IMPLEMENTING HEALTH REFORM

Ending Preexisting Condition Exclusions for Kids

One of the hallmarks of the Patient Protection and Affordable Care Act is that people with preexisting medical conditions will no longer be denied coverage by insurance companies. For adults, this protection begins in 2014, but for many of those younger than age 19 years, it takes effect on Sept. 23. New regulations from the U.S. Department of Health and Human Services bar health plans from refusing to offer a policy because of a child's preexisting medical condition, and from imposing benefit limitations once the child is on a plan.

Dr. Judith S. Palfrey, president of the American Academy of Pediatrics, explains what this part of the law will mean for children.

DR. PALFREY

PEDIATRIC NEWS: How important is the ban on preexisting condition exclusions in children, in terms of access to insurance and coverage for treatments?

Dr. Palfrey: This is one of the most significant provisions within the health reform law in terms of what it means for improved access and care for some of the country's most vulnerable children. Before, if a child had a chronic condition like asthma, or a debilitating disease like cancer, it was possible for insurers to deny them care, when—ironically—they were the ones who needed treatment the most.

Although this provision is an enormous step forward, there is work to be done to make sure children can benefit whether they are enrolled in a new health insurance plan or an existing one. The AAP is working with Obama administration officials to make sure that the ACA provides access to as many children with preexisting health conditions as possible.

The ACA also guarantees an array of preventive services for all children, to be offered without copay or deductible, including a yearly physical, well-child visits, and routine immunizations as well as hearing, vision, developmental, and behavioral screenings. This will help physicians detect many diseases before they cause morbidity, then treat and monitor them as needed. These essential benefits could be life saving, especially for children with preexisting and often chronic or complex conditions.

PN: How many children are likely to benefit from this provision in the near future, and what are the implications for their future health?

Dr. Palfrey: We don't have data specifically on how many children are expected to benefit from this provision, but the Congressional Budget Office estimates that about 200,000 Americans will enroll in the Preexisting Condition Insurance Plan during 2011-2013. The plan will provide an option for many sick children to gain access to coverage they don't currently have, and since a good number of these children may have forgone care or treatment because of costs or being denied insurance, the enactment of this provision should improve their future health.

PN: Will this change the way pediatricians and other physicians who treat children and adolescents are able to care for their patients?

Dr. Palfrey: This should certainly make it easier to provide care to more children, because services now will receive some level of payment. This provision also should help provide a pathway for families to get private insurance for their children, increasing access to care.

This provision applies to all new insurance plans that begin after Sept. 23.

PN: Will this new requirement apply to all health plans, and what can physicians do to ensure that their patients are protected under the new law?

Dr. Palfrey: This provision applies to all new health insurance plans that begin after Sept. 23 It does not apply to plans that were already in existence when the ACA was signed into law last March, as long as those plans have not made any significant changes in coverage, like raising premiums or cutting benefits. The administration has issued additional guidance on the preexisting condition exclusions ban after some insurance companies threatened to drop child-only coverage options, citing concern about families who might enroll children only when they fall ill and drop coverage if their children are healthy.

The guidance allows insurers to limit families to specific periods of "open enrollment" when they can apply for insurance coverage for their children, rather than giving families the flexibility of applying throughout the year. The AAP is concerned that restricting families to an open-enrollment season prevents many vulnerable children from attaining health insurance when they need it. For example, if a child becomes ill outside of the open-enrollment period, parents may have to wait for months to get the child coverage. The AAP has commented publicly on this provision, and we hope to work with the administration to make sure that children can access care when they need it, regardless of their health status or the time of year. ■

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POLICY & PRACTICE

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Senate Okays Healthy Lunches Bill

The Senate approved by voice vote a $4.5 billion bill to create new, healthier standards for all foods sold in schools, including vending machine items. The legislation would authorize spending of $1.2 billion to increase the number of children receiving daily free meals and $3.3 billion to improve the nutrition of school meals, create school gardens, and purchase local produce. American Academy of Pediatrics spokesman O. Marion Burton praised the unanimous Senate action. "In addition to reauthorizing federal child nutrition programs, the bill will address childhood obesity by reducing the fat and calorie content of school meals," Dr. Burton said in a statement. The bill sets strict limits for the nutritional content of food in school vending machines and that served outside school lunch and breakfast programs. Similar legislation is pending in the House.

Many New Enrollees Had Insurance

About 60% of children newly enrolled in the Children's Health Insurance Program (CHIP) as part of the federal-state program's 2009 expansion probably had private coverage and switched to less expensive public insurance when it became available, according to a report in the journal Forum for Health Economics & Policy. The private-to-public shift means that CHIP has not expanded to as many uninsured children as intended, the report said. But switching from private to public coverage helps the families involved, allowing them to reduce out-of-pocket medical and insurance payments by more than $100 per month. According to the report, families typically put these savings toward transportation or retirement accounts. "These results suggest that the SCHIP expansions substantially improved the material well-being of the low-income families it is intended to assist—including those who had previously been paying for their own coverage," the researchers concluded.

Coaches to Aid Enrollment

In an effort to reach the roughly 5 million uninsured children who are eligible for Medicaid and CHIP, the Department of Health and Human Services will educate youth sports coaches about the public insurance programs and encourage the coaches to help enroll eligible children. The HHS will pilot the "Get Covered, Get in the Game" initiative in Colorado, Florida, Maryland, New York, Ohio, Oregon, and Wisconsin. Uninsured children often miss out on sports activities because they cannot afford the required physicals or because their families worry about the potential cost of injuries, according to the HHS. "Kids should not have to miss out on their favorite sports and other activities that get them moving because they lack health insurance coverage," HHS Secretary Kathleen Sebelius said in a statement.

Many Children Still Live With Smokers

Nearly 18% of children in West Virginia and Kentucky live with smokers, making those children the most likely in the nation to suffer from secondhand tobacco smoke in their homes, according to a study published in Pediatrics. Nationwide, more than 7% of children—5.5 million overall—live with smokers, according to 2007 data analyzed by researchers at the Health Resources and Services Administration and the University of Nebraska. Children in Utah and California had the lowest odds of living with a smoker—in Utah, about 1% of children and in California, just under 2% of children breathed secondhand smoke at home. Children from higher socioeconomic backgrounds, Hispanic families, and non–English speaking households were less likely than were others to have secondhand smoke exposure, the study found.

Youth Drinking Yields Emergencies

Nearly 189,000 patients aged 12-20 were treated for alcohol-related problems at emergency departments in 2008, highlighting the extent of the underage drinking problem in the nation, according to the Substance Abuse and Mental Health Services Administration. The episodes accounted for about one-third of the drug-related ED visits by adolescents and teenagers, the report said. About 30% of the alcohol-related ED visits also involved drugs such as marijuana, anti-anxiety medications, narcotic pain relievers, and cocaine.

Senators Push Rare-Diseases Bill

Three senators have introduced bipartisan legislation that would create financial incentives for drug manufacturers to develop new treatments for rare pediatric diseases. The Creating Hope Act of 2010, sponsored by Sen. Sherrod Brown (D-Ohio), Sen. Sam Brownback (R-Kan.), and Sen. Al Franken (D-Minn.), would allow companies developing treatments for rare pediatric diseases to expedite Food and Drug Administration review of other, more commercially viable drugs. A drug maker that develops a treatment for a rare, neglected pediatric disease would receive a "priority review voucher" from the FDA that it could use to speed review of another product it wished to market, providing "a strong financial incentive for the development of treatments for otherwise neglected diseases," Sen. Brown said in a statement.

—Jane Anderson