index.htm.

The implementation grants typically fund programs that address the CTG focus areas (e.g., physical activity, healthy eating, safe and healthy environments). Thus, while most implementation recipients have similar general descriptions for their 5-year grants, each community will have its unique stamp on program implementation. In many cases, state departments of health are the recipients of multi-million dollar CTG implementation grants, with the intention that they will distribute smaller grants to fund community recipients (e.g., county departments of health, nonprofits). The following lists CTG recipients in some Midwestern and Great Plains states:

Iowa. Iowa received an implementation award and has involved 25 counties in a variety of initiatives, http://www.idph.state.ia.us/CTG/.

Illinois. The We Choose Health Initiative at the Illinois Department of Public Health involves 60 counties with more than 3 million residents in its implementation award, http://www.idph.state.il.us/wechoosehealth/. In 2012, Quality Quest for Health of Illinois, Inc. and Chicago Public Schools, District 299, received small communities CTG grants.

Michigan. The Together We Can small communities grant at the Central Michigan Health Department involves six counties in Central Michigan, http://www.together-we-can.org/index.php/community-transformations/. Spectrum Health Hospitals received a capacity-building award, http://www.spectrumhealth.org/body.cfm?id=677&action=detail&ref=683 and the Sault Tribe of Chippewa Indians received an implementation award, http://up4health.org/.

Minnesota. The Minnesota Department of Health is using the existing structure and capacity of the Statewide Health Improvement Program (SHIP) to implement CTG in five regions of Northern Minnesota, http://www.health.state.mn.us/divs/oshii/ctg.html. Hennepin County's Human Services and Public Health Department also received a CTG implementation award, http://www.hennepin.us/portal/site/HennepinUS/menuitem.b1ab75471750e40fa01dfb47ccf06498/?vgnextoid=ab6a782bd67e7310VgnVCM10000099fe4689RCRD **(see page 18).** The Minneapolis Heart Institute Foundation received a small communities CTG grant.

Montana. The Montana Department of Health and Human Services distributes its CTG implementation award funds throughout the state, http://www.dphhs.mt.gov/mtctg/index.shtml.

Nebraska. Live Well Omaha and Douglas County Public Health partnered to receive CTG implementation funds for distribution to nonprofits, government agencies and others, http://livewellomaha.org/about/.

North Dakota. The Center for Rural Health, University of North Dakota and the North Dakota Department of Health received a capacity-building CTG, http://ruralhealth.und.edu/projects/community-transformation-grant.

Ohio. Activate Allen County, a collaborative effort of Lima Family YMCA and Allen County, received a small communities grant in 2012, http://www.activateallencounty.com/1235. Austen BioInnovation Institute, Spectrum Health Hospitals, and Dayton and Montgomery County Public Health received capacity-building grants.

South Dakota. The South Dakota Department of Health (specifically, Tacoma-Pierce County) received an implementation CTG, http://www.tpchd.org/environment/community-transformation/.

Wisconsin. The Wisconsin Clearinghouse for Prevention Resources at University Health Services, University of Wisconsin at Madison, partnered with Wisconsin's Department of Health Services, to receive a CTG implementation grant that will be distributed to communities in Wisconsin (33% of which will be rural), http://www.wiclearinghouse.org/about-transform-wi.html. The Great Lakes Inter-Tribal Council in Wisconsin received a capacity-building grant.

Community Transformation Grant: Programs in Hennepin County, Minnesota

by Deborah Hennrikus, PhD

Hennepin County, Minnesota, encompasses 45 cities, including Minneapolis, and has 1.2 million residents. Hennepin County Public Health obtained Community Transformation Grant (CTG) implementation funding in September, 2011; funding will continue for five years. The grant includes partnerships with the independent health departments in Minneapolis and Bloomington (also serving Edina and Richfield) and other organizations in the county to implement a variety of programs.

The cost savings of banning smoking in subsidized housing alone in the US has been estimated as $521 million per year

Hennepin County is using the award to continue and amplify a number of initiatives and to begin new ones. Some current CTG-funded programs in Hennepin County are intended to:

- Promote active recess periods in Minneapolis public and charter schools;
- Create active living strategies, including pedestrian and bicycle plans and adoption of Complete Streets standards. This approach views "transportation improvements as opportunities to create safer, more accessible streets for all users,"[1] in several municipalities;
- Promote healthy food availability in concessions and vending in parks and recreation facilities in three municipalities;
- Develop and implement action plans for improving nutrition in four school districts; and
- Implement plans to better manage high blood pressure and high cholesterol levels in five Hennepin County Medical Center clinics.

Hennepin County is also exploring methods to increase mental well-being in the community. CTG funding requires grantees to conduct focused evaluations of CTG-funded programs. Hennepin County is conducting two such evaluations. The County also uses its population-based Survey of the Health of All the Population and the Environment (SHAPE) survey (http://www.co.hennepin.mn.us/SHAPE) to track CTG core measures.

One of Many Hennepin County CTG Initiatives: Smoke-free Living

While the CTG funds are used for many activities and serve many populations, one of the initiatives at Hennepin County is to promote smoke-free multi-unit rental housing. The goal is to decrease the secondhand smoke exposure (SHS) of rental housing residents. SHS is the smoke that comes from the burning end of a cigarette, pipe or cigar, and the smoke exhaled by smokers. Inhalation of SHS by nonsmokers can cause or exacerbate a variety of serious health problems, including lung cancer, cardiovascular disease, respiratory infections and asthma.[2] A 2006 US Surgeon General's report concluded that there is "no risk-free exposure to secondhand smoke."[2] Exposure of children and those with compromised health is a particular concern because they are more vulnerable to the effects of smoke.[3]

Multi-unit dwellings are an important site for decreasing smoking because smoke typically migrates between units.[4-6] Although smoke migration can be reduced by sealing boundaries between units, these mitigation measures do not completely

eliminate involuntary exposure to SHS.[7] In addition to the health risks posed by SHS to nonsmokers living in multi-unit buildings, cigarettes also cause fires and other damage to apartments.[7] The cost savings of banning smoking in subsidized housing alone in the US has been estimated as $521 million per year: it is estimated that $341 million would be saved in SHS-related health care; $108 million saved by not having to renovate units with smoke damage; and $72 million saved in smoking-attributable fire losses.[8] Surveys of residents have found that nonsmokers generally prefer to live in smoke-free residences.[9-11]

To date, Hennepin County Public Health, working with a nonprofit partner, Live Smoke-Free, and using Statewide Health Improvement Program (SHIP) and CTG funding, has played a role in establishing smoke-free environments in 165 multi-unit rental properties in Hennepin County. Surveys of residents have indicated interest in living in smoke-free buildings and building owners have reported no change or a decrease in turnover and vacancy rates.[12] In addition, the Minneapolis Public Housing Authority has decided that the 42 buildings that it manages will become smoke-free. Some CTG funds are being used to prepare residents for the change and to evaluate the effort. Residents are being surveyed before the smoking ban is implemented and will be surveyed again six months after implementation to examine attitudes about the ban and its effectiveness in decreasing SHS exposure.

For More Information

Hennepin County's CTG activities – Available from: http://www.hennepin.us/portal/site/HennepinUS/menuitem.b1ab75471750e40fa01dfb47ccf06498/?vgnextoid=ab6a782bd67e7310VgnVCM10000099fe4689RCRD

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THE HIGH COST OF HEALTH CARE IN THE UNITED STATES

A New York Times series of articles by Elisabeth Rosenthal, "Paying Till It Hurts: A Case Study in High Costs," examines health care costs around the world to illuminate why the US has such relatively high health expenditures. The articles began in June 2013 and include:

- "The $2.7 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures" examined the high cost of preventive care in the US, using colonoscopies as an example. "Colonoscopies… are the most expensive screening test that healthy Americans routinely undergo—and often cost more than childbirth or an appendectomy in other developed countries," according to the article (http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html?pagewanted=all&_r=1&);
- "American Way of Birth, Costliest in the World" examined the high cost of childbirth in the US, comparing maternity care in the US to care in other developed countries (http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html); and
- "In Need of a New Hip, but Priced Out of the U.S." examined medical tourism for joint replacement because the procedure is significantly cheaper in other developed countries than it is in the US. (http://www.nytimes.com/2013/08/04/health/for-medical-tourists-simple-math.html).

Rosenthal also participated in a National Public Radio interview about health care costs on August 7, 2013 (http://www.npr.org/2013/08/07/209585018/paying-till-it-hurts-why-american-health-care-is-so-pricey).

The Affordable Care Act and Women's Health

Improved Access to Preventive Services

by Wendy L. Hellerstedt, MPH, PhD

According to a 2012 Henry J. Kaiser Family Foundation report, "Among the 96 million women ages 18 to 64, most have some form of coverage. However, the patchwork of different private sector and publicly-funded programs in the US leaves one in five women uninsured."[1] National survey data from 2008-2010 show that 13% of women in the US had an unmet need (i.e., delayed care or did not obtain care) for health care.[2] The women most affected were uninsured and poor (Figure 1). However, unmet need was reported even among women with insurance and those whose household incomes were more than 400% of the Federal Poverty Level (FPL).[2]

In 2012, 20% of women 18-64 years of age in the US were uninsured and likely did not qualify for Medicaid or have access to employer-based plans

The Affordable Care Act (ACA) has the potential to expand coverage for millions of currently uninsured women as well as to stabilize and expand coverage of those who are currently insured. Most of the provisions of the ACA will affect women and men equally, but the following highlight some of the access and coverage components of the ACA that could reduce unmet need and improve health outcomes for women specifically.

Expanded Access to Insurance

Women are disproportionately affected by insurance loss through divorce and switching from full- to part-time employment. According to data from the March 2012 Current Population Survey, women are less likely than men to receive insurance through their own employer (34% vs. 45%) and more likely to be covered as a dependent (23% vs. 14%).[1] Further, in 2012, 20% of women 18-64 years of age in the US were uninsured and likely did not qualify for Medicaid or have access to employer-based plans.[1] The ACA will address the insurance needs of women through:

Medicaid expansion. Women will have more access to Medicaid in states that expand eligibility **(See Page 4 for more information about Medicaid expansion)**. Pre-ACA, only low-income women who were pregnant, mothers of children younger than 18 years, or disabled typically qualified for Medicaid (state rules varied). Medicaid expansion will eliminate categorical criteria (i.e., maternity, disability) and extend coverage to **all** individuals below 138% of the FPL; some states will extend coverage to those above this level. Kenney, et al. estimated that, if every state opted into Medicaid expansion, about 7 million women could gain insurance access and about 2.5 million of them would be 45-64 years old.[3] While nation-wide expansion will not happen, the authors showed significant gains in coverage in detailed state-by-state data.

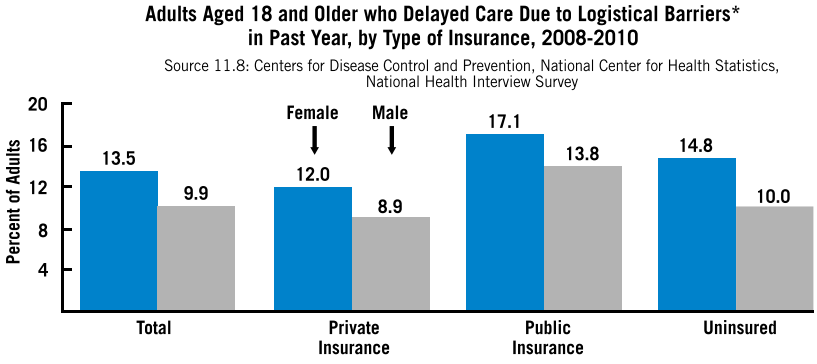
Elimination of sex discrimination in premiums and eligibility. Many insurers have charged women up to 50% more than men for the same insurance plans. A 2012 report of national health plans showed

that, in the 33 states that had not banned or limited "gender rating," 92% of the best-selling insurance plans (only 3% of which included maternity care coverage) were more expensive for 40-year-old women than 40-year-old men.[4] The report further estimated that US women consumers paid more than $1 billion/year more than men for health care insurance, not including their expenses related to excluded maternity care coverage.[4] The ACA requires that insurers stop gender rating in 2014: premiums for women and men must be the same.

Elimination of pre-existing condition clauses. Women have been disproportionately affected by pre-existing eligibility clauses to health insurance. While there is variation among states, some individual health insurance carriers consider pregnancy a pre-existing condition. In 2014, insurers cannot refuse to cover women who have had breast cancer, cesarean deliveries, or any pre-existing condition.

Expanded Insurance Coverage

Coverage for maternity care. In 2012, only nine states required insurers to provide maternity care coverage; even in those states coverage may have been less than comprehensive and not affordable.[4] Most women with employer-based health insurance receive maternity benefits because of state and federal anti-discrimination protections, but there are generally no such protections in the individual insurance market (about 12% of such plans included maternity care in 2012).[4] In 2014, all plans sold inside the ACA's health insurance exchanges—and all new plans sold outside of the exchanges—will be required to cover maternity and newborn care as an "essential health benefit" (see page 5). Lactation support, counseling, and supplies (e.g., pumps) will be covered without co-pay or cost-sharing as long as the woman is breastfeeding. The ACA offers the first national standard for breastfeeding employees: employers will have to offer hourly nursing employees a clean and safe space (not a bathroom) in which to pump milk. For Medicaid recipients in some states, mandates will require coverage for comprehensive smoking cessation programs for pregnant women and



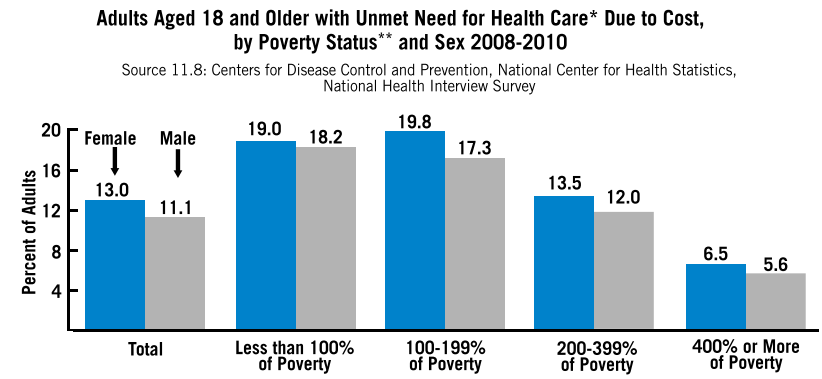


Figure 1. Women: Delayed Care and Unmet Need

Source: Women's Health USA, 2012.[2]

support for midwives, birth attendants, and birth centers.

No co-pays for preventive care. Starting in 2011, all new insurance plans must cover key prevention services, like contraception, well-woman exams (more than one visit/year if needed), and breast and cervical cancer screenings. In 2014, the ACA requires that new private plans cover even more preventive services and vaccines recommended by federally sponsored committees ("essential health benefits") without co-pays or other cost sharing, including bone density tests, the HPV vaccine, annual screening for sexually transmitted infections, and screening for domestic violence. Women may also receive genetic testing and counseling about the breast cancer susceptibility gene (i.e., BRCA).

Coverage for reproductive health services. The following are highlights about this special class of preventive services:

- **Contraceptives.** All FDA-approved contraceptive methods (i.e., plans cannot exclude any FDA-approved contraceptive), sterilization procedures, education, counseling and management services about contraceptive methods have been covered since 2012. **Contraceptive services for men (e.g., condoms, vasectomies) are not covered under the ACA.** Contraceptive coverage is controversial and may change with pending legislation (as of August 2013, there were 41 pending legal cases challenging the contraceptive coverage).
- **Abortion.** Where not restricted by state law, abortion may be included in health coverage. As of September 2013, 23 states banned abortion coverage by insurance sold in the health marketplaces (eight

of those states also banned abortion coverage for insurance plans outside of the exchanges). The ACA stipulates that health plans cannot be required to cover abortion. If abortion is covered, tax credits or cost-sharing (i.e., federal funds) cannot be used for abortion services not covered by the Hyde Amendment. This amendment restricts abortions to pregnancies caused by rape or incest, or that endanger the life of the woman.

US women consumers paid more than $1 billion/year more than men for health care insurance, not including their expenses related to excluded maternity care coverage

Expanded coverage for senior women. As enumerated in a report by the National Partnership for Women and Families,[5] the ACA expands coverage for senior women (and men) by:

- **Filling gaps in Medicare coverage.** Before the ACA, Medicare did not cover annual wellness visits or some preventive services (e.g., cancer and heart disease screenings, bone density tests). In 2011, Medicare beneficiaries became eligible for such services without co-pays.
- **Closing Medicare's "donut hole".** As described by the National Partnership for Women and Families,[5] the "donut hole" refers to the following provision of the Medicare Part D benefit: Medicare beneficiaries paid 25% of the cost of their prescription drugs (after paying their deductible) and Medicare covered the remaining 75% until the annual costs reached $2,840. At this point—the "donut hole"—Medicare paid nothing and beneficiaries paid the full cost of prescriptions until they paid $4,700 out of pocket. After they reach this "catastrophic cap" their prescription drug costs went down. It is estimated that 16% of Medicare beneficiaries reached this point every year—with women most likely to do so.[6]

  In 2011, the ACA started to close the "donut hole" by reducing the cost of brand-name drugs for Medicare beneficiaries. The U.S. Department of Health and Human Services estimated that 2.05 million women saved $1.2 billion on their prescription drugs in the first year.[6] By 2020, the "donut hole" will close: beneficiaries will have to cover 25% of prescription drug costs until the "catastrophic cap" is reached. After that, they will pay 5% of drug costs.[5]
- **Improving health services delivery.** Many of the funded initiatives of the ACA are specifically designed to help seniors and individuals with chronic diseases. The ACA created the Center for Medicare & Medicaid Innovation Program to test, evaluate and rapidly expand new care delivery models that improve quality and care coordination. Such models include Patient-Centered Medical Home and a Medicare-shared Savings Program that provides incentives for health care providers to coordinate treatment of an individual across care settings. The ACA provides funds to hospitals and community-based groups to provide transitional care to high-risk Medicare beneficiaries (e.g., funds to reduce re-hospitalizations). The Geriatric Education Centers are important for women who are both caregivers and recipients, as they provide "…support training in geriatrics, chronic care management, and long-term care for family caregivers, as well as health professionals and direct care workers."[5] The ACA also provides bonuses to primary care providers, include those in geriatrics.

Conclusion

Through the elimination of discriminatory practices, extended coverage, and health systems reform, the ACA has the potential to improve the health of women of all ages and at all income levels. Despite anticipated gains in women's health, there will likely be continued disparities related to variations in state decisions to expand Medicaid and in their mandates about benefits that must be covered by insurers; logistical issues; key stakeholder opposition to reproductive health service coverage; and the legislative battles about specific ACA provisions.[7]

For More Information

1. The National Women's Law Center has many up-to-date factsheets about women and the Affordable Care Act from: http://www.nwlc.org/our-issues/health-care-%2526-reproductive-rights/health-care-reform.

2. The National Partnership for Women and Families has several resources about the Affordable Care Act from: http://www.nationalpartnership.org/site/PageServer?pagename=issues_health_reform_anniversary

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Immigrant Access to Health Care

Fewer Resources, Less Political Will to Provide Safety Net Service

by Jessie Kemmick Pintor, MPH, and Lynn A. Blewett, PhD

Immigrants make up the fastest-growing group in the US, representing 13% of the population in 2011. The proportion of Minnesota residents that are immigrants has increased by 38% over the past decade, and in 2011 immigrants represented 7% of the state's population, or 389,000 residents.[1] (Note: these figures include only immigrants and exclude any children of immigrants who were born in the US.)

While the US explicitly restricts access to private and public health insurance coverage for immigrants, both documented and undocumented, we implicitly rely on our formal and informal safety nets to provide medical care for them when they need it

Numerous federal policies enacted over the past two decades have had a significant impact on immigrants' access to health care, and the 2010 Patient Protection and Affordable Care Act (ACA) is no exception. This article reviews the key provisions of national legislation pertaining to access to care for immigrants, highlighting the most recent provisions of the ACA.

Immigrants in Minnesota

As shown on Figure 1, Minnesota is home to immigrants from around the world. Almost one-fifth of the state's immigrants come from Mexico (17%), the largest single category of immigration, followed by immigrants from Europe (14%). Africa is also a leading source of immigration, making up 20% of the immigrant population when the African categories are combined.[1]

Immigrants can be in the US as either naturalized citizens or non-citizens. Non-citizens may be here either with or without authorization (Table 1), or fall within a number of temporary status categories. In the US and in Minnesota, non-citizens are more likely to be from young, working families: over two-thirds are in the 18–44 age range; more than half are married; and two-thirds reside in households with children present. While most immigrants are working, non-citizens are much more likely to have incomes below the poverty level. Across the US and in Minnesota, non-citizens are four times more likely to be uninsured than their citizen counterparts.[2]

Federal Policies on Immigrant Access to Coverage

Prior to 1996, legal permanent residents and their children were eligible for health care coverage under the Medicaid program if they met state-specific income and asset eligibility criteria. Undocumented immigrants and "non-immigrants" were not eligible for Medicaid or any other federally funded public programs, and they remain ineligible to this day. In 1996, President Clinton signed the Illegal Immigration and Immigrant Responsibility Act and the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which restructured the US welfare system and had a significant impact on legal permanent residents' access to federally funded programs. Under the legislation, legal permanent residents lost eligibility for all means-tested, federally funded programs, including Medicaid, for the first five years that they were in the US. Post-1996, states had to proactively enact their own legislation to cover undocumented immigrants or legal permanent residents subject to the five-year ban. As of January 2013, 15 states, including Minnesota, had opted to do so.[2]

Policies constructed over the next decade attempted to open up coverage for immigrant pregnant women and children. The State Children's Health Insurance Program (CHIP) Unborn Child Amendment of 2002 provided states with the option of using federal matching funds to cover care for pregnant women regardless of

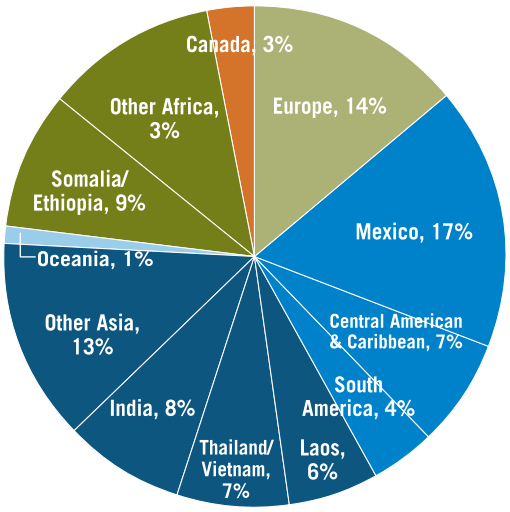

Figure 1. Countries of Origin: Minnesota's Immigrants, 2011

Source: 2011 American Community Survey, US Census Bureau

immigration status. Once again, coverage would be extended only to states proactively pursuing (and passing) legislation to cover prenatal care for these women and care was "officially" provided or justified only for the "unborn child" whose immigration status was unknown—not the pregnant woman herself.

Legislation passed in 2009—the Immigrant Children's Health Improvement Act—once again gave states the option to cover legal permanent resident pregnant women and children currently subject to the five-year ban and to receive federal financial matching payments to assist with the cost of coverage. As of January 2013, 24 states and the District of Columbia (DC) had opted to cover legal permanent resident children and 20 states and DC covered pregnant women during the five-year waiting period; Minnesota covers both groups.[2]

Finally, the ACA—signed into law in March 2010—will increase access to affordable health insurance for millions of Americans but has specifically excluded many immigrants. Improved access to affordable coverage, both public and private, will be facilitated through the implementation of federal and state health insurance exchanges; Medicaid expansions for all persons under age 65 with family incomes up to 138% of the federal poverty level (FPL) (133% FPL plus a 5% income adjustment); and an individual mandate that will require all US citizens (and legal permanent residents) to purchase health insurance coverage in 2014. Despite these far-reaching expansions, about 29 million people will continue to be uninsured as of 2017,[3] including a substantial proportion of the population due to their immigration status.

Significant Barriers to Access to Care

Since 1996, significant restrictions on access to public health benefits have been placed on both documented and undocumented immigrants. The ACA has not addressed the health care needs of immigrants under health reform. Under the ACA, in most circumstances, legal permanent residents are still subject to the five-year ban and undocumented immigrants—regardless of length of time in the US—will remain ineligible for public program coverage through Medicaid or CHIP. Undocumented immigrants are also specifically prohibited from purchasing coverage in federal and state insurance exchanges as the ACA requires that individuals purchasing exchange-based coverage meet citizenship/legal eligibility requirements. Undocumented immigrants are exempt from the individual mandate, along with a small group of individuals including, American Indians and those with financial hardship or religious objections.

States have had some flexibility in providing coverage for excluded immigrant pregnant women under the re-authorization of the CHIP, but only about half of all states have opted for this specific and targeted expansion. Illinois, New York, Massachusetts, and Washington, as well as DC and several counties in California, have pursued state or locally funded children's health insurance programs following a "Cover All Kids" strategy, with no federal financial support. The expansion of state-sponsored children's programs is highly unlikely given the downturn in the economy, state budget deficits, and the growing political divide between the two governing political parties.

Conclusion

Who will provide care to our immigrant population? Interestingly, while the US explicitly restricts access to private and public health insurance coverage for immigrants, both documented and undocumented, we implicitly rely on our formal and informal safety nets to provide medical care for them when they need it. Hospitals that provide services to Medicare and Medicaid recipients must triage all patients and admit those who are in an emergency situation, regardless of legal status and regardless of health insurance

TABLE 1. IMMIGRANT STATUS OF NON-CITIZENS

Non-citizens include legal immigrants, non-immigrants, and undocumented immigrants

- **"Legal" immigrants** are legal permanent residents ("green card" holders), asylees and refugees, and some other immigrants with unique situations.
- **"Non-immigrants"** are individuals in the US on a temporary tourist, student, or work visa.
- **Undocumented immigrants*** are persons who: 1) have entered the country without approval from immigration authorities, or 2) have violated the terms of a temporary admission (e.g. overstaying a tourist/student visa without status adjustment.*

*It is estimated that of all undocumented immigrants currently in the US, slightly more than half entered without approval, while others have overstayed a temporary visa.

coverage status. Those without coverage often wait until their health problems have reached a crisis state before seeking care—often in the emergency room of a community hospital or at a tax-supported local public hospital whose mission is to provide care to the poor and underserved.

Community Health Centers (CHCs, also known as Federally Qualified Health Centers)—nonprofit clinics located in medically underserved areas, both urban and rural—share a mission of making comprehensive primary care accessible to anyone regardless of insurance status, immigrant status, or ability to pay. The small but growing network of 17 CHCs operating in over 70 locations in Minnesota has played an essential role in facilitating care for immigrants, providing basic primary care as legal residents wait for the five-year ban to expire and as undocumented families obtain basic checkups and primary care services for their children. In light of the growing restrictions under health reform, CHCs will play an even more pronounced role in covering insurance gaps for immigrants.

It is a difficult time to be talking about doing more when there is less funding at both the state and national levels, and less political will to provide the basic safety net services to those in need. We are likely to see lower state and federal tax revenue, targeted to fewer and more narrowly defined US populations.

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HOW DOES THE AFFORDABLE CARE ACT AFFECT INDIVIDUAL STATES?

Because most individuals in the US receive health care insurance through their employers, the implementation of the ACA in 2014 will not change their source for insurance. There are two good resources about the potential individual state impact of the Affordable Care Act (ACA):

1. The US Department of Health and Human Services (HHS) has a state-by-state ACA impact statement at http://www.hhs.gov/healthcare/facts/bystate/statebystate.html The statement uses estimates from a number of data sources, including the American Community Survey (ACS), the National Health Interview Survey (NHIS), and the Medical Expenditure Panel Survey (MEPS), to provide information for every state on several impact measures. These measures include: the number and demographics of uninsured individuals who are eligible for Marketplace coverage, the number of young adults who have gained coverage through the young adult dependent coverage expansion, the number of Pre-Existing Condition Insurance Plan (PCIP) enrollees, and how the health systems reforms will affect the state.

2. The Henry J. Kaiser Family Foundation developed an interactive tool to that shows how the ACA will affect communities throughout the US. One interactive map focuses on increases in the number of people who will be enrolled in Medicaid and the other map focuses on the future reductions in the number of people who are uninsured. The maps are at: http://bit.ly/1eb7TqF

SWITZERLAND HAS A HEALTH INSURANCE SYSTEM SIMILAR TO THE AFFORDABLE CARE ACT

The Swiss system, enacted in 1996, is probably the closest model to the emerging US system of providing health insurance. It encourages competition; insurers are required to provide insurance to everyone, irrespective of age or medical condition; and citizens are required to purchase insurance. It is de-centralized among 26 canons (geographic areas) in Switzerland. Like the Affordable Care Act (ACA), Switzerland regulates insurers and has a prescribed package of health/medical care that must be covered. Unlike the ACA, employers don't offer insurance; the Swiss choose from among 92 insurers. Like the ACA, lower income families receive a subsidy for their insurance premiums (monthly premiums in Switzerland cannot exceed 8% of personal income). Ninety-nine percent of the Swiss are insured (the uninsured are mostly new immigrants). A nationally representative (age, sex) sample of 1,000 Swiss adults, aged 18 and older, in April 2011, reported that their health system worked fairly well (10% gave it a grade of "A" and 43% a grade of "B"), although the respondents shared concerns about efficiency and costs (http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_Switzerland2011ConsumerSurvey_091911.pdf).

The Affordable Care Act and Children

by Charles N. Oberg, MD, MPH

The Patient Protection and Affordable Care Act (ACA), when passed and signed into law on March 23, 2010, was intended to expand access, reduce cost and improve the quality of health for all Americans. There were a number of components of the ACA designed to specifically meet the needs of children and youth, including changes to both the private and public health sectors, as well as an emphasis on expanding benefits and promoting primary care and prevention. A recent study by Georgetown University Health Policy Institute's Center for Children and their Families estimates that the overall number of uninsured children has actually decreased from 6.4 million children in 2009 to 5.5 million in 2011, in part due to the adoption of some of the early provisions of the ACA.[1]

The ACA's expansions should ensure that children have access to affordable quality care, regardless of their parents' household financial situation or their employment status

The Private Health Insurance Market

There are several ACA provisions that affect the private health insurance market directly. The first is the extension of dependent coverage for youth up to the age of 26 years that allow them to stay on their parents' health care plan. This stipulation applies to all plans in the individual market, all new employer plans, and existing employer plans if the young adult is not eligible for employer coverage on his or her own. In addition, beginning in 2014, children up to age 26 years of age can stay on their parent's employer plan even if they have an offer of coverage through their employer. The second major change in the private insurance market has been the prohibition of insurers from excluding coverage of children because of pre-existing conditions. The inability of children with pre-existing conditions to obtain health insurance has been a major impediment to access for over the last fifty years. Thirdly, access will be expanded through the creation of state-based health insurance exchanges to offer uninsured families private insurance choices, including multi-state plans to foster competition and increase consumer options. The exchanges will provide a listing of health insurance choices to families who presently lack job-based coverage and will provide a subsidy to families who find the cost of insurance prohibitive. It is hoped that by delivering standardized, easy-to-understand information on different health insurance plans offered in a geographic region, families will have the opportunity to compare prices and health plans and decide which quality, affordable option is right for them and their children. Finally, in regard to private sector changes, the ACA has included pediatric preventive services as part of an Essential Benefit Set (see page 5). This will require new plans to cover prevention and wellness benefits with no deductibles and other cost-sharing requirements. In addition, the Pediatric Benefit Package expands the mandated services to include oral and vision coverage for all children starting in 2014.

Publicly Funded Health Programs

Expansion of publicly funded health programs is also a critical component of the ACA. Medicaid has been the primary insurer of low-income Americans since its inception in 1965. As has been noted in several articles in this issue of *Healthy Generations* (see page 4), the law included the expansion of Medicaid to all Americans making less than 138% of the Federal

Poverty Level (FPL). The Supreme Court's ruling in 2012 on the ACA upheld the law's constitutionality. However, it placed the decision to expand Medicaid coverage in the hands of the states. It should be noted that, if fully implemented, there would be 22.3 million uninsured individuals with incomes less than the 138% FPL threshold who would be eligible if all states participated. However, there are a number of Medicaid and Children's Health Insurance Program (CHIP) provisions that will be instituted even if states choose not to expand the eligibility threshold.

CHIP was first enacted in 2006 and was designed to extend coverage to uninsured children. The initial legislation provided three options to states, which included expansion of a state's Medicaid program, the creation of new initiatives directed toward uninsured children and/or a combination of both options. The ACA re-authorized CHIP and extended federal funding through September 30, 2015. Despite the past success of previous Medicaid expansions and the creation of the CHIP program, there remain an estimated 2.9 million children who are presently eligible for Medicaid or CHIP who are not enrolled.[2] The ACA provides funding for increased outreach efforts to expand enrollment of eligible children to address this issue.

Finally, the ACA attempts to identify other vulnerable childhood populations that have traditionally lacked access to care. In particular, there are provisions addressing the lack of coverage for children in the foster care system. Specifically, children aging out of the foster care system face many challenges, including finding quality, affordable health insurance. The ACA provides expanded coverage for children aging out of foster care by mandating Medicaid coverage for them up to age 26, effective 2014.

Reduction in Costs

Cost will also be reduced both for families with children, as well as hopefully for the entire health care system. The ACA eliminates all lifetime limits on insurance companies' coverage for beneficiaries who get sick and bans insurance companies from dropping people from coverage when they become ill. In 2014, all annual limits for health insurers will be prohibited. It should be noted that two-thirds of middle class families with access to employer-based coverage said their children remained uninsured because the health plans' deductibles, co-payments and limits on coverage were too prohibitive to allow them to selected dependent coverage for their family.[3] These reforms will help reduce health care costs for families and help to ensure more children are covered. Going forward, plans in the new Health Insurance Exchanges and all new plans will have a cap on what insurance companies can require beneficiaries to pay in out-of-pocket expenses, such as co-pays and deductibles.

Promoting Prevention and Primary Care

Increased access to primary care providers for children was also included in the law. The ACA expands the primary care workforce of pediatricians, pediatric nurse practitioners, specialists in pediatrics, and pediatric oral health professionals to ensure that children will have access to high quality health care. Parents who enroll in new plans will be allowed to select their child's pediatrician among a list of participating providers. In addition, the ACA expanded access to Medicaid for children by increasing reimbursement rates for primary care. As of January 1, 2013, Medicaid payment rates were raised to at least Medicare rates for primary care and immunization services until 2015.[4] A recent article estimates that expansion of the primary care components of the ACA will substantially increase primary care utilization.[5]

The ACA also promotes new prevention programs designed to improve the care that the Nation's children receive. An example is an initiative to address childhood obesity by providing $25 million in funding for the Childhood Obesity Demonstration Project. The effort will award grants to states to develop comprehensive and systematic approaches for reducing childhood obesity. This initiative is designed to provide guidance to health care providers on obesity prevention strategies and expand the array of services available to Medicaid enrollees. In addition, it will require each state to design a public awareness campaign for such services.

In conclusion, children who are uninsured have decreased access to well-child care, immunizations, basic dental services, and prescription medication. The ACA's expansions should ensure that children have access to affordable quality care, regardless of their parents' household financial situation or their employment status. In addition, the expansion of preventive and primary care should enhance their health, development and overall well-being, laying the foundation for a healthy life.

For More Information

First Focus on their Web Page provides a summary of positive impact that the ACA will have for children and is entitled, "Top 10 Affordable Care Act Wins for Kids" and can be accessed at, http://www.firstfocus.net/top-10-affordable-care-act-wins-for-kids-0%20

The Children's Defense Fund provides an informative snapshot on the state of health for America's Children on their Web Page and can be accessed at, http://www.childrensdefense.org/policy-priorities/childrens-health/

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The Affordable Care Act

Children and Youth with Special Health Care Needs (CYSHCN)

by Zobeida Bonilla, MPH, PhD

The Maternal and Child Health Bureau (MCHB) defines the population of children and youth with special health care needs (CYSHCN) as "...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[1] An estimated 15% of children and youth (birth to 17) in the US have a special health care need.[2] Several provisions of the Affordable Care Act (ACA) will directly affect CYSHCN.

The ACA's expansions should ensure that children have access to affordable quality care, regardless of their parents' household financial situation or their employment status

The ACA will provide coverage to CYSHCN that is universal, continuous, adequate, and affordable in four major areas:[3]

- "Covering more children and youth;
- Closing benefits gaps;
- Paying for services that were not covered prior to the ACA; and
- Building capacity in health care systems."[3]

ACA Provisions That Affect CYSHCN

There are several provisions in the ACA that directly affect CYSHCN. The following summarizes ten such provisions, as described by AMCHP[3,4] and the Catalyst Center:[5]

1. No denial of coverage by private insurance companies because of pre-existing conditions (Section 2704)

Preexisting conditions were barriers to coverage and service gaps for CYSHCN before the implementation of the ACA. Private insurance can no longer deny coverage for pre-existing conditions. This became effective for children up to 19 years of age in September 23, 2010.

2. New coverage under the PCIP option of the ACA (Section 1101)

Although most children are covered under private insurance, Medicaid, or a combination of both,[2] the new coverage option under the Pre-existing Condition Insurance Plan (PCIP) can benefit some uninsured CYSHCN and young adults. Medicaid and the Children's Health Insurance Program (CHIP) are available to CYSHCN, but this option may be attractive to CYSHCN and young adults who are not eligible for coverage, such as "those who have been uninsured for six months or more, whose countable income is higher than their state's Medicaid or CHIP program eligibility, and/or whose age (over 18) means they are not yet protected by section 2704."[3]

3. No annual and lifetime benefit caps (Section 2711)

Under the ACA, there are no annual and lifetime benefit caps for children and adults. The first requirements of this provision went into effect on September 23, 2010, which helps families cover the care of children who have high medical costs.

4. Young adults covered under parents' policy (Section 2714)

The ACA allows coverage of young adults on the parent's policy until the age of 26.

5. Required coverage of preventive services (Section 2714)

Preventive care and screening, critical to CYSHCN, are required under the ACA with no cost sharing.

6. Medicaid coverage expansion (Sections 2001, 2002, 2004)

Fifty-two percent of CYSHCN with autism spectrum disorder conditions, and 42% of CYSHCN with other conditions, receive Medicaid/CHIP, either as their sole source of health insurance or as a supplement to their private coverage.[4] While states have the option to NOT expand Medicaid to special populations (i.e., non-disabled, childless, not pregnant adults), there is a mandatory change in Medicaid eligibility of children (younger than 19 years old) that will take effect on January 1, 2014 in every state. Income Medicaid eligibility for every child will go up to 133% of the federal poverty level (FPL). Also beginning in 2014: children with family incomes under 133% of the FPL who are receiving CHIP will be moved to Medicaid and will thus have access to Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) Program. This program provides early and periodic screenings to identify and treat any physical, mental, developmental, or other health needs. EPSDT is especially important for CYSHCN who often require specialized health services. EPSDT guarantees that if a child has a medically necessary health care need, the state's Medicaid program must provide it, even if the service is not included in the state's list of covered benefits.

7. Maintenance of Effort (MOE) (Section 2001(b))

Under the MOE provisions, states cannot change the income eligibility criteria and enrollment procedures for Medicaid and CHIP that were in place when the ACA went into effect on March 23, 2010.

8. Coordinated and simplified application process (Section 1413)

New coordination among Medicaid, CHIP and the state and federal Exchanges will facilitate the application process for families through a simpler application process that will screen applicants for "eligibility in their state's Medicaid and CHIP program and for premium tax credits through the Exchange."[3] This coordinated application process is also known as "no wrong door."

9. Help navigating the system (Section 1002)

ACA grants to the states will create consumer assistance programs that will help everyone (including families with CYSHCN) in navigating the complexities of the system to obtain the care needed. Examples of assistance that these consumer programs can provide include enrollment, benefits counseling, consumer education, and assistance in filing complaints and appeals.

10. Hospice care (Section 2302)

Effective March 23, 2010, children receiving Medicaid or CHIP hospice benefit "may receive care related to their terminal illness concurrently with hospice care"[6]

The implementation of the ACA has already positively impacted the provision of care for many CYSHCN, expanding coverage, increasing accessibility to needed services, and removing barriers to receive needed care. In the future, we hope that more doors to care will open as the full implementation of the ACA goes into effect advancing the health of *all* children throughout their life cycle.

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WHAT IS MCH? WE ARE MCH!

Do you ever wonder how to explain the depth and breadth of MCH public health work? Our HRSA training grant colleagues at the University of South Florida/Tampa developed a series of Prezi presentations to address this issue. Each presentation begins by posing the question, "What is MCH?" It then describes MCH in terms of our work with individuals, families, and communities. The Prezi presentations end with brief "stories" that were submitted by our University of Minnesota Center for Leadership Education in MCH, and other HRSA-funded training grant colleagues across the nation, to describe our varied work. There are four Prezi presentations available at the following links. The main one is the longest version; the mini-Prezis can be quickly viewed and each has different stories from the main Prezi. Take a look—you might recognize a story from someone you know!

- "We are MCH" Main Prezi: http://prezi.com/rz0qkn_wwzvp/we-are-mch/
- "We are MCH" Mini #1: http://prezi.com/c7e6u6hpyk2u/we-are-mch-mini-1/
- "We are MCH" Mini #2: http://prezi.com/wc9jvevjv3nz/we-are-mch-mini-2/
- "We are MCH" Mini #3: http://prezi.com/kyjdfgl9b17o/we-are-mch-mini-3/

Adolescents and Young Adults

Will the Primary Prevention Initiatives of the Affordable Care Act Affect Life Course Health and Well-Being?

by Wendy L. Hellerstedt, MPH, PhD

Adolescence and young adulthood are generally periods of good health. For example, according to the National Health Interview Survey (NHIS) in 2011, 81% of 12-17 year-olds stated they were in excellent or very good health.[1] Five percent reported that they missed 11 or more days of school in the past 12 months because of injury or illness.[1] However, adolescence and young adulthood are also times for the onset of health conditions and of health-promoting or health-defeating behaviors. For example, US survey data show that:

- An estimated 18.4% of 12-19 year-olds was obese in 2009-2010;[2]
- Drug use is generally highest among 18-25 year-olds compared to any age group: in 2010, in the past month, 21.5% reported any illicit drug use; 18.5% reported marijuana use; 41% reported any tobacco use; 14% reported heavy habitual alcohol use; and 41% reported binge drinking.[3]
- Adolescence and young adulthood are important periods for reproductive and sexual health. For example, the Centers for Disease Control and Prevention estimates that over half of the 20 million new cases of sexually transmitted infections in the US occur among 15-24 year-olds;[4] and
- Young people have chronic medical conditions (e.g., 14% of adolescents report being diagnosed with asthma).[1]

Thus, while adolescents and young adults are generally healthy, they have health care needs for immunizations, behavioral counseling, and medical treatment. In the US, however, many young people lack health insurance (private or public). According to the 2011 NHIS, 26% of 18-24 year-olds were without health insurance at the time of the survey (Figure 1), with the percentage being greater (36%) for those not insured for at least part of the past year.[5] NHIS estimates indicate that 5.2 million children younger than 19 years and 8.4 million 19-25 year-olds in the US were not insured at the time of the 2011 survey; 8.1 million children younger than 19 years and 10.8 million 19-25 year-olds were not insured for at least part of the year prior to the survey.[5]

While adolescents and young adults are generally healthy, they have health care needs for immunizations, behavioral counseling, and medical treatment

There are many reasons why young adults, especially, have low insurance rates in the US. They are more likely than other adults to be unemployed. Among those who are employed, many work at part-time and/or entry-level positions without access to employer coverage. Also, prior to the Affordable Care Act (ACA), many young adults did not meet the criteria for Medicaid coverage (i.e., they were not parents of a minor child or disabled). The following are some ways the ACA will affect the health of young people:

- **Increased numbers of insured young people** because of Medicaid expansion, expanded dependent coverage (as of 2010) on parents' insurance until age 26, coverage of children in the foster care system to age 26, and mandated private insurance requirements. The NHIS has already shown a positive effect on youth insurance rates that are likely the result of the ACA's expansion of dependent coverage. There has been an 8.3% increase in young adults with insurance between September 2010 and June 2011 (approximately 2.5 million young adults).[5] The insurance gains occurred for black, white, Asian, American Indian and Hispanic youth, with the greatest gains among minority race youth.[6] It is

likely that Medicaid expansion and the insurance mandates will further increase youth insurance rates.

- **Assurance of essential benefits.** Like all Americans, insured youth will be guaranteed coverage for the "essential health benefits" (see page 5), emphasizing preventive services, including mental health and substance use treatment. This is especially important because youth is a time of substance use experimentation and onset of mental health problems. Symptoms of lifetime diagnosable mental health problems occur by age 14 for about half of the affected population; almost three-quarters of those with lifetime mental health problems experience symptoms by 24 years of age.[7]
- **Better medical care for vulnerable youth.** Certain vulnerable youth groups may especially benefit from Medicaid expansion, including homeless youth and those who have been involved in the criminal justice system. As described by English, et al., "Each of these groups is at high risk for having multiple serious health problems, including mental health and substance abuse disorders. They also frequently have encountered severe difficulties accessing needed medical care. States [AZ, ME, NY] that have expanded Medicaid in the past to childless adults have experienced significant enrollment by these groups… benefits included improved access to care and self-reported health, as well as decreased mortality."[8]
- **More access to sexual health education for students.** The ACA provides $75 million per year from 2010-2014 through the Personal Responsibility Education Program (PREP), a state grant program to fund comprehensive approaches to sexuality education. In 2013, 49 states received such funds. The ACA also re-instated the Title V Abstinence-only education program ($50 million per year from 2010-2014). In 2012, 36 states received grants from this program.

Conclusion

Like older people, youth will benefit from the ACA provisions that are meant to improve insurance access: for example, they will be eligible for subsidies to help pay insurance premiums and those with pre-existing conditions will be able to buy insurance. The minimum essential health benefits, which will ensure access to immunizations, mental health and substance use treatment, and chronic disease screenings, may be especially important for young people. Primary prevention programs, as well as initiatives that promote early diagnoses and treatment, will likely have a significant effect on life course health and well-being.

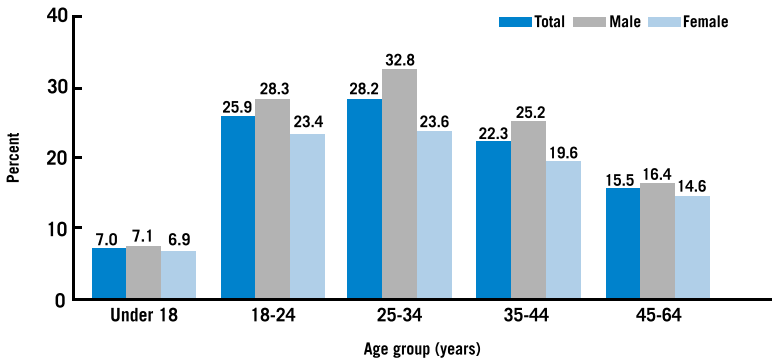

Figure 1. Percent of non-institutionalized civilians, younger than age 65, without health insurance at the time of the interview, by age and sex, 2011 National Health Interview Survey.

Source: Cohen and Martinez, 2012[5]

For More Information

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Immunization in Minnesota:

Expanded Possibilities

by Michaela McDonald

Immunization is important throughout the life course.

— Annie Fedorowicz

Annie Fedorowicz, MPH, earned her degree in Maternal and Child Health at the University of Minnesota in 2012. After graduation, she accepted a position as an Adult Immunization Outreach Specialist in the Immunization, TB & International Health Section at the Minnesota Department of Health (MDH). Ms. Fedorowicz shared her excitement about how the Affordable Care Act (ACA) will improve immunization rates in Minnesota.

Healthy Generations (HG): What are some key things that our readers might want to know about the status of immunization in Minnesota?

Annie Fedorowicz (AF): The good news is that Minnesota's vaccine coverage rates are higher than national rates. We have a really robust program here with extensive partnerships in the private and public sector. However, specific adolescent and most adult coverage rates are well below our Healthy People 2020 (HP2020) goals, while pediatric rates are closer to these goals. HP2020 goals are used as a benchmark for our child, adolescent, and adult immunization rates.

The coverage rate goals for HP2020 are 80-90% for various immunizations. For completion of the childhood diphtheria, tetanus toxoid, and acellular pertussis series (DTaP), the estimated national coverage was 83.5% among children born in July 2008–November 2010 and the Minnesota coverage was 88.8% for children born during this same time period.[1] Nationally, 33.4% of adolescents (13–17 year olds) and 33.1% of Minnesota adolescents completed their 3-dose HPV series in 2012, while tetanus, diphtheria, and pertussis booster (Tdap) coverage nationally was 84.6% and in Minnesota was 85.6% in that same year.[2] During the 2011-2012 influenza season, approximately 38.8% of adults in the United States received their seasonal flu shot, while coverage was slightly higher in Minnesota, with 45.6% adults receiving their flu shot.[3]

HG: What about adult immunization?

AF: Immunization is important throughout the life course. Adult immunization doesn't get the same attention that childhood immunization gets. We are consistently trying to incorporate messaging about adult immunization into our programs and educational outreach. Adult schedules[4] provide information about how adults who missed immunizations as children or adolescents can "catch-up," as well as provide universal recommendation, such as seasonal flu and Tdap. There are also specific immunization recommendations for pregnant women, adults living with special health conditions, adults with behavioral risk factors, and older adults.[5]

Adult immunization rates remain low in Minnesota and across the country. We are actively trying to engage providers in non-traditional settings and expand provider partnerships to augment our adult immunization coverage. The majority of children are receiving their flu immunizations in clinical settings, while adults are receiving their flu immunizations at pharmacies and stores, worksites, and other non-medical places.[6] Therefore, we are providing resources and supporting non-traditional providers to help ensure that adults receive appropriate immunizations at convenient locations.

HG: What is the focus of the Immunization Program at the Minnesota Department of Health?

AF: We are focusing on three goals in the next 5 or 10 years, some of which are tied to Prevention and Public Health Fund (PPHF) grants through the ACA. The first goal is to improve public confidence in immunization, to reduce the number of people in Minnesota who are "vaccine-hesitant." The second goal is to broaden and deepen provider relationships, including those who work in non-traditional immunization sites, such as worksites, community settings, and pharmacies. And the third goal is to continue outreach to un- and under-immunized people, which includes maintaining safety net programs.

Two MDH programs focus on reducing financial barriers and increasing accessibility to adult and childhood-recommended vaccines. The first, The Minnesota Vaccines for Children (MnVFC) program, is Minnesota's version of the federal VFC program. It provides free vaccines to uninsured children and children who participate in one of Minnesota's Medicaid programs. Over 800 clinics are enrolled in the MnVFC program throughout the state of Minnesota. The second, the Uninsured and Underinsured Adult Vaccine (UUAV) program, provides vaccines to uninsured and underinsured adults at over 100 select safety-net clinics throughout Minnesota.

There is also a new focus on making the best possible use of available immunization data. The Minnesota Immunization Information Connection (MIIC) is a system that stores electronic immunization records. MIIC makes keeping track of immunizations easier and helps ensure Minnesotans get the right vaccines at the right time. Recently, MIIC has been working on expanding immunization assessment capabilities to include adolescents and improving its reminder/recall functions.

HG: How important are local health departments (LHD) to immunization coverage?

AF: Extremely important. LHDs have their own missions and operations. They work both independently and with MDH to improve the health of all Minnesotans. For example, during the H1N1 influenza outbreak in 2009 and 2010, LHDs directly provided over 264,000 immunizations and were instrumental in ensuring access to anti-viral medications. LHDs are also MnVFC providers, and help coordinate immunization programs in schools, worksites and other community settings.

HG: How could the ACA affect immunization rates?

AF: Immunizations are covered as essential benefits under the ACA. The ACA will affect rates in two ways. First, the ACA requires most health plans to cover recommended preventive services, including immunizations, without cost sharing. This means that immunizations will be a covered service in most plans, and will be covered even if a deductible is unmet and without co-pays. Second, many more people will be insured due to Medicaid expansion and the introduction of health insurance exchanges.

HG: Tell us how your work at MDH may help local health departments navigate the changing health insurance landscape as a result of the ACA.

AF: As access to health insurance expands under the ACA, LHDs may choose to develop billing systems to take advantage of revenue streams. In the fall of 2012, we received a grant from the Centers for Disease Control and Prevention (CDC), through the Prevention and Public Health Fund (PPHF) of the ACA to work on a set of activities to make it easier for immunization providers in Minnesota (especially LHDs) to maximize their billing and reimbursement capacity.

HG: What kind of activities will the Immunization Program at MDH undertake to help providers understand how to bill for immunization services under the ACA?

AF: We are doing a variety of things to better understand the current billing landscape in Minnesota. MDH will create useful resources that address the billing issues identified through the assessment phase of this project. These resources will also provide guidance to support LHDs (and other providers) in expanding their capacity to bill for immunization services.

THE MINNESOTA DEPARTMENT OF HEALTH NATIONALLY RECOGNIZED FOR EFFORTS TO INCREASE IMMUNIZATIONS AMONG UNINSURED AND UNDERINSURED ADULTS

In May 2013, The National Influenza Vaccine Summit (NIVS), coordinated by the American Medical Association and the Centers for Disease Control and Prevention, presented one of five Immunization Excellence Awards to the Minnesota Department of Health (MDH). These awards recognize individuals or organizations that have made extraordinary contributions towards improving adult and/or childhood influenza vaccination rates in their communities during the 2012-13 influenza season. MDH was the first to receive an award in the new category recognizing activities focused on the adult population beyond influenza: *Overall Adult Immunization Activities—Beyond Flu.*

In January 2011, Minnesota's federally funded Uninsured and Underinsured Adult Vaccine (UUAV) Program (http://www.health.state.mn.us/divs/idepc/immunize/adultvax/index.html) began providing free immunizations for qualifying adults via public and private health clinics in Minnesota. Since that time, it has provided more than 65,000 immunizations at 156 sites across the state for adults who lack health insurance or who have insurance that does not cover immunizations.

For More Information

1. Minnesota Department of Health, Immunization Program. Available from: http://www.health.state.mn.us/immunize

2. Immunization Action Coalition. A nonprofit organization for individuals and providers with many reports and briefs about immunization. Its focus is on broad, national education, rather than local resources or programs. Available from: http://www.immunize.org/

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Interested in Making a Difference?

Consider a Master's in Public Health (MPH) Degree in Maternal and Child Health

by Michaela McDonald

Jessie Kemmick Pintor received her Masters in Public Health (MPH) in Maternal and Child Health (MCH) in 2009, with a concentration in Public Policy. She is now a PhD student in Health Services Research, Policy, and Administration and a Research Assistant at the State Health Access Data Assistance Center (SHADAC; http://www.shadac.org/) at the University of Minnesota. Pintor's work at SHADAC allows her to translate data into a usable format for policy-makers at the state level. "I really like policy analysis and providing policymakers with data they can use to better the lives of community members," she said. Her dissertation will be a mixed-methods analysis of whether a parent's immigration status affects health care coverage of the child **(see Pintor's article about the ACA and immigrants on page 23).**

Pintor said that her career in public health began "without my knowledge." After receiving her bachelor's degree in sociology from Concordia University in 2002, Pintor was employed by Centro (http://centromn.org/), a Minneapolis organization that serves Latino immigrants. She had a variety of tasks that she now recognizes as public health work. At Centro, she worked in an early childhood program, helped families apply for medical assistance, and taught sex education to adolescents. The latter role led to her involvement with the Health Commissioner's MCH Advisory Task Force at the Minnesota Department of Health (http://www.health.state.mn.us/divs/fh/mchatf/).

Through Pintor's work with the MCH Advisory Task Force, she was exposed to the idea of obtaining an MPH in MCH at the University of Minnesota. While she never intended to pursue an advanced degree, she realized that the policy and advocacy/practice focus of the MPH would allow her to deepen her work with vulnerable populations, especially Latino immigrant families. MCH faculty, including Lynn Bretl and Carolyn Garcia, helped her clarify her professional goals. Pintor's master's project was derived from an intervention Dr. Garcia conducted to promote coping skills in Latina adolescents. "I was able to be involved in the entire life of that project," she said, "and that was invaluable in terms of skills development."

Pintor continued working with the Latino community while earning her MPH. She facilitated a work group to write sex education into the Minneapolis Public Schools curriculum for the Minneapolis Department of Health and Family Support, contributed to the outreach efforts of the HRSA-funded MCH Training Grant, and conducted rapid HIV testing and outreach in the community with the MN Latino HIV/AIDS Network. "The combination of the work I was doing in the community, along with the courses I was taking in MCH content, advocacy, and policy, made the experience of getting my MPH very rich," she said.

While Pintor may have once been reluctant to pursue a graduate degree, she matriculated into a PhD program in Health Services Research, Policy, and Administration after she earned her MPH in MCH. After working with several faculty members on a variety of research projects, she said she is committed to conducting research that "...integrates the needs and desires of the community and that bridges the divide between academia and the community…Having my foundation in Maternal and Child Health gave me that grounding in advocacy that will forever determine the kind of research that I do: research to inform community and policy efforts to improve the health of vulnerable populations." Recently Pintor received a Health Services Research Dissemination Award from the Agency for Healthcare Research and Quality. After she finishes her PhD, Pintor plans to be an academic researcher who will never lose her community advocacy roots. She looks forward to directing Community-Based Participatory Research (CBPR) projects and mentoring students. "I want to do CBPR projects with students," she said, "and encourage them to have those difficult conversations with community colleagues about what it really means to partner in research and forge connections for years and years."

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THE AFFORDABLE CARE ACT: UNINTENDED CONSEQUENCES

The Affordable Care Act (ACA) is a bold experiment to provide good insurance to Americans. It will likely have some unintended consequences, which may include:

- **Employer and employee burden.** The ACA is not a national health care law. Some of the cost of health insurance will fall upon employers (as it does now). With the mandated requirements (delayed until 2015), employers with 50 or more employees will be required to provide health insurance or pay a heavy penalty. Employer-borne insurance costs are common in the US and thus not new with the ACA: the Kaiser Foundation reports that 95% of employers with 50 or more employees offer health benefits to their employees. There are theoretical concerns that employers may cut employee hours to avoid responsibility for providing health insurance benefits (the mandate only covers employees who work 30 or more hours/week). However, there is also an option for employers to discontinue offering employer-sponsored insurance and send their employees out to the Individual Public Exchange. Employers can either disband coverage completely or they can give their employees a credit toward insurance purchases (e.g., give each employee $200/month toward premium payments). There are also concerns that employees in hospitality, retail, and other service businesses will be unduly burdened as they may live paycheck-to-paycheck and employer-provided insurance premiums may be too high, given that all insurance coverage has to include a minimum set of essential benefits. Some suggest that even with individual subsidies to offset the cost of premiums, very low wage earners may find insurance unaffordable.

- **Insurance premiums may be so high that individuals forego insurance.** The individual adult penalty for foregoing insurance will be low in 2014 ($95/year) but will escalate in subsequent years (e.g., $695 in 2016). If penalties are lower than annual premium costs, there is a risk that healthy individuals, especially, will forego insurance. This would present a personal risk for individuals who choose to be uninsured and an economic risk for insurers because the low insurer costs of healthy people are intended to offset the high costs of insuring people who are ill. However, it is not clear that the ACA will result in higher insurance premiums. For example, in July 2013, New York State insurance regulators reported that insurance premiums under the ACA in 2014 would be at least 50% lower than those available in mid-2013. Their estimates of increased savings for individuals did not even take into account federal insurance subsidies to help individuals pay their premiums. Similarly, *Covered California* announced in July 2013 that the rates for the 2014 individual market ranged from 2% above to 29% below the 2013 average premiums for small employer plans in California's most populous regions.

- **Healthy people will be negatively affected.** One of the intentions of the ACA is to end discrimination against sick people. It is likely that individuals with pre-existing illnesses will have better, and more affordable, insurance because of the ACA. It is thought that the system may raise prices at the low end (younger, healthier people) and reduce them at the high end (older, sicker people). As previously mentioned, there is a concern that healthy people will forego expensive premiums and pay a penalty for their lack of health insurance instead.

- **"High-risk" individuals will have a mixed experience.** "High-risk" individuals, especially those who cannot receive insurance pre-ACA because of pre-existing illnesses, will have access (without excess premiums) to insurance under the ACA. This could be a very positive thing for such individuals who are uninsured. However, the effect on "high risk" individuals who receive some sort of state insurance because of their health condition will likely be variable, especially if they had access (or cheaper access) to expensive treatments under a state plan that will not be available to them after they transfer to Medicaid or an Exchange plan.

- **The Medicaid "welcome mat" will be substantial.** The Medicaid expansion will affect every state's Medicaid program for two reasons: (1) enrollment will likely increase among those who are eligible, but not previously enrolled; and (2) eligibility criteria in some states will expand to make enrollment possible for more people (e.g., adults without children who are not pregnant). A July 2013 analysis by Sonier, Boudreaux, and Blewett in *Health Affairs*—using Massachusetts 2006 health reform data—found a 19% increase in Medicaid enrollment among low-income parents in Massachusetts as a result of the state's health reform law. Their data suggest that states should anticipate significant increases in their Medicaid populations and be prepared to meet such increases in terms of resources and services.

Web Resources: The Patient Protection and Affordable Care Act (ACA)

The following websites—and those listed at the end of several articles in this volume—provide resources about the ACA.

ACA and HIV

http://www.nbgmac.org/uploads/ACA_and_HIV.pdf

Crowley J, & Kates J. The Affordable Care Act, the Supreme Court, and HIV: What Are the Implications. Kaiser Family Foundation, ed. Menlo Park: The Kaiser Family Foundation, 2012.

American Public Health Association

http://www.apha.org/advocacy/reports/reports/

This site provides several current and detailed briefs about elements of the ACA, including articles about the public health workforce provisions and the Prevention and Public Health Fund.

Catalyst Center

http://hdwg.org/sites/default/files/ACAsidebyside-catalystctr.pdf

The Catalyst Center provides a detailed account of ACA provisions for children and youth with special health care needs. The volume was written in February 2011, so some of the content may be dated.

Center for Medicare & Medicaid Innovation

http://innovation.cms.gov

Established under the ACA, the Center for Medicare & Medicaid Innovation (CMI) focuses on identifying and testing ways to: (1) test new payment and delivery modalities; and (2) evaluate and enhance best practice models. A total of $10 billion dollars has been appropriated to CMI between 2011 and 2019, with at least $25 million designated each year for the design, implementation and evaluation of models to achieve CMI's goals. The CMI website, as well as the www.cms.gov website, has information on state-based innovative projects that have been recently funded as well as up-to-date information about the ACA.

Healthcare.gov

https://www.healthcare.gov

This site provides information for individuals, families, and small businesses. It also provides information about state-specific exchanges and links to state plans. It is a good "first stop" for consumers who want to learn about how the ACA could affect them.

Henry J. Kaiser Family Foundation

http://kff.org/health-reform/

One of the most comprehensive—and up-to-date—sites about health care reform. It has information for consumers, researchers, policymakers, and providers.

The Arc

http://www.thearc.org/document.doc?id=3898

In September 2012, The Arc's policy team put together a guide called *The Affordable Care Act. What disability advocates need to know.* It focuses on major provisions of the ACA (e.g., Medicaid expansion, focus on prevention, long-term care services) and how they affect people with intellectual and/or developmental disabilities.

Trust for America's Health

http://healthyamericans.org/health-issues/category/implementation-of-the-affordable-care-act/community-transformation-grants

This site has a map of national Community Transformation Grants (CTGs), state-specific media coverage, and other information about CTGs.

Urban Institute, Health Policy Center

http://www.urban.org/health_policy/index.cfm

The Urban Institute has several well-researched reports on the ACA and health care reform in general, from the perspective of individual states' budgets, national budgets, Medicaid, health markets, small businesses, and individuals.

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American Public Health Association (APHA) Annual Meeting & Exposition
Boston, MA
http://www.apha.org/meetings/AnnualMeeting

NOVEMBER 8, 2013
Women Impacting HealthCare Conference: Preparing to Lead
Minneapolis, MN
http://ce.pharmacy.umn.edu/discover/women-impacting-healthcare/index.htm

NOVEMBER 15-17, 2013
National Federation of Families for Children's Mental Health Annual Conference
Washington, DC
http://conference2013.ffcmh.org/

NOVEMBER 20-23, 2013
National Association for the Education of Young Children Annual Conference & Expo
Washington, DC
http://www.naeyc.org/conference/

DECEMBER 9-13, 2013
National Head Start Association 30th Annual Head Start Parent Conference and Family Engagement Institutes
Atlanta, GA
http://www.nhsa.org/?e=events.detail&event_id=91

DECEMBER 11-14, 2013
Zero to Three's 28th National Training Institute
San Antonio, TX
http://www.regonline.com/builder/site/Default.aspx?EventID=1185937

JANUARY 25-28, 2014
Association of Maternal and Child Health Programs (AMCHP) Annual Conference
Washington, DC
http://www.amchp.org

APRIL 3-5, 2014
Michigan Association for Education of Young Children (MiAEYC) Early Childhood Conference
Grand Rapids, MI
www.miaeyc.org/conferences/earlychildhood.htm