Op-Ed

Searching for a Child Health Policy in a Post-Reform World

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AT SOME POINT, THE POLITICAL STALEMATE THAT HAS PLAGUED the Affordable Care Act (ACA) since its passage will ease,¹ and the modification process will begin. When this window of opportunity opens, a clear sense of what needs to be done and how to do it will be essential.

Much of the ACA reform discussion focuses on hot-button issues such as the employer and individual mandates. But at the top of the list should be the ACA's performance for children, which, I hope, will attract bipartisan support.

The ACA was built on existing means-tested public subsidy pathways: Medicaid and its companion, the Children's Health Insurance Program (CHIP). For Medicaid, the ACA increased the mandatory eligibility standard for children aged 18 and under to 138% of the federal poverty level. Previously, the mandatory coverage of children aged 6 to 18 had ended at 100%. (The mandatory expansion of Medicaid for children was untouched by the United States Supreme Court in *NFIB v Sebelius*). But Congress took another tack concerning CHIP. Lawmakers reasonably assumed that subsidized exchange plans eventually would replace CHIP, which was enacted in 1997 and designed to cover uninsured "targeted low-income" children with incomes higher than Medicaid permits, and therefore they stopped funding CHIP after FY 2015.

But Congress did not simply end CHIP. Instead, in broad legislative strokes, it outlined steps to ensure the incorporation of pediatric principles into the exchanges. This expression of legislative intent took several forms.

First, lawmakers extended the ACA's premium tax subsidies (for individuals and families with incomes 100% to 400% of the federal poverty level) and cost-sharing discounts (for individuals and families with incomes 100% to 250% of poverty), both to children as individuals and to families.

Second, Congress incorporated preventive pediatrics into its preventive benefit reforms, which apply to the entire non-grandfathered-insurance and employer-sponsored plan market.

Third, Congress included a special “pediatric services” category in the essential health benefit standard applicable to plans sold in the individual and small-group markets. While the “pediatric” services category is explicit regarding only oral and vision care, Congress inserted “including” after “pediatric services,” thus signaling the Obama administration that it was empowered to adopt a broad coverage policy for children.

Finally, Congress provided for the sale of child-only plans for children whose parents had coverage, thereby allowing the purchase of policies comparable to CHIP. CHIP funding was continued through the end of FY 2015 in order to allow a transition period, with a report required from the secretary of health and human services (HHS) on the quality of pediatric coverage on the exchanges. It all made a lot of sense.

Then everything blew up.

The firestorm that ensued immediately after the passage of the ACA, which continues to cripple implementation, led 36 states to reject the implementation of the exchanges. This rejection, coupled with the technical problems plaguing nearly all states that attempted to run exchanges on their own, effectively scotched all efforts to move toward the integration of the exchanges and CHIP.

Moreover, the ACA itself contains 2 basic design flaws. Although both might have been remedied in implementation, neither was. The first flaw is its cost-sharing help for low-income families. The ACA discount boosts the actuarial value (AV) of a silver plan to 94%, but only for families with incomes below 150% of the federal poverty level. Discounts for families with incomes between 150% and 200% and 200% and 250% of federal poverty max out at 87% and 73%, respectively. This inadequate protection is in addition to premium subsidies that are inadequate for low-income families. A recent study² examining Arizona’s decision to terminate its CHIP program in favor of relying exclusively on the exchange found that families who previously relied on CHIP experienced a steep increase in their child health care costs.

The ACA’s second design flaw concerns access to exchange subsidies by children of parents with employer coverage. Premium subsidies are available to people who meet the income test and have no offer of “affordable” employer coverage of “minimum [actuarial] value” (an AV of 60%). But an ambiguity in the law appears to limit the “affordability”

test to self-only coverage. Workers whose employers offer affordable self-only coverage (the affordability is set at 9.5% of adjusted gross income) are barred from obtaining premium subsidies for their children, even if family coverage is completely unaffordable (overwhelmingly the case for lower-income workers). The “affordability” problem affects several million children.³

The Obama administration chose to lock in these 2 problems. First, officials interpreted the act’s ambiguous “affordability” provisions in the harshest terms. The administration claimed the power to ease implementation through a liberal interpretation of the ACA, such as in its 2013 decisions to delay enforcement of the employer mandate and to permit insurers to continue selling noncompliant policies after the law took effect. Yet in regard to affordability, the administration took the toughest position possible, possibly out of budget concerns and possibly out of concern over the further erosion in employer-sponsored family coverage. No one knows for sure, but the effect is huge.

Rather than adopting a robust definition of pediatric coverage, however, the administration punted coverage design to the states as part of its decision to tie essential health benefits to state benchmarks. Final regulations do require the states to cover pediatric vision and oral care. But the then secretary of HHS, Kathleen Sebelius, ignored Congress’s expectation that pediatric coverage would be broader than the general rule, perhaps by requiring insurers to disregard plan coverage limits applicable to adults, to adopt a child-oriented standard of medical necessity, and to use a more generous AV for pediatric coverage. (The ACA’s AV standard is part of the provision that defines essential health benefits generally, affording the HHS secretary ample power to use the pediatric coverage class to address both benefits and cost-sharing.)

To make matters worse, the administration decided to bar premium subsidies and cost-sharing discounts in the case of stand-alone pediatric dental plans, which, by law, may be sold in exchanges. This means that the promised pediatric dental coverage is effectively unaffordable for families whose qualified health plans do not offer pediatric dental coverage and who must therefore buy separate plans.

The administration could reverse its interpretation of premium affordability, set a robust pediatric coverage and AV standard, and revise its pediatric dental decision. Alternatively, Congress should step in and ensure that its original vision proceeds. Until something is done, CHIP

must continue, of course, if only to overcome the premium subsidy barrier facing parents without access to affordable workplace family plans.

CHIP does possess one strength: Like Medicaid, children have access to CHIP when they need it. Neither program is encumbered by the open enrollment rules that apply to private insurance plans. But the states could remedy the loss of access to CHIP at the point of need by increasing Medicaid eligibility standards for children. This would accommodate the limited number of children who fail to gain coverage during open enrollment and do not qualify for one of the exchange's special-enrollment period exceptions.

The problems confronting children under the ACA are great, but they readily lend themselves to sensible solutions that would not be expensive. These steps would improve coverage, simplify overall administration by eliminating multiple subsidy pathways, and have the added benefit of bringing millions of children into the insurance risk pool, a benefit that presumably would more than offset any incremental costs of introducing these solutions.

In the coming and complex debate over reforming the ACA, children's health and welfare should be at the top of the heap and above the battle.

References

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