Children's Hospital of Philadelphia
PolicyLab

Improving the ACA for Kids

Population Health Sciences

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Note: This blog post is based on research for an article published in the Health Affairs December issue. The analysis was conducted by researchers from PolicyLab at The Children's Hospital of Philadelphia; Children's National Health System in Washington, DC; Johns Hopkins Bayview Medical Center; and the Milken Institute School of Public Health at the George Washington University (GW).

As some members of Congress and others debate the future of the Affordable Care Act (ACA), there is something the Administration can do right now to ensure that children with special health care needs have access to appropriate and affordable services regardless of where they live.

Under the ACA – as implemented – if you are the parent of a child with birth defects and purchase a "qualified health plan" through one of the new Marketplaces, you may have access to services for your child if you live in one state, but not if you live in another. This state-by-state variation is true if your child is autistic and needs Applied Analysis Behavior Therapy (ABC), or needs hearing aids, or has a speech problem from developmental delay or stuttering.

"Pediatric benefits" is one of ten benefit classes required by the ACA that must be covered in all health insurance plans sold in the individual and small-group health insurance Marketplaces. However, other than oral health and vision care, neither the ACA nor the regulations for implementing it define "pediatric benefits." And while the ACA gave the Health and Human Services (HHS) Secretary the ability to define a pediatric benefit

standard at the national level, HHS chose instead a state-by-state benchmark plan approach, which affords greater discretion to both states and payers.

The result is a state-by-state patchwork of coverage for children and adolescents that has significant exclusions, particularly for children with developmental disabilities and other special health care needs.

HHS made a commitment to review its “benchmark plan” approach for the 2016 plan year. This means HHS still has an opportunity to define a pediatric benefit standard at the national level. There are several options for the Secretary to consider.

First, pediatric treatment limits and exclusions, particularly exclusions based on mental retardation, mental disability, or other developmental conditions, could be barred. Second, states could be required to incorporate some concept of “medical necessity” into the defined pediatric benefit. Medical necessity should include not only the clinical utility and appropriateness of a covered service, but also whether the service is appropriate in the pediatric developmental health context. Third, the essential health benefits standard for pediatric services should be revised to address both covered services, particularly for children with special needs, and actuarial value (the percentage that the average person can expect the plan to cover). HHS could use an actuarial value of 90 percent for qualified health plans sold in the Marketplaces, to reduce the burden of high deductibles, coinsurance, and other forms of cost sharing. This is the current practice under the Children’s Health Insurance Plan (CHIP), the program created in 1997 to provide health insurance to children who are ineligible for Medicaid but cannot afford private insurance. CHIP currently provides health insurance coverage to about eight million children, and it works well. Finally, the Secretary could allow the use of CHIP plans as a benchmark plan for pediatric services.

Coverage of basic services for children with special needs should not have to depend on where they live. They all deserve a minimal package of services, and the Administration is in a position to make that happen.

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