Children and the Patient Protection and Affordable Care Act: Opportunities and Challenges in an Evolving System

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ABSTRACT

The Patient Protection and Affordable Care Act (ACA), passed in 2010, focused primarily on the problems of adults, but the changes in payment for and delivery of care it fosters will likely impact the health care of children. The evolving epidemiology of pediatric illness in the United States has resulted in a relatively small population of medically fragile children dispersed through the country and a large population of children with developmental and behavioral health issues who experience wide degrees of health disparities. Review of previous efforts to change the health care system reveals specific innovations in child health delivery that have been designed to address issues of child health. The ACA is complex and contains some language that improves access to care, quality of care, and the particular needs of the pediatric workforce. Most of the payment models and delivery systems proposed in the ACA, however, were not designed with the needs of children in mind and will need to be adapted to address their needs. To assure that the needs of children are met as systems evolve, child health professionals within and outside academe will need to focus their efforts in clinical care, research, education, and advocacy to incorporate child health programs into changing systems and to prevent unintended harm to systems designed to care for children.

KEYWORDS: child health; health reform; health care systems; pediatrics

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WHAT'S NEW

The Patient Protection and Affordable Care Act (ACA) is intended to expand insurance coverage, enhance the range of services covered, and change the payment and incentive structure of medical practice in the United States. The coming changes may have unintended consequences for children and for child health providers. Active engagement is required by the pediatric community to assure that children's health is not adversely affected by implementation of the ACA.

> NO COUNTRY CAN be strong whose people are poor and sick.
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> —President Theodore Roosevelt (1912)

The explosion of knowledge in the life sciences over the last century has changed the morbidity, mortality, and life course of people in the developed world. As medicine improved the diagnosis and treatment of illness, health care delivery and payment systems evolved to support physicians' efforts. In 1929, as physicians and hospitals began incorporating science and technology into practice, the first Blue Cross health insurance plan began in Texas.[1] The concept quickly spread throughout the country, accelerated by tax incentives afforded companies that provided health insurance as an employee benefit during World War II.[2] After the war, the need for improved access to care for the newly insured led to passage of the Hill-Burton Act, fueling construction of thousands of hospitals across the country.[3] The new diagnostic and therapeutic modalities were expensive. To fill the gaps in care to the poor, disabled, and elderly, public insurance programs (Medicare and Medicaid) were created in the 1960s, expanding insurance coverage to those outside the private health insurance system.[4,5] In the 1970s, new delivery systems (community health centers and health maintenance organizations) were promoted, extending services to rural and urban underserved areas.[6,7]

The United States has developed a wide variety of health care delivery systems that move medical science into medical practice. Each system is, in a sense, an answer to a larger societal question: "What level of access to care should we provide for patients, at what level of quality, and at what cost?" The multiplicity of responses to that question have resulted in a patchwork system, delivering excellent care locally to specific subpopulations within states or regions,

with little capacity to align care of the sick with health needs of the whole population. In 2010, Congress and the Obama administration passed the Patient Protection and Affordable Care Act (ACA) in an effort to align the interests of a wide range of stakeholders, focusing on the triple aim of better health, better health care, and lower cost.[8] The ACA is focused on solving the problems of adults, but the changes in payment for and delivery of health care it fosters will likely impact the health care of children.[9,10] Here we focus on children and US health care reform. We review the ways in which children and child health providers have been affected in past health reform, suggest ways the reforms embodied in the ACA could affect the care of children, and highlight opportunities for pediatricians to engage in ACA implementation to address the health needs of children.

Evolving Epidemiology of Pediatric Illness

Children and children's health care are rarely at the center of health reform,[11,12] and the existing environment is no exception. The current focus on cost-containment mandates policy shifts being tailored to adults, particularly those with dual-diagnoses and serious chronic illness because the total cost of pediatric care in the United States (roughly $300 billion per year) is dwarfed by adult costs ($2.4 trillion in 2010).[13–15]

Unfortunately, a sound policy approach for adults may undermine health access for children. The epidemiology of pediatric illness has shifted over the last 50 years, where the prevalence of serious acute illnesses and accidental injury has fallen while the prevalence of chronic disease has risen. In 1962, a total of 25% of pediatric admissions were for chronic conditions, compared with more than 50% in 2003 (excluding normal newborns and trauma).[16] The 16% of children with special health care needs consume 41% of pediatric health spending.[17] For the most medically fragile children, spending is further skewed: across 37 children's hospitals 19% of admissions and 23% of inpatient charges were accounted for by 3% of patients with frequent recurrent hospitalizations.[18] Because this subset of medically complicated children is relatively small, their care has become regionalized in pediatric specialty centers over the last 30 years, in some cases leading to increased survival and improved outcomes.[19]

A second epidemiological pattern includes increasing health disparities described by Dr Judy Palfrey: "In the ever-moving swirl of environmental and social change, there is now a new 'millennial morbidity.' The causes of poor physical and mental health are multi-focal. The ever-widening gap between rich and poor has produced large differentials in child health outcome by class and race. Moreover, underlying cultural, racial, and ethnic misunderstandings, biases, and miscommunication have resulted in an inequitable distribution of health care that is unconscionable."[20] The health disparities seen in the 2 most prevalent child conditions, asthma and obesity, are significant, and the morbidity is borne largely by the poor.[21] The ACA's focus on prevention, including the responsibility of physicians for the health of populations through accountable care organizations, may incentivize community engagement and a combined medical and public health approach to reduce health disparities.[22]

Child Health Reform in the 20th Century

With strong advocacy, past efforts for change in health care delivery have focused on children. After President Roosevelt's call for a healthier public in 1912, the Children's Bureau was established, leading eventually to the establishment of the Maternal Child Health Bureau (MCHB) through Title V of the Social Security Act in 1935.[23,24] Working with state governments over the decades, MCHB has supported system changes addressing the needs of the most vulnerable children in America. When Congress passed Medicare in 1965, providing universal health coverage for the elderly, it also created Medicaid to care for America's poorest children through Title XIX of the Social Security Act. After the failure to pass omnibus health reform legislation in 1994, a bipartisan effort in Congress resulted in the State Children's Health Insurance Program (SCHIP),[25] covering 8 million children of the working poor whose families earned too much to qualify for Medicaid but whose jobs did not provide private health benefits. Evaluation of SCHIP showed that it improved quality access to care and led to better use of care.[26] SCHIP became the focus of attention in the latter years of the Bush administration, when its reauthorization was vetoed twice. A continuing resolution by Congress sustained the program until it was reauthorized as the first act of the Obama administration in January 2009. The ACA authorizes SCHIP until 2019 and provides $40 million to support Medicaid and SCHIP outreach and enrollment.[27] Funding for SCHIP under the ACA, however, ends in 2015.

Children have benefited when federal policy has recognized the connection between public health and primary health care. After the measles epidemic of 1989 to 1991, the Centers for Disease Control reported afflicted children were unimmunized despite having access to medical care. Congress responded by establishing the Vaccines for Children (VFC) Program as section 1928 of the Social Security Act.[28] VFC improved immunization delivery through a combination of access for the uninsured, improved payments to providers, and enhanced distribution systems.

Overall, while children and their unique health care needs have not always been the focus of US efforts at health reform, history shows that focused advocacy can create policies that direct evolving systems to meet the needs of children.

Role of Child Health Services Research in Previous Efforts at Health Reform

In the past, health reform efforts have used child health research to address the unique needs of children. A series of studies funded through the Children's Bureau in the