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Children, Families, and Disparities: Pediatric Provisions in the Affordable Care Act

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The Affordable Care Act (ACA; "Obamacare") "has the potential to do more to meet the health needs of America's racial and ethnic minorities, and more to reduce racial and ethnic health disparities, than any other law in living memory," wrote Dr. John McDonough, former Senior Advisor on National Health Reform to the U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP).¹ Indeed, U.S. Representative James Clyburn (D-SC) called the ACA "the civil rights act of the 21st century."¹ Others have challenged the constitutionality of the ACA and have been concerned about its implementation. The ACA has caused and continues to cause sweeping changes throughout the health system in the United States. Poorly explained, complex, controversial, confusing, and subject to continuous legal and regulatory definition, the law stands as a hallmark piece of legislation that will change the health sector in America forever. What is the ACA, and how does it affect children and families? While it is impossible to discuss the ACA in one paper, in this article we summarize this significant law, with a focus on children, families, and disparities. We also provide the context of the current system of health care coverage in the U.S.

SETTING THE STAGE: A REVIEW OF CHILDREN'S HEALTH INSURANCE PROGRAMS

In the U.S. in 2011, 18% of the total population under 65 (Medicare non-eligible) was uninsured; within this group, 16% were children, 25% were parents, and 59% were adults

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without dependent children.² Currently, children in the U.S. have the following primary health insurance options (whose scope and provisions are changing with implementation of the ACA, as later described):

Private insurance

Private insurance is available to children and families through employer-based insurance as well as through buying insurance on one's own (in the individual market). In 2011, 49% of all Americans were covered through employer-sponsored insurance, and 5% had private non-group insurance.³ In 2009, 51% of children had employer-sponsored insurance, 33% had Medicaid or CHIP, 4% had individual coverage, 1% had other public insurance, and 10% were uninsured.⁴

The growth of employer-sponsored insurance in the U.S. emerged after World War II. Price controls limited the amount of wages that employers could provide; as such, benefits such as health care became the incentives that lured workers to jobs. Over the decades, employer-sponsored insurance has become a standard in the U.S. Covered benefits, cost sharing, and treatment limitations/exclusions tend to be at the discretion of insurers, under applicable state and/or federal law.

Historically, when parents enrolled in private insurance, either through their employer or in the individual market, children have also been covered according to plan specifications as dependents. Prior to the ACA, children aged out of parents' private insurance plans at age 19, or possibly age 22 if they were full-time students.

Medicaid

Established in 1965, Medicaid has historically covered pregnant women, low- and middle-income children, and poor elderly and disabled people in the U.S. In 2010, 66.4 million people were enrolled in Medicaid, including 49% children, 27% adults, 9% elderly, and 15% disabled.⁵ In general, only citizens and lawfully residing residents in the U.S. for five years are eligible. Medicaid is a joint federal-state program, with states with lower incomes receiving a higher percentage of federal payments in what is called the Federal Matching Assistance Percentage (FMAP).

Contrary to common public understanding, Medicaid has not historically covered all people below the federal poverty level (FPL; \$11,670 per year for individuals and \$23,850 per year for a family of four in 2014). Federal law establishes minimum federal eligibility criteria, which states may choose to exceed at their option. These minimum criteria include coverage of all pregnant women under 133% FPL, all children up to 6 years old under 133% FPL, and all children aged 6–18 under 100% FPL.⁶ However, state-by-state variations in Medicaid coverage thresholds make the current system patchy and inconsistent. One saying goes, "If you've seen one Medicaid program, you've seen one Medicaid program." Medicaid programs in different states may also have different names (i.e., MediCal in California), and/or may be combined with their Children's Health Insurance Program (CHIP). Additionally, many children and their parents may be eligible but not enrolled,⁷ or may "churn" between Medicaid and other insurance coverage due to eligibility changes.⁸ By

statute, Medicaid covers the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, considered a comprehensive standard of benefits for pediatric care.⁹

Children's Health Insurance Program (CHIP)

Established in 1997 as part of the Balanced Budget Act, CHIP covers children in low- and middle- income households who are not eligible for Medicaid as another joint federal-state program (with higher federal reimbursement than Medicaid). States have flexibility to design their CHIP programs. For example, states can use CHIP funds to expand their Medicaid programs, create separate CHIP programs, or offer a mix of both types. In separate CHIP programs, states have flexibility, within federal rules and guidelines, to determine benefit packages and cost sharing requirements. CHIP covers nearly 8 million children, and has helped to protect children against declining private coverage that has left many adults without adequate insurance in the past two decades.¹¹ Indeed, since the enactment of CHIP in 1997, the share of children who are uninsured has fallen by half—from 13.9 to 7.1 percent.¹²

The CHIP Reauthorization Act (CHIPRA) in 2009 increased appropriations for the program and included funding to encourage enrollment of children eligible but not enrolled such as Express Lane eligibility (whereby states can use administrative data from other programs such as Supplemental Nutrition Assistance Program or food stamps to enroll individuals in Medicaid), 12-month continuous eligibility,¹³ and state bonuses for reaching enrollment goals. It also improved benefits, enhanced data collection, and created a new emphasis on measuring the quality of care that children received.¹¹

Military

TRICARE, which provides health benefits for eligible uniformed service members and dependents, covers unmarried children of active duty service members and eligible other members up to age 21, or 23 if in college.

Indian Health Service

The Indian Health Service (IHS) is not a portable insurance system, but provides health services for federally recognized American Indian and Alaska Natives in the U.S. in specific geographic locations.

A BRIEF HISTORY OF HEALTH REFORM

Medicare and Medicaid were enacted in 1965 under President Lyndon B. Johnson, and were the largest sweeping changes to the health sector in U.S. history. In the 1970s, efforts by Senator Ted Kennedy to establish a national health insurance program, and by President Richard Nixon to establish universal coverage, were ultimately unsuccessful.¹⁴ President Bill and First Lady Hillary Clinton in the 1990s also worked for health reform; however, their efforts also failed. In 2006, Massachusetts passed significant health reform under Governor Mitt Romney, designed to provide near-universal health insurance coverage for the state's residents.

President Barack Obama made health reform a large part of his 2008 presidential campaign. An early victory for President Obama was the passage of CHIPRA in 2009. After tremendous Congressional efforts, the Patient Protection and Affordable Care Act was signed into law on March 23, 2010. It was further amended by the Health Care and Education Reconciliation Act (HCERA, also known as the reconciliation sidecar) on March 30, 2010, and this amended law is referred to as the Affordable Care Act (ACA).

While the ACA has faced numerous legal challenges since its enactment, its constitutionality was most directly challenged in the Supreme Court case of *National Federation of Independent Business v. Sebelius*. In 2012, the Supreme Court ruled that the ACA was indeed constitutional, as it ruled that the penalty for not having insurance (the “individual mandate”) was within the government’s ability to tax. However, it ruled that mandatory Medicaid expansion (to be addressed below) was unconstitutional since it was unnecessarily coercive to states. As such, most provisions of the ACA stood, other than a significant crux of the law’s design: Medicaid expansion to the poorest of the poor in America. A second Supreme Court challenge in *King v. Burwell*, currently ongoing, seeks to determine the legality of federal subsidies based on whether the insurance Marketplace is run by the state or the federal government.

AN OVERVIEW OF THE ACA

The ACA’s 900+ pages, not including its amendments and implementing regulations, create legislation that is complex, powerful, and – at times – overwhelming. The ACA has ten parts, or titles, and each is packed with numerous reforms. An excellent, comprehensive overview of each title and its reforms can be found elsewhere.¹ Notably, Title I changes insurance rules and sets up Marketplaces (“Exchanges”, see below). Title II modifies public programs, focusing on Medicaid. Title III focuses on quality improvement across the health system and modifies Medicare’s drug benefit and creates a new preventive benefit in the program. Title IV focuses on prevention, establishes a prevention and public health trust fund, and establishes new menu labeling rules. Title V creates a significant investment in the healthcare workforce. Title VI invests in program integrity, with strategies to decrease so-called “fraud and abuse,” as well as modifying a patient-centered outcomes research body. The sidecar legislation added important improvements that addressed access in Medicaid by funding states to improve Medicaid payments for primary care services to Medicare levels, and also smoothed income and tax credit rules while closing the Medicare Part D “donut hole.”¹⁵

Many of the ACA’s provisions work to address racial/ethnic and socioeconomic status disparities in the U.S. The “ABC’s” of the ACA include Access to coverage, Better insurance, and Consumer protections:

Table 1

“ABC” Acronym to Describe Affordable Care Act (ACA)

	Keywords	Description	Details
A	Access to Coverage	More Individuals with Insurance Coverage	<ul style="list-style-type: none"> - Expansion of health insurance to cover nearly thirty-two million more children, parents, and other individuals. - Creation of health insurance Marketplaces (“exchanges”) for individuals to shop for affordable health insurance. - Expansion of Medicaid to those up to 138% Federal Poverty Level (FPL), with strengthening of both Medicaid and CHIP. - Provision of insurance subsidies on a sliding scale for those with incomes up to 400% FPL. - Individual mandate to purchase health insurance, or pay a small penalty. - Young adults can stay on their parents’ plans until age 26.
B	Better Insurance	Higher Quality, Lower Cost	<ul style="list-style-type: none"> - Preventive care covered with no cost sharing. - Essential health benefits requirements. - Medical loss ratio requirements: Insurance companies must spend at least 80–85% of beneficiaries’ premiums on medical care (not administrative costs), or else pay a rebate. - Decrease fraud and abuse.
C	Consumer Protections	Beneficial Market Reforms	<ul style="list-style-type: none"> - No pre-existing condition exclusions. - No annual or lifetime limits on insurance coverage.

ACA PROVISIONS AFFECTING CHILDREN AND FAMILIES

Numerous provisions within the ACA affect children, whether directly or via reforms that impact their parents and family members. Many have the potential to be very successful in improving health coverage and care for children.

A: Access to Coverage

Medicaid—Title II of the ACA mandates the most comprehensive and far-reaching set of changes to Medicaid since its establishment in 1965.¹ While states have had a significant degree of freedom in implementing Medicaid (in accordance with some set federal principles), the ACA makes Medicaid into a more federally-directed program. Many ACA changes affect children and families.

By 2014, Medicaid coverage will be available for all individuals not previously eligible (i.e., childless, non-pregnant, non-elderly adults) with household incomes at or below 133 percent of FPL; however, because the first 5 percent of every enrollee’s income is not counted, the

new national eligibility standard for Medicaid will be 138 percent FPL.¹ The federal government will pay states for the costs of services to newly Medicaid-eligible individuals at 100% in 2014, 2015, and 2016; 95 percent in 2017; 94 percent in 2018; 93 percent in 2019; and 90 percent thereafter.¹ While this sweeping Medicaid eligibility expansion was the intent of the ACA as passed originally, the Supreme Court's 2012 ruling established that the Medicaid expansion is now optional for states. At the time of this writing, only 29 states (including DC) have actually adopted the Medicaid expansion.¹⁶ Since federal subsidies in the Marketplaces take effect for individuals above the Medicaid eligibility threshold, effectively the poorest of the poor in the U.S. may continue without reliable and affordable access to coverage.

The ACA also establishes requirements to streamline and coordinate enrollment processes and provides federal support to establish “navigators” to assist with public education and enrollment.

Medicaid has much lower rates of reimbursement to providers compared to private insurance (generally highest reimbursement) and Medicare (Medicaid rates have historically been approximately 70% of Medicare's rates¹⁷). This lower reimbursement has resulted in practices limiting or not taking Medicaid patients, thus limiting access to care by Medicaid enrollees. Under the ACA, Medicaid reimbursement rates for many primary care services (including the administration of vaccines) were increased to at least Medicare rates for calendar years 2013 and 2014, and were available to physicians with a primary specialty designation of internal medicine, family medicine, or pediatrics. While this two-year funding increase has expired at the time of this writing, advocacy efforts persist for Congress to continue Medicaid payment parity for pediatric providers, and many states have decided to extend the provision using state funds.

Young Adults and Foster Youth—Under the ACA, young adults may stay as dependents on their parents' health plans until age twenty-six. Recent evidence suggested that as many as three million young adults have gained coverage as a result.¹⁸ A 2013 study based on data from two nationally representative surveys compared young adults who gained access to dependent coverage under the ACA to a control group (ages 26–34) who were not affected by the new policy. The study found strong evidence of increased access to care because of the law, with significant reductions in the number of young adults who delayed getting care and in those who did not receive needed care because of cost.¹⁸ Two studies have demonstrated that enactment of the dependent-coverage provision was associated with financial protection from medical costs.^{19,20} However, a November 2014 study evaluated nationally representative data surrounding the implementation of the ACA confirmed that health care coverage for young adults increased but that young adults do not report improved health status, affordability of health care, or use of flu vaccination, compared with their older counterparts.²¹ Persons aged 19–25 years were more likely to have a usual source of care than those aged 26 to 34 years, but both age groups saw declines in this measure of access to care. The authors inferred that efforts must continue to address access and quality in addition to coverage for young adults, as insurance may be necessary but not sufficient to alter health care use and overall health.²¹ Children who were covered by Medicaid or CHIP and become

young adults may or may not be eligible for Medicaid depending on their state's eligibility levels. However, foster youth may stay on Medicaid up to age 26.

Parents—Research shows that expanding coverage for parents leads to significant increases in coverage for children and more stable coverage for children over time; studies also show that, when parents are covered, children are more likely to receive needed care.¹³ As such, insurance expansions for *both* adults and children can help to improve children's health.

Children with Special Health Care Needs—The ACA creates a Medicaid state option to provide medical assistance in a medical home (“health home” in the law’s provision) to individuals with chronic conditions (i.e., a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and obesity) or one chronic condition and the likelihood of contracting at least one additional chronic condition.²² Implementation of this provision offers states a higher federal match to fund their health homes program, though few states have taken this option. In this program, an enrollee may select, as his or her designated health home, a physician, a team of health care professionals operating with a physician, or a health team. The payment methodology for the program can be determined by states and may be tiered to reflect the severity or number of a patient’s chronic conditions and the specific capabilities of the health home.²²

B: Better Insurance

Preventive Care without Cost Sharing—Section 2713 of the ACA requires the coverage of specific preventive care benefits for adults and children in all non-grandfathered individual and group health care plans without cost sharing. For children, the following must be provided without cost sharing²³:

1. Immunizations for routine use that are recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention²⁴;
2. Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). These guidelines specifically include the periodicity schedule and screenings of the Bright Futures Recommendations for Preventive Pediatric Health Care²⁵ and the Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children.²⁶

Essential Health Benefits—The ACA defined an “essential health benefits” provision, which specifies three primary elements²⁷:

1. A list of benefit categories that must be provided in non-grandfathered insurance policies in the small group market (grandfathered plans are those existing at the time of ACA passage [March 23, 2010]);
2. A requirement that the scope of plans subject to the standard be equal to the scope of a “typical employer plan” currently existing in the marketplace; and

3. Rules regarding actuarial value (the percentage that the average person can expect the plan to cover) and cost sharing. (The actuarial value is expressed through “metal” tiers: platinum [90 percent], gold [80 percent], silver [70 percent], and bronze [60 percent], with a separate cost-sharing calculation for some participants in silver plans²⁷).

The categories of essential health benefits that apply to plans inside and outside the Marketplace include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.²⁸ ACA coverage of certain benefit categories that were not always covered by insurance plans, such as mental health/substance use disorder treatment, maternity and newborn care, and habilitative services, is a significant step forward. “Habilitation” services are “health care services that help a person keep, learn or improve skills and functioning for daily living,”²⁹ such as physical therapy to help a child with cerebral palsy function maximally, versus rehabilitative services that help to restore a child to previous functioning). Additionally, the fact that “pediatric services” was defined as an essential health benefit was considered a great win for children.

However, the law was implemented as a “benchmark plan approach” (where the essential health benefits were defined based on existing commercial norms in selected state benchmark plans) instead of as a national standard (using a model such as Medicaid’s EPSDT Program or recommendations from the American Academy of Pediatrics). A recent study sought to determine how states address pediatric coverage in their benchmark plans, specifically which pediatric services were explicitly included or excluded. The study found that the benchmark plan approach to the definition of essential health benefits, particularly pediatric services, has resulted in a state-by-state patchwork of coverage with exclusions.²⁷ As HHS has indicated its intention to review its approach to essential health benefits regulation for the 2016 year, the study authors recommended that HHS revise its regulations to address both covered services and actuarial value; bar pediatric treatment limits and exclusions, particularly exclusions based on mental retardation, mental disability, or other developmental conditions; incorporate the concept of medical necessity into a defined pediatric benefit; and permit CHIP plans to be used as a benchmark for pediatric services.²⁷

C: Consumer Protections

Insurance Market Reforms—Significant private insurance market reforms seek to decrease discrimination and improve consumer protections. Many of these reforms impact both children and families, and they include, among others:

- Guaranteed issue and prohibition on pre-existing condition exclusions: Health plans must permit all comers to enroll regardless of age, gender, health status, or other factors that would otherwise predict the use of health services. Plans also cannot deny coverage for those with pre-existing conditions.

- Ban on medical underwriting (the practice of covering, or refusing to cover, someone or pricing premiums based on the applicant's medical history).¹ Insurers will be allowed to vary premiums within a geographic region by only three categories: age (older enrollees must pay no more than three times the premium of the youngest participants; the current practice in most states is much higher); use of tobacco products; and whether the enrollee is part of an employer or insurer program that rewards them for participating in certain wellness activities.¹
- Coverage of young adults. The law allows young adults to stay on their parents' health insurance plans until age 26, and foster youth to stay in Medicaid up to age 26.
- Ban on rescissions. A rescission is a retroactive termination of health coverage. Health care plans can generally no longer retroactively cancel individuals' health insurance coverage if they get sick.
- Ban on annual or lifetime dollar limits on health insurance coverage.
- Limits on out-of-pocket expenditures: The maximum out-of-pocket cost limit for any individual Marketplace plan for 2015 can be no more than \$6,600 for an individual plan and \$13,200 for a family plan.³⁰

EFFORTS TO ADDRESS RACIAL AND ETHNIC HEALTH DISPARITIES

The ACA invests in increased data collection and research about health disparities, as well as initiatives to increase the racial and ethnic diversity of health care providers and provide them with strengthened cultural competency training.³¹ The law also demonstrates an increased focus on minority health, as it elevates the National Center on Minority Health and Health Disparities at the National Institutes of Health to a full Institute.³¹ The ACA's impact on selected special populations follows.

American Indians and Alaska Natives

American Indians (AI) and Alaska Natives (AN) experience significant health disparities, including an infant mortality rate 1.7 times the non-Hispanic white population, the highest rate of Sudden Infant Death Syndrome (SIDS) of any population group, and suicide rates for AI/AN youth that were three times greater than rates for whites of similar age.³² The ACA strengthens the Indian Health Service (IHS) and benefits AI/AN populations through multiple avenues³³:

1. Permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) which prescribes the duties and responsibilities that allow IHS to improve its health care delivery systems and permit tribal governments to make technical changes in the future.
2. Support of comprehensive Native American youth suicide prevention efforts by streamlining the Substance Abuse and Mental Health Services Administration grants for Indian youth suicide prevention including demonstration projects on

telemental health and youth suicide prevention curriculum programs in schools serving Indian youth.³⁴

3. Increases in clinician recruitment and retention in tribally-operated health programs.
4. Structures that increase revenue through third party payments to the IHS that support both direct care and contract health services.
5. Elimination of premiums and deductibles for AI/ANs who receive IHS, tribal programming, or urban Indian health services.
6. Elimination of cost sharing for AI with income at or below 300 percent FPL enrolled in coverage through a state exchange.³⁵
7. Enrollment in Marketplace coverage any time of year, with no limited enrollment period. AI/AN populations can also change plans up to once per month.³⁶

Home Visiting for Communities at Risk

The ACA established the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which “facilitates collaboration and partnership at the federal, state, and community levels to improve the health of at-risk children through evidence-based home visiting programs.”³⁷ The programs for home visiting reach pregnant women, expectant fathers, and parents and caregivers of children under the age of five. MIECHV is administered by the Health Resources and Services Administration (HRSA) in collaboration with ACF.³⁷ In particular, the statute specifies that at-risk communities include those with concentrations of premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child maltreatment.

ONGOING CHALLENGES

Despite the ACA’s progress, multiple challenges remain in the post-ACA landscape for children and families.

CHIP Funding Extension

CHIP is at a crossroads under the new ACA landscape. CHIP has historically had bipartisan support and has helped to improve insurance coverage for low-moderate income children in the U.S. With the ACA, multiple questions arise: How do CHIP plans compare to plans in the Marketplace? Should CHIP continue to exist, and if so, for how long? The ACA included important provisions for CHIP, including a “maintenance of effort” provision such that all states must maintain their CHIP eligibility levels at least through September 30, 2019. However, funding for CHIP is set to expire by October 2015 unless Congress acts to extend it. If CHIP funding is not extended, children could transition to coverage through the Marketplace, many with subsidies. However, some children will not have access to subsidized coverage if their families fail to sign up or if they are caught in the family glitch (see below).

Several studies have demonstrated that CHIP plans offered better financial protection (with less cost sharing and minimal premiums), and similar or more comprehensive benefits^{38–40} compared to plans in the Marketplace. Another study focused on separate CHIP plans found that they provide robust coverage of pediatric benefits, and substantial financial protection for families, reinforcing that CHIP is a “strong model for ensuring comprehensive and affordable coverage for children.”⁴¹ The Medicaid and CHIP Payment and Access Commission (MACPAC)’s formal recommendation to Congress was to extend CHIP for at least two more years, but many pediatric advocacy groups would like to extend CHIP for at least four more years.

Pediatric Dental Care

As above, while “pediatric services, including oral and vision care,” is considered one of the essential health benefits, the dental benefit for children has actually become a “loophole.”⁴² The ACA specifies that, if a separate stand-alone dental plan also exists in the Marketplace, then qualified health plans (QHPs) in the Marketplace do not also have to offer a pediatric dental benefit. However, there is no requirement for families to purchase these stand-alone plans. Additionally, families face affordability issues for dental coverage when it is not embedded in a Marketplace plan, as those non-QHPs may not have the same assistance in terms of subsidies, cost-sharing reduction, or out-of-pocket limits as do QHPs.⁴³ Finding dental plans in some Marketplaces has also proven difficult.⁴² Outside the Marketplace, plans have to assure that their customers have access to all of the essential health benefits, including pediatric dental coverage, and be “reasonably assured” that their customers have purchased dental coverage. As such, many children within and outside the Marketplace may go without dental coverage, despite being an essential health benefit.

The “Family” or “Kid” Glitch

Many parents will continue to receive coverage through their employers. Employer-sponsored insurance is considered too expensive if it exceeds 9.5% of income. However, this affordability test for employer coverage is based on a calculation of the individual coverage relative to a worker’s wages (not the cost of more expensive family policies).¹³ Families not able to afford family employer-based coverage would not be eligible for exchange subsidies. This situation, referred to as the “kid glitch” or “family glitch,” has the potential to leave more children uninsured, particularly if CHIP were not extended (see above).

Network Adequacy

Network adequacy refers to a health plan’s ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty clinicians, as well as other health care services included under the terms of the contract.⁴⁴ The ACA requires that QHP issuers maintain provider networks that are “sufficient in number and type of providers” and include essential community providers such as Federally Qualified Health Centers, family planning providers, and school-based health centers, many of which serve large numbers of children and youth in many communities.⁴⁵ However, concerns have arisen regarding the adequacy of provider networks under Marketplace plans for children. For example, it was reported that Seattle Children’s Hospital was initially excluded from some health plans in the state’s exchange, prompting legal challenges based

on network adequacy to ensure that children in Washington State have access to this important pediatric hospital.⁴⁶

IMPLICATIONS: WHAT SHOULD PEDIATRIC CLINICIANS DO?

It is important for pediatric clinicians to understand the basics of the ACA, as discussed in this article. Moving forward, specific action steps include:

Table 3

ACA Action Steps for Pediatric Clinicians

ADVOCACY	<ul style="list-style-type: none"> - Collect stories about how the ACA has impacted your patients or your practice and share them with your members of Congress. If there are unanticipated negative consequences of health reform experienced by your patients, bring them to the attention of your AAP chapter, medical society, public health officials and/or Congressional representatives. - Be aware of opportunities to advocate for child health policy issues that arise, including reauthorization of CHIP, Medicaid payment parity, strengthening of essential health benefits standards, and dental coverage, to name a few. - Consider joining the AAP's Key Contact network by kids1st@aap.org.
RESEARCH	<ul style="list-style-type: none"> - Much more pediatric-specific research is needed to assess the impact of the ACA on children, families, disparities, and pediatric practitioners. - Potential research topics include monitoring changes in insurance coverage, enrollment, benefits and network adequacy for children, adolescents, young adults and parents, as well as monitoring quality of care, sentinel health outcomes, cost, and socioeconomic and racial/ethnic disparities related to implementation of the ACA.
CLINICAL CARE	<ul style="list-style-type: none"> - Inform families about the law, and encourage parents to sign up for insurance if they are uninsured. - Pediatric clinicians can offer resources to patients and families in the clinical setting to help them navigate the insurance marketplaces and help in the decision-making regarding the most appropriate plan to meet the child and family's needs. The AAP public-facing website (healthychildren.org/ACAMarketplace) has information for families, and is also available in Spanish. The federal government has also launched the HealthCare.gov Web site and a 24-hour call center at 1-800-318-2596 to provide educational information and enrollment assistance.⁴⁷ - Ensure that children have a dental home and are receiving care in light of dental care loopholes in the ACA. - Connect families and collaborate with home visiting programs in your area.

CONCLUSION

The ACA faces multiple challenges to come, including a Republican-controlled Congress whose leaders have repeatedly stated their intention to alter or repeal the legislation.

However, the ACA's many successes remain: Due to better Access to insurance, there are twenty-five percent less uninsured people in the U.S.⁴⁸ Additionally, countless Americans have Better insurance and new Consumer protections. We expect the impact of the ACA to be far-reaching for children and families, and to decrease disparities. Time will tell.

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