Short Paper #7

The ACA and Essential Benefits for Children in the Exchanges
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Introduction

The Patient Protection and Affordable Care Act (ACA) creates a new mechanism for individuals and small businesses to compare different health insurance packages and purchase coverage: the Exchanges.[1] States will receive federal funding to assist with establishing the Exchanges and will have considerable flexibility in operating them. One requirement of all insurers offering plans for purchase through the Exchanges, however, is the coverage of the "essential benefit package." Although the ACA lists the services that, at a minimum, must be included in the essential benefit package, the Secretary of Health and Human Services will define the package fully. This definition, which the Secretary is considering with assistance from the Institute of Medicine, will decide much about the scope of coverage provided by plans in the Exchanges.[2] Ensuring a robust and comprehensive essential benefit package is critically important for children, especially those who are low-income and/or who have special health care needs.

This issue brief will examine the components of an essential benefit package for children, propose that Medicaid should serve as a model for the scope of services, and make recommendations for the Exchanges.

ACA §§ 1301, 1302 and 1001

Section 1301(a)(1)(B) of ACA requires that all plans participating in the Exchanges, known as "qualified health plans," must provide essential health benefits. Section 1302 defines the characteristics of an essential benefit package; limits cost-sharing for such coverage; and provides for either a bronze, silver, gold or platinum level of coverage.[3] This section also requires the Secretary to define the essential health benefits, which must include at least the following: "ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse treatment, including behavioral health

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[1] Pub. L. No. 111-148, 124 Stat. 119 (2010). That statute was amended by the Health Care and Education Reconciliation Act (Pub. L. No. 111-152, 124 Stat. 1029 (2010)), which the President signed on March 30, 2010; the resulting combined legislation is referred to in this issue brief as "the ACA."

[2] Information on the Institute of Medicine study is available at: http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx.

[3] ACA § 1302 (2010).

treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services including oral and vision care."[4] In defining the benefit package, the Secretary must ensure that the scope of benefits is equal to "the scope of benefits provided under a typical employer plan."[5] The Secretary of Labor shall conduct a study of employer-sponsored coverage to inform this consideration. [6]

Section § 1001 of ACA, adding Section 2713 to the Public Health Service Act, also informs the benefits that will be covered by Exchange plans. This section, which applies to both group and individual plans (thus covering plans both inside and outside of the Exchanges) requires coverage of preventive services with no cost-sharing.[7] For children, the law specifies that this includes services recommended by the United States Preventive Services Task Force, immunizations recommended by Centers for Disease Control and Prevention, and preventive care and screenings in *Bright Futures*, guidance developed by the American Academy of Pediatrics and the Health Resources and Services Administration.[8] Interim final rules issued jointly by the Departments of Health and Human Services, Treasury, and Labor clarified that this coverage must be offered without cost-sharing for plan years beginning on or after September 23, 2010.[9]

Beyond these parameters, much is left to be decided about the essential benefit package. Advocates must ensure that the service package is defined in a broad and comprehensive way so as to adequately meet low-income children's unique health and developmental needs. Children with special health care needs must be able to obtain comprehensive coverage consistent with evolving standards of care and evidence-based treatment.

Which children will get coverage through the Exchanges?

Children of families with varying levels of income will be able to obtain coverage through the Exchanges. The ACA provides government subsidies in the form of premium tax credits, as well as cost-sharing reductions, for families with incomes below 400% federal poverty level (FPL).[10] An estimate by Georgetown Center for Children and Families concludes that more than half of the people who get coverage through the Exchanges (approximately 66% or 19

[4] ACA § 1302(b) (2010).
[5] ACA § 1302(b)(2)(A) (2010).
[6] *Id.*
[7] ACA § 1001 (adding § 2713 to the Public Health Services Act) (2010).
[8] *Id.*
[9] The proposed regulations clarify that the requirement to cover preventive services without cost-sharing does not apply to plans that have "grandfathered status." Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 137 (proposed July 19, 2010) (to be codified at 45 C.F.R. pt. 147).
[10] ACA § 1401 (2010).

million people) will be eligible for subsidies, while 17% will enroll through their small business employer and 17% will have unsubsidized coverage.[11] While all children below 133% FPL will be eligible for Medicaid in 2014, and thus ineligible for subsidies, many between 134 and 400% of FPL will be covered through the Exchanges. Particularly in states that have income eligibility cut-off levels below 200% FPL in their Children's Health Insurance Programs (CHIP), such as Idaho, North Dakota, Alaska and Oklahoma, children between 134 and 200% FPL will seek coverage through the Exchanges.[12] Although many other states cover children up to 250% FPL (or higher) in their CHIP programs, it is likely that at least some of these children will look to the Exchanges for coverage.[13] Further, children who are above the income eligibility cut-off for CHIP but below 400% FPL will be eligible for subsidies in the Exchanges.[14] Many low-income, legal immigrant children who are otherwise eligible for Medicaid and CHIP, but are subject to a five-year bar on entering those programs, may also obtain coverage through the Exchanges.

What should the benefit package look like?

It is well established that low-income children are more likely to have poor health than other children.[15] Publicly-insured, low-income children have a higher prevalence of special health care needs and conditions such as obesity, asthma, and attention deficit hyperactivity disorder.[16] Low-income children are at greater risk for dental problems, such as toothaches and infection, elevated blood lead levels, behavioral health problems and extreme prematurity, which can result in a host of long-term disabilities and limitations.[17] Moreover, children's health care needs are different from adults' and require a tailored benefit package. Given these complex and evolving needs and the significant number of low-income children who will be covered through

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[11] Dawn C. Horner & Sabrina Corlette, Georgetown Center for Children and Families, Health Insurance Exchanges: New Coverage Options for Children and Families (August 2010).

[12] Kaiser Family Foundation, Income Eligibility Levels for Children's Separate CHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, December 2009 and Income Eligibility Levels for Children's Regular Medicaid and Children's CHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), December 2009, *available at:* www.statehealthfacts.org.

[13] For example, Arizona currently has a freeze on enrollment for CHIP, which was in place before the ACA was enacted.

[14] New York, however, is the only state that provides coverage for children up to 400% FPL in CHIP. In addition, 14 states allow children with family income levels above CHIP eligibility to buy coverage through the CHIP program. www.statehealthfacts.org.

[15] *See, e.g.,* Leighton Ku et al., Center on Budget and Policy Priorities, Improving Children's Health: A Chartbook About the Roles of Medicaid and SCHIP (2d ed. 2007).

[16] *See, e.g.,* Sara Rosenbaum & Paul H. Wise, *Crossing the Medicaid-Private Insurance Divide: The Case of EPSDT*, 26 HEALTH AFFAIRS, 382-93 (2007); C. Bethel et al, *National, State and Local Disparities in Childhood Obesity*, 29 HEALTH AFFAIRS, 347-56 (2010).

[17] *See, e.g.,* The George Washington University, Comparing EPSDT and Commercial Insurance Benefits (September 2005); Clarisa Ramirez, *Toothaches more likely in minority, poor, special needs children, study finds*, Medill Reports Chicago, Nov. 4, 2010.

the Exchanges, it is imperative that all participating plans offer a comprehensive essential benefit package for children.

Medicaid should serve as a model for the scope and breadth of essential benefits for children. Medicaid's pediatric standard of coverage – the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service – was developed specifically to meet the physical, emotional, and developmental needs of low-income children. Medicaid covers, for all children and youth under the age of 21: medical screens according to a periodicity schedule, including a comprehensive health and developmental history, an unclothed physical exam, immunizations, lab tests, and health education; vision, hearing, and dental services; and the necessary treatments and services (consistent with the scope of benefits under the Medicaid Act, 42 U.S.C. 1396(d)(a)) to correct or ameliorate physical and mental illnesses.[18]

Using EPSDT as a model for essential pediatric benefits will ensure that plans in the Exchanges are required to provide not only frequent screening and preventive measures,[19] but also comprehensive treatment to correct or ameliorate physical and mental conditions, including for chronic diseases and developmental conditions. This coverage will differ from that of current private insurers that have a narrow definition of medical necessity, limited to services that diagnose or treat illnesses and are needed to restore normal functioning.[20] In fact, a recent study in the New England Journal of Medicine found that children in private plans are more likely to be *under*insured than their counterparts in public programs. This underinsurance includes inadequate coverage of charges (i.e. unmanageable cost-sharing), insufficient benefits, and barriers to accessing providers.[21]

In addition to using Medicaid as a model, the Secretary should consider existing state laws that require coverage of certain services for children. For example, 16 states and District of Columbia mandate that insurers in the individual market cover services for autism.[22] These laws should be assessed for possible incorporation into the essential benefits package. Including these state-mandated benefits in the essential health benefits package would mean that states would not have to absorb any additional premium costs as a result of requiring coverage of these benefits in

[18] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). For further explanation, *see, e.g.*, National Health Law Program, Towards a Healthy Future: Medicaid Early and Periodic Screening, Diagnostic and Treatment Services for Poor Children and Youth (Apr. 2003).
[19] Fortunately, the ACA § 1001 requires plans to cover, without cost-sharing, preventive care and screening for children as outlined in *Bright Futures*. This important requirement will help to ensure that children receive the most effective and up-to-date preventive interventions.
[20] *See, e.g.*, Rosenbaum & Wise, *supra* note 16, at 387-91.
[21] Michael D. Kogan, Ph.D. et al., *Underinsurance Among Children in the United States*, 363 NEW ENG. J. MED., 841-51 (2010).
[22] Horner & Corlette, *supra* note 9, at 5.

the Exchanges.[23] At the very least, existing laws should be preserved because the establishment of Exchanges does not nullify the individual market outside the Exchanges.

Congress understood the heightened need for ensuring that the Exchanges adequately cover low-income children. The ACA requires the Secretary, in 2015, to review benefits and cost-sharing for children in the Exchanges and certify that they are at least comparable to benefits and cost sharing in CHIP.[24] Considering that many states cover EPSDT benefits for children enrolled in CHIP (in addition to those enrolled in Medicaid), states will be better able to satisfy this requirement if they ensure a robust pediatric benefit package when initially setting up the Exchanges.[25]

Conclusion

The ACA gives the Secretary of Health and Human Services broad discretion to define essential health benefits. Advocates should push for regulations that ensure robust coverage for low-income children and children with special health care needs. The Secretary should use the Medicaid EPSDT scope of services and "correct or ameliorate" coverage standards as a foundation for deciding the scope of essential benefits for these children.

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[23] The ACA provides that states may require additional benefits beyond the essential benefits package, but must assume any additional costs. ACA §§ 1311, 10104(e)(1) (2010).
[24] ACA § 10203(c) (amending 42 U.S.C. § 1397ee (a)(3)(F)(iii)) (2010).
[25] For example, 11 states and D.C. use their CHIP funds to expand their Medicaid program to cover more children. Donna Cohen Ross & Caryn Marks, Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009 (January 2009).