Making the ACA Work for Children

Population Health Sciences

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Ninety-one percent. That's the proportion of children who had insurance coverage in the U.S. when the Affordable Care Act (ACA) was passed in 2010. Not perfect, but respectable given the policy success of the prior decade in expanding Medicaid and the Children's Health Insurance Program (CHIP) for children in this country. So, pre-ACA, most children were able to access primary care at rates far higher than their parents.

But even as we celebrated some of these achievements of the last two decades, the landscape for child and family well-being, both in healthcare and outside, was eroding. As healthcare costs spiked in this country past 16% of GDP by 2010, federal budgets became weighed down by financial commitments to Medicaid and Medicare, and state budgets likewise were consumed by the state Medicaid match. This led to shortfalls for many public systems, including behavioral health, education, and child welfare. At the office, employee wages were stagnating due to the increasing cost of healthcare benefits. Family premiums were rising. And greater out-of-pocket costs were being passed along to families.

The ACA, with its focus on providing affordable coverage to families and slowing the rate of growth of healthcare spending, is intended to help reverse some of these dynamics. And that is a good thing. At the same time, the changes brought about by the ACA have the potential to create inadvertent consequences, and for children and families, these issues, at least in the near term, will be acute. Front-end policy choices as well as design issues with the healthcare.gov websites have already created a significant burden for parents, who may be put in the unenviable position of navigating two or three plans to cover their family. For example, in one family a father may be eligible for exchange subsidies but quickly realize that his pregnant wife will require Medicaid and his children can receive coverage through CHIP. The result: three health plans to obtain full family coverage. And the CHIP coverage for all children faces an uncertain future past 2015, when its funding lapses unless it is reauthorized.

The ACA also raises critical implementation issues related to cost and quality that are making their way to pediatrics. Truth be told, the ACA is only accelerating what many payers and providers have been trying to tackle for years: restraining the rate of growth of healthcare spending. What we now see coming on line for pediatrics are payer models that are moving away from fee-for-service payments toward global or shared risk models that reward value.

As these changes trickle down to children and families, those of us serving families, whether in healthcare, or in the community at large, will be pressed to adapt our programs to meet the needs of increasing numbers of children with complex challenges, even as we face shrinking budgets and resources. Healthcare delivery systems will need to optimize their approaches in population management, provide better value for their services they deliver, and strengthen protections to ensure that clinician-patient relationships preserve a strong family-centered approach. Public partners will need to strengthen the approach by which they manage their own quality of services, and add protections to ensure that children are not slipping through the cracks. And we

will have to work with families to help them navigate an increasingly complicated health environment, where technology and new forms of social media may change the way they interact with their providers.

There are two points of view at this moment in time: glass half-empty or glass half-full. We at PolicyLab see the latter. The daunting challenges that drove the need for reform are bringing about a dynamic time of innovation for our healthcare and public systems serving children. Success in this environment requires new partnerships and smart solutions.

PolicyLab was founded based on our vision that our collective experience as healthcare providers at the Children's Hospital of Philadelphia could inform a model of "evidence to action" where deeply engaged partnerships with families, providers, health executives, public program leaders, and policymakers could identify and implement programs and policies for children that were informed by the best research. Our research falls into three broad areas: improving health care delivery, improving public systems, and improving child health outcomes. Although the topics we cover are diverse, we are unified in our approach. As we launch our revised website, we hope it serves as a new resource for a wide range of users who, like us, are committed to improving health outcomes for children and families.

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