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Children's Health Care and the Patient Protection and Affordable Care Act:

What's at Stake?

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Abstract

Although the Patient Protection and Affordable Care Act (hereafter referred to as the ACA) of 2010 does not explicitly target the health care needs of children, its significant reforms and cascading effects throughout our complex health system are likely to directly and indirectly affect children's health care. The ACA increases insurance coverage for children and their families by covering comprehensive preventive services with no cost sharing, eliminating exclusions for preexisting conditions, prohibiting lifetime dollar limits, extending dependent health benefits to 26 years of age, and expanding coverage to many previously uninsured parents. Despite these advances, some provisions of the ACA have the potential to compromise children's health care in unanticipated ways. Because children account for a disproportionately small percentage of overall health care spending, the effect of the ACA on children is not on the radar of those individuals implementing the ACA who are more focused on insurance expansion and cost control among adults. Thus, it falls to children's health advocates to monitor the ACA's effect on child health care, to both minimize harm and maximize opportunities for improvement.

Children and the US Child Health System

Children are characterized by their developmental vulnerability, dependency on parents and other adults, unique patterns of diseases and disabilities, increasingly growing racial and ethnic diversity, and disproportionate experiences of poverty. The developmental nature of children's physiology creates critical and sensitive periods of health development, when the

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child is acutely susceptible to both the toxic influences of adverse childhood events and the benefits of nurturing relationships and appropriately timed interventions. Relatively minor declines in a child's health trajectory can be compounded over time, resulting in serious lifelong health consequences.¹

Despite evidence supporting the need for special attention to health in the early years, a history of incremental and piecemeal policy making has left us with a patchwork child health system.² The locus of children's health care delivery is highly dispersed, including outpatient clinics and physician offices, school-based health centers, early intervention programs for developmentally delayed children, and a host of other specialized programs. These services are frequently difficult to navigate and of variable quality. Although Medicaid is the largest payer for children's health care, a variety of other state-funded and state-administered or locally administered programs have been created to serve populations with specific risks and needs. Our current child health system is ill-matched to the special requirements of children, and its fragility makes it particularly vulnerable to the disruptive changes of the ACA.

Medicaid Expansion and Children's Access to Care

Before the ACA, fully half of all persons enrolled in Medicaid were children. Now, many states are expanding Medicaid coverage to include previously ineligible adults. Previous expansions of public insurance to cover parents have had a positive ripple effect on the enrollment of eligible children.³ However, the ACA's higher federal Medicaid matching rates for newly eligible adults as compared with currently eligible but unenrolled children may create incentives for states to prioritize adults over children in enrollment efforts. Of perhaps more concern, rapid enrollment of newly eligible adults in an era of increasingly capitated reimbursement may lead Medicaid providers to shift resources and focus their care management efforts on costly adult chronic conditions, at the expense of care coordination for children.

In addition to these cost-containment pressures, an influx of adult Medicaid enrollees may also strain the capacity of our primary care infrastructure. Although others have already called attention to this issue⁴ and the experience in Massachusetts bears this out,⁵ the particular consequences for children have been largely ignored. Most physicians working in community health centers are family physicians, and children account for about a quarter of visits to these providers, especially in rural and underserved areas.⁶ Increased numbers of newly eligible adult Medicaid enrollees, combined with already increasing numbers of elder adults, have the potential to crowd out pediatric care from these primary care settings.

Essential Health Benefits for Children

Although the ACA makes significant advances in guaranteeing that virtually all insurance products cover the full range of preventive services without cost sharing, there is some cause for concern regarding children with special health care needs covered through state exchanges. The ACA's "essential health benefits" establish a benefits framework for products sold through the exchanges. Because children in low-income families eligible for federal subsidies constitute a new and potentially growing population under this new

framework, it will be important to track its effect on children's health care. Notably, the ACA bars Medicaid from acting as a secondary payer to supplement subsidized coverage through the exchanges, in contrast to its traditional role for children covered through an employer-sponsored plan. Thus, many low- and middle-income children with special health care needs will no longer benefit from Medicaid's comprehensive early and periodic screening, diagnosis, and treatment benefits package. This is problematic because current regulations allow for considerable state-level discretion in the definition of specific pediatric essential health benefits, including habilitative services, which are those services and devices that help children with special health care needs attain and maintain skills and functioning for daily living. It will be important to follow how state discretion in defining key child benefits affects outcomes for these children.⁷

Accountable Care Organizations and Children With Complex Medical Conditions

Accountable care organizations (ACOs) have the potential to improve health system performance by achieving the "triple aim" of enhancing care and population health while reducing costs. The ACO payment model requires that providers restructure care or risk being shut out of these purchaser-defined high-value care networks. The current ACO fiscal model, however, is not well suited to the needs of children with complex medical conditions who, given their relatively low numbers and geographic dispersion, are most effectively cared for through a regionalized system of care that has been carefully fostered and developed over the last half century. Although the ACO model requires differentiation of services and flexibility in the assumption of risk, regional specialty care institutions for children— primarily children's hospitals— must maintain multiple high-cost specialty service lines, and their case-mix index yields little flexibility for assuming risk. In many states, regionalized systems for children with complex medical conditions include federally sponsored "wrap-around" services, such as home- or community-based services supplemented with additional state funds and delivered by state-authorized providers that may not be easily integrated into ACO arrangements. Although ACOs are a reasonable mechanism for rede-signing and improving primary care for adults, the ACO business models may be ill-suited for the special needs of children with complex medical conditions.

Conclusions

Implementation of the ACA ushers in a new era of health care delivery and holds the promise for fundamentally improving access to and the quality of US health care services. Although the areas of concern that we have raised speak to the need for carefully monitoring implementation to avert potential negative consequence for children, they also point to opportunities for positive transformation. The expansion of Medicaid to adults means that our largest public insurance program will be in the business of covering individuals over their entire lives. This creates a new incentive for health plans to address the early life origins of adult health and disease in the context of a longer time horizon for managing risks and returns. While ACOs are currently focused on achieving short-term cost savings from

chronically ill adults, innovators must now pursue the challenging but critical work of forming pediatric ACOs, with children's hospitals at the helm.

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