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Promise and Perils of the Affordable Care Act for Children

Tina L. Cheng, MD, MPH[1], **Paul Wise, MD, MPH**[2], and **Neal Halfon, MD, MPH**[3]

[1]Department of Pediatrics, Johns Hopkins School of Medicine, Baltimore, MD; Department of Population, Family and Reproductive Health, Bloomberg School of Public Health

[2]Department of Pediatrics, Stanford University, Palo Alto, CA; Center for Policy Outcomes and Prevention

[3]Department of Pediatrics, David Geffen UCLA School of Medicine, Los Angeles, CA; Department of Health Policy and Management, Fielding School of Public Health, Department of Public Policy, Luskin School of Public AffairsCenter for Healthier Children, Families and Communities

Implementation of the major provisions of the Affordable Care Act (ACA) is now underway. Insurance marketplaces known as exchanges are on-line and millions of Americans are enrolling in what were previously unobtainable insurance products. While the ACA's major thrust is to provide coverage for the uninsured, the ACA is also benefitting children by eliminating restrictions on pre-existing conditions, limiting life-time benefit caps, extending coverage to young adults to age 26 years on their parents' policies, and insuring more parents.

Despite these clear benefits, the ACA could also potentially destabilize well-functioning elements of the current child health delivery system and undermine the ACA's promise for improving child health. Child health is a foundation for adult health and should be a priority in ACA implementation. However, children's health care is not the cost driver of US health care spending, and designers of health reform, therefore, have not been particularly attentive to the special requirements of child health care provision. In addition, the ACA gives each state considerable autonomy over how they implement many provisions, creating opportunities for experimentation but also demanding vigilance in monitoring potential untoward effects on child health.

Access to Insurance

Studies suggest that the ACA should decrease the number of uninsured children by 40% and uninsured parents by almost 50%.[i] Recent estimates show that 7.2% of American children are uninsured.[ii] Of those insured, 61% have employer based or private insurance and 39% have government insurance (primarily Medicaid or the Children's Health Insurance Program (CHIP)).[iii] Although Medicaid for children will continue, the future of CHIP, which currently covers almost 8 million children nationwide, is unclear as reauthorization of the

Correspondence: Tina L. Cheng, M.D., M.P.H. Johns Hopkins University General Pediatrics & Adolescent Medicine, 200 N. Wolfe Street, Suite 2055, Baltimore, MD 21287. Phone: 410 614-3862; Fax: 410 502-5440; tcheng2@jhmi.edu.

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program is required by October 2015. CHIP provides federal matching funds to states and covers children in families with incomes too high to qualify for Medicaid but who can't afford private coverage. Concern exists that amid fiscal pressures legislators may falsely believe that ACA coverage provisions could replace CHIP. It is estimated that if CHIP funding was allowed to lapse and Medicaid coverage for children allowed to roll back, the number of uninsured children could more than double and be higher than if the ACA had not been enacted.[1]

Enrollment in Insurance

While the ACA expands insurance availability, this does not automatically translate into enrollment. Of 6.6 million uninsured American children in 2009, about two thirds were eligible but not enrolled in Medicaid or CHIP.[iv] While many states have made progress in increasing enrollment, similar vigilance in ACA enrollment is needed. ACA navigators must be clear on options for children and their families. Lessons learned from successful Medicaid/CHIP family-centered outreach and consumer assistance are instructive.[v,vi]

Immigrant children are a large proportion of uninsured children. While over 90% of Latino children are citizens and eligible for public insurance, undocumented children are prohibited. With the ACA, legal immigrant children may have undocumented parents who may be fearful of enrolling their children in the new system. Finally, the ACA's reduction of Disproportionate Share Hospital program payments threatens the safety net for residents who are undocumented.

Churning or Instability of Insurance Coverage

It is expected that many children will move among different public and private insurance programs. This "churning" can occur due to changes in Medicaid eligibility thresholds, fluctuating family incomes, and aging out. Churning is more likely for families whose incomes hover near the Medicaid eligibility threshold of 133% of the federal poverty level. Moving from Medicaid/CHIP to subsidized insurance in the exchanges may result in more costly and less comprehensive coverage. Anticipating these problems, states should eliminate or shorten waiting periods, streamline enrollment, retention and transfer policies, and develop systems to avert coverage disruptions. Aligning benefits for children across different insurance products, adopting minimum guaranteed eligibility periods, and "dually certifying" plans to serve both Medicaid/CHIP and exchange enrollees can minimize discontinuity of care.[vii]

Benefits Packages Meeting the Needs of Children

An important provision for children in the ACA is the requirement that all plans have a comprehensive age-appropriate child benefits package without cost-sharing for preventive services, including services in Bright Futures[viii] guidelines and medically necessary periodic screenings, vision, hearing and dental services. States were charged with defining their essential health benefits by selecting a benchmark plan; however, a review of benchmark plans in 5 states compared with their Medicaid/CHIP benefits found that coverage of pediatric services was lacking.[ix] Mental health, substance use, and habilitative services such

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as occupational or speech therapy or home care, had limited or no coverage. States may need to review and supplement their benchmark plans to meet the needs of children. Of special concern are exchange plans with limited provider networks and high deductibles and copays that may result in financial burdens for families of children with serious illness.

Access to Clinicians with Expertise in Children's Health Care

Federal guidance requires that plans guarantee availability of clinicians with appropriate scope of practice. For children this means access to pediatric specialists and surgeons, pediatric mental health and dental professionals, and hospitals with appropriate pediatric expertise. However, states have great latitude in allowing plans to choose "essential community providers" and may not respect longstanding Medicaid and CHIP-supported networks of specialty pediatric care.

Of immediate concern is how the exchanges, new global contracting schemes or accountable care organizations will affect regionalized systems of specialty care for children. Regionalized systems for high-risk newborns and children with serious disorders such as cystic fibrosis and sickle cell disease have been the basis of major advances in pediatrics. Since many payment models are being developed to meet the needs of adults who generate the majority of costs and profits, longstanding regionalized pediatric systems may be under threat and are less accessible in some insurance plans. Adult systems are less dependent upon regionalization and can provide specialty care in community settings. Without special attention, pediatric regionalized systems could unravel, disrupting an essential component of pediatric care that has taken years to construct.

Conclusion

The ACA has introduced both potential improvements in and challenges to the provision of child health services in the United States. Realizing the promise of the ACA for children will demand a deeper recognition of their special requirements. Clinicians and policymakers should consider how to: 1) adopt lessons from CHIP and other state models for implementation of innovations and best practices; 2) monitor multiple potential effects on access, quality of care, and health outcomes with real time feedback to policymakers; and 3) implement policies that are attentive to improving the health and well-being of American children.

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