

American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Testimony of
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On behalf of the
American Academy of Pediatrics

Before the
U.S. Department of Health and Human Services
Senior Department Officials Considering the Composition of
Essential Health Benefits

My name is Patience White and I join you today on behalf of the 60,000 primary care pediatricians, pediatric subspecialists and pediatric surgical specialists of the American Academy of Pediatrics. Let me begin by thanking you for the opportunity you've afforded to the AAP to respond to your questions with respect to essential health benefits – which I'll call EHB. I understand we have been asked to be brief and I intend to respect that request by restricting my remarks to the specific questions raised by HHS. However, the Academy would like to point out that while HHS requested feedback on a list of EHB questions from sections in the statute, there is another important section that does not form the basis of questions for which you requested a response. This requirement is found in section §1302(b)(4)(C). This section requires HHS to “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.” We urge you to prioritize this section.

Beyond this request, the essential message that I would ask that you take away from AAP is this: the health care needs of infants, children, and adolescents are sufficiently distinct from those of adults that a health care system designed for adults will not meet the needs of children and should not be imposed upon them. Care for children is different. For example, the number one cause of death in children is injury, not heart disease or cancer. Obesity is epidemic and children and youth with special health care needs constitute around 15% of the population but only around 40% of the costs associated with financing health care for the pediatric population, even with a Medicaid benefit constrained by medical necessity. Children are dependent upon caregivers for interactions with the health care system. They are in continuous stages of development, so their capabilities, physiology, judgment, and response to interventions constantly changes and must be continuously re-assessed. Additionally, an important and growing segment of children suffer from chronic conditions that affect their development and that require specific attention to generating, maintaining, and restoring age appropriate functioning. Finally the economic, ethnic, and racial demographics of children in the U.S. put them at risk of adverse outcomes due to health disparities that are more prevalent in the pediatric population. Note that 22% of children now live in poverty and that certain pediatric populations have much higher rates – 26.6% of Hispanics and 27.4% Blacks now live in poverty according to the most recent census data.¹

The AAP urges HHS to build in purposeful consideration of the unique characteristics of children in establishing and updating the EHB. These considerations must and should frame all plans for the design and financing of health care services for the pediatric population. As to your specific inquiries:

Question 1. How can the Department best meet the dual goals of balancing the comprehensiveness of coverage included in EHB and affordability?

¹ U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, Issued September 2011, Retrieved from: <http://www.census.gov/prod/2011pubs/p60-239.pdf>

The Academy has set forth the standards of benefits that are necessary for children in its Scope of Benefits Policy Statement, of which I am a co-author, and included the limitations of those benefits in its Medical Necessity Model Contract Language policy statement. We urge your review of these documents initially. Beyond these statements and to the question of cost and balance, we believe that §1302(b)(4)(A) obligates the Secretary to consider other issues beyond cost alone as the basis for achieving an “appropriate balance” and weight attributed to each EHB category. In the context of children, we urge you to remember that most pediatric care is preventive, but the cost of these services is relatively low in comparison to other listed services that are also medically necessary. If affordability – based on actuarial value - is the dominant gauge, children will be shortchanged because medically necessary care receives a high actuarial value but is very inexpensive in practice.

AAP respectfully suggests that the Secretary consider the impact on specific populations as a way to set forth an “appropriate balance,” noting that children constitute more than one quarter of the US population. Public health needs could be another standard used by the Secretary to perform an analysis to achieve “appropriate balance.” In this regard, we note that investments in children lead to long-term savings in the adult diseases that create significant costs for the US health system, such as heart disease, diabetes and cancer.

We would also urge that the Secretary include in the initial EHB consideration an analysis of the impact on state budgets of a “small” EHB package. The ACA creates an interaction between state mandates and the EHB in that state mandates that are not covered in the EHB must be paid for by states. Such an analysis would tend to suggest that significant state mandates not included in the EHB will negatively impact state budgets – which at this time are incredibly fragile. We would urge a large EHB to decrease this burden as well as to best help children.

If the Secretary does choose to inject financial considerations into the EHB analysis, we would note the relatively low cost of pediatric services. In the Medicaid program, for example, children constitute more than half of all enrollees but account for only 20 to 25% of the costs of the program.² This includes coverage for all medically necessary services, which one might assume would lead to massive costs, but simply does not due to the relative health – and low-cost nature - of much of the pediatric population. We urge the Secretary to remember these realities, as opposed to cost projections alone, in setting forth an analysis of the weight of differing EHB categories.

Question 2. How might the Department ensure that EHB reflect an appropriate balance among the categories so that they are not unduly weighted toward any category?

² The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) and CMS-64 reports from the Centers for Medicare and Medicaid Services (CMS), 2011.

The Academy hopes to respectfully remind HHS that the inescapable actuarial reality for children remains that the benefits of certain interventions in children become manifest only with a significant time lag. This creates a built in incentive for enterprises with limited time horizons to minimize the importance of these interventions placing children at a distinct disadvantage when coverage decisions are being entertained. The EHB does not need to reinforce these constraints.

Children also need a medical home. A medical home is not a building, house, hospital, or home healthcare service, but rather an approach to providing comprehensive primary care. In a family-centered medical home the pediatric care team works in partnership with a child and a child's family to assure that all of the medical and non-medical needs of the patient are met. Through this partnership the pediatric care team can help the family/patient access, coordinate, and understand specialty care, educational services, out-of-home care, family support, and other public and private community services that are important for the overall health of the child and family. The American Academy of Pediatrics (AAP) developed the medical home model for delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, including children and youth with special health care needs. A benefit package for children that limits benefits in the name of decreased cost stands the chance to decrease coordination within a child's medical home and fragment their primary and specialty care.

Question 3. What policy principles and criteria should be taken into account to prevent discrimination against individuals because of their age, disability status, or expected length of life as the Affordable Care Act requires?

AAP believes that the section of the statute that provides the foundation for this question (sec. 1302b(4)(D)) establishes a further bulwark for children against discrimination regarding coverage decisions. We respectfully remind HHS that this prohibition applies not only to discrimination on the basis of old age but also of youth. Children are often excluded from coverage determinations because of lack of clinical evidence, but more often because they are simply assumed to be similar to adults. As an example of this bias in the health system, we note that coverage determinations are often made through the Medicare program. A recent Medicare decision to provide coverage for intensive behavioral therapy to treat overweight and obesity, applies only to adults.³ Because so few children are covered by Medicare, it is understandable

³ Proposed Decision Memo for Intensive Behavioral Therapy for Obesity (CAG-00423N); available at <https://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=253&fromdb=true>. This document states the following:
Intensive behavioral therapy for obesity consists of the following:

1. Screening for obesity *in adults* using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed in kg/m²);
2. Dietary (nutritional) assessment; and
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

that the program would not approve these services for children below the age of 19. But considering the epidemic nature of obesity in children, this decision is an example of what can happen when children are not explicitly considered in structures for coverage determinations. Reminding those who make decisions about insurance to remember that children can be forgotten if they are not explicitly protected is paramount and militates against limiting children's benefits based on non-clinical considerations.

Question 4. What models should HHS consider in developing EHB?

Children are arguably widely discriminated against under the current employer-based health system because their care is generally inexpensive and the focus of health insurance is often on adults, whose care is more expensive on the whole--more expensive because of conditions that could have been prevented in childhood, where lifetime health begins. Medicaid is often the only appropriate home to address the needs of the sickest children and youth with special health care needs. Thus, Medicaid provides an essential foundation for employer-based private insurance, which should be capable of financing the care of the most vulnerable children but too often fails to do so.⁴ This is because the standard for coverage of services in many employer plans is simply inadequate to meet the developmental needs of the sickest children.

The AAP believes that the Secretary should turn to the well-established medical necessity requirements found in the Medicaid program to answer question 4. The standard of coverage for the services in Medicaid is bounded by appropriate clinical limits on pediatric care (which in private plans often finance only the care of children to "improve" health status). The medical necessity standard requires that children receive comprehensive treatment to correct or ameliorate physical and mental conditions, including chronic diseases and developmental conditions. It should also be noted that insurers are familiar with this standard due to the fact that most children currently covered by Medicaid have their care financed by Medicaid Managed Care Plans. These plans are intimately familiar with financing the care of children based on medical necessity because they finance the work of Medicaid care providers every day.

Question 5. What criteria should be used to update essential health benefits over time and what should the process be for their modification?

The Academy would urge the Secretary to turn to medical professionals and their associated medical societies, like the AAP for this information. As has been stated, basing coverage determinations on Medicare consideration will limit children's access to medically necessary care.

(emphasis added)

⁴ See Michael D. Kogan, Ph.D., et. al, "Underinsurance among Children in the United States," N Engl J Med 2010; 363:841-851. August 26, 2010.

Additionally, the Academy understands the desire that interventions be evidence based but since large scale randomized controlled trials are significantly less plentiful for children than for adults, when that standard is lacking, observational studies, professional standards of care, or consensus of pediatric expert opinion must serve as acceptable substitutes. And again, Medicaid's benefit – EPSDT - bounded by medical necessity should serve as the standard along with Bright Futures recommendations.

Modifications to the EHB should include input from physicians specialized in the care of the populations at issue. The mechanisms for receiving and processing this information should be placed on a schedule of periodic review to insure that they reflect ongoing changes in our understanding of clinical and social science in a timely manner.