

From EPSDT to EHBs: The Future of Pediatric Coverage Design Under Government Financed Health Insurance

abstract

We review the evolution of federal financing for child health care over the past 40 years. The Social Security Amendments of 1967 established the program of early and periodic screening, diagnosis and treatment (EPSDT) as a required Medicaid benefit. The EPSDT amendments directed agencies to cover “early and periodic” screening and diagnostic services to ascertain “defects” and “chronic conditions” in children, as well as health care and treatment needed to “correct or ameliorate” such defects and conditions discovered during the screening examinations. The 1997 enactment of the Children’s Health Insurance Program (CHIP) shifted federal policy from the use of an early coverage standard to one that gives insurers much more discretion to define medical necessity and coverage exclusions. CHIP programs offer coverage that is narrower than the benefits available under Medicaid. The Affordable Care Act (ACA) requires significantly more classes of care to be covered than does CHIP but well below the level of coverage under Medicaid. Implementation of the ACA to date suggests that the US Department of Health and Human Services will only demand pediatric coverage pegged to the commercial insurance market standards, rather than Medicaid’s unique pediatric coverage standard. Although EPSDT’s emphasis on early, developmental, and ameliorative services might result in more comprehensive benefits for children, particularly those with special health needs, one might still describe the ACA coverage as providing a basic, minimal level of services from a distributive justice perspective. It may, however, vary from state to state. States have the authority to decide whether to use an EPSDT-style approach or to follow the more restrictive approach of commercial insurance plans. Advocacy at the state level will determine which approach different states take. *Pediatrics* 2013;131:S142–S148

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KEY WORDS

Medicaid, Affordable Care Act, distributive justice, resource allocation, public policy

ABBREVIATIONS

ACA—Affordable Care Act

CHIP—Children’s Health Insurance Program

EHB—essential health benefits

EPSDT—early and periodic screening, diagnosis, and treatment

HHS—US Department of Health and Human Services

IOM—Institute of Medicine

www.pediatrics.org/cgi/doi/10.1542/peds.20130252e

doi:10.1542/peds.20130252e

Accepted for publication Jan 23, 2013

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FINANCIAL DISCLOSURE: *The authors have indicated they have no financial relationships relevant to this article to disclose.*

FUNDING: No external funding.

The Affordable Care Act (ACA) established a health benefits framework for health insurance products sold in the individual and small group insurance markets. Known as essential health benefits (EHBs),¹ this framework is of great importance to pediatric health policy: beginning in 2014, the EHB standard will apply to health plans sold in the small employer group market as well as to products sold in the individual insurance market and purchased directly by families. In the case of low- and moderate-income families who purchase subsidized coverage through state health insurance Exchanges, the EHB standard establishes the level of coverage that families in need of government assistance to gain access to affordable benefits will receive. In December 2011, the US Department of Health and Human Services (HHS) took initial steps to implement the EHB framework by issuing guidelines that begin to define the scope of the EHB obligation.² Although formal proposed regulations are expected to be issued before the end of 2012, this initial guidance sheds considerable light on how the EHB standard will affect the insurance market and the level of care that will be financed for children. Most notably, the 2011 guidance affords insurers considerable discretion to define and apply the EHB coverage standard. Under the ACA, states have the authority to refine this standard through their insurance regulatory powers; they also have the power to extend the scope of required health benefits for children beyond the scope of benefits that fall within the EHB definition. (States that elect to add classes of benefits beyond those falling within EHB coverage groups will also be expected to supplement the federal premium assistance available to families purchasing coverage through state Exchanges, using their own funds to do so.) How insurers interpret the EHB

standard where pediatrics are concerned, as well as the extent to which states act to refine the scope and meaning of the EHB coverage standard to curb insurer discretion, thus become matters of central importance to pediatric health.

HHS's decision to vest power in insurers and states has been criticized as allowing both geographic inequities and discrimination against people with rare, severe, or costly health conditions.³ On the other hand, some experts have argued that this structure effectively encourages states (and insurers) to test different approaches to managing health care costs and quality under the new market for subsidized health insurance created by the ACA.⁴ Because, as discussed below, one of the specific EHB coverage classes is "pediatric" services, pediatricians may have a unique opportunity in the coming years to become involved in shaping the future of pediatric coverage policy in their states. In this vein, it is helpful to review the evolution of pediatric coverage standards under government-financed health insurance, as well as the underlying principles on which these evolving coverage standards rest.

Addressing the scope and depth of pediatric coverage policy can be expected to emerge as a matter of high-level importance as we implement the ACA, especially for children who experience the types of severe and chronic physical, mental, and developmental conditions that long have been subject to exclusionary and discriminatory insurer coverage standards. It is in this context that the coverage standards under Medicaid's early and periodic screening, diagnosis, and treatment benefit (EPSDT) came into being. Although the EPSDT coverage standard has long been associated with coverage for the nation's most impoverished children, in fact millions of children

with disabilities from moderate- and middle-income working families have benefitted from EPSDT as both a primary payer and as a secondary payer that supplements coverage available under an employer-sponsored plan. Because the ACA bars Medicaid from playing this traditional secondary-payer role in the case of children receiving subsidized coverage through state Exchanges,⁵ however, the imperative grows to ensure the broadest possible interpretation of the EHB "pediatric" benefit class in the case of children with long-term disabilities.

THE EVOLUTION OF PEDIATRIC COVERAGE STANDARDS UNDER FEDERAL LAW

From a public policy perspective, EPSDT stands as a watershed in US pediatric coverage policy. Passage of the Children's Health Insurance Program (CHIP) in 1997 marked a significant retreat from this early standard, moving government financing away from the comprehensiveness and depth of coverage that is EPSDT's hallmark and toward commercial insurance norms. The ACA continues along the CHIP commercial insurance coverage trajectory through its EHB provisions, even as it strengthens CHIP's framework in several notable respects and directs the HHS secretary to take steps to bar coverage discrimination against persons with disabilities in the case of health plans that operate under EHB rules. Whether, and the extent to which, the EHB improvements, along with the ACA's bar against discrimination in coverage, will translate into effective protections for children with disabilities is unclear, especially since the December 2011 HHS guidelines do not address either the question of what might be fully encompassed in the EHB "pediatric" service class or the types of insurer practices that will be considered to constitute discrimination.

EPSDT

The Social Security Amendments of 1967, which established EPSDT as a required Medicaid benefit, ushered in a new era in public policy related to government-financed health insurance for children. The original Medicaid statute treated children no differently from adults where the content of coverage was concerned. However, seminal studies documenting widespread and preventable disability among young military draftees, as well as the health status of young children enrolled in the earliest Head Start programs, resulted in legislation representing a conceptual breakthrough in health insurance coverage policy for children.⁶

The 1967 EPSDT amendments directed case-finding and comprehensive health care interventions by state maternal and child health agencies operating under cooperative agreements with state Medicaid agencies. Over the years, EPSDT gained notoriety as a result of confusion and uncertainty on the part of federal and state policy makers over how best to implement its case-finding and outreach provisions.⁷ At the same time, and crucial to Medicaid's operation as a source of pediatric health care financing, the EPSDT amendments established new coverage requirements under Medicaid, directing agencies to cover "early and periodic" screening and diagnostic services to ascertain "defects" and "chronic conditions" in children, as well as health care and treatment needed to "correct or ameliorate" such defects and conditions discovered during the screening examinations.⁸ This uniquely sweeping language from the amendments has survived essentially in its original form. Furthermore, in 1989, Congress built on its original provisions to establish the broadest articulation of pediatric coverage ever codified in law.^{9,10} The reframing of EPSDT explicitly broadened coverage to enable

comprehensive coverage of health treatments for children with disabilities.

In its current form, the EPSDT benefit is uncommonly sweeping, not only in its primary preventive coverage (comprehensive health examinations, assessment of developmental health, and comprehensive vision, dental, and hearing care) but also in the degree to which its terms encompass all medically necessary treatments and services falling within any of Medicaid's dozens of enumerated benefit classes, regardless of whether coverage would be available under a state Medicaid plan in the case of individuals aged ≥ 21 . Moreover, because EPSDT's purpose is early and preventive, courts have interpreted its provisions to encompass not only treatments that improve health, but also treatments that enable children with disabilities to attain and maintain maximum developmental health.¹¹ As a result, the EPSDT benefit bars limitations and exclusions used by commercial insurers to exclude otherwise-covered treatments that promote the health of children with chronic and serious physical and mental health conditions that delay development.^{10,12,13}

CHIP

The 1997 enactment of CHIP marked a distinct turn in the evolution of child health policy under government insurance programs.¹⁴ Whereas Medicaid's hallmark for children is comprehensiveness and depth of coverage, CHIP emphasized alignment with the commercial insurance market and its coverage norms. Rather than mandating coverage of numerous benefit classes and the use of an "early" and "ameliorate" coverage standard, CHIP uses a "premium support" approach to coverage of Medicaid-ineligible "targeted low-income" children. This approach permits states that elect to

operate separate CHIP programs to use commercial insurance models to design pediatric coverage. Under this design, few benefit classes are specified (inpatient and outpatient hospital services, physician services, laboratory and x-ray services, "well-baby" and "well-child" care including immunizations, and (beginning in 2009) pediatric dental care).¹⁴ Furthermore, insurers are given discretion to define medical necessity and the terms of coverage exclusions. As a result, insurers have the power to exclude otherwise-covered services and treatments that are needed to achieve or maintain developmental health. Separately administered CHIP programs therefore offer coverage that is narrower than the benefits available under Medicaid.¹²

THE EHB STATUTE

The EHB statute mirrors the CHIP approach to coverage design, while introducing important improvements. The ACA applies EHB coverage design rules to all health plans sold in the individual and small group health insurance market,¹ regardless of whether such coverage is offered inside or outside state health insurance Exchanges.¹⁵ Because low- and moderate-income qualified individuals who lack other forms of coverage and who purchase individual coverage for themselves and their family members through Exchanges are entitled to premium affordability and cost-sharing assistance, Exchanges become a crucial source of affordable insurance coverage for families whose incomes exceed the upper threshold for Medicaid eligibility but fall within the limits specified for affordability assistance (400% of the federal poverty level).¹⁵ Included in this large group of families qualified to receive affordability assistance are millions of low- and moderate-income children. Thus,

indirectly at least, the EHB statute operates as an extension of US public policy regarding the design of pediatric coverage under government-financed insurance. EPSDT remains in effect for all children enrolled in Medicaid.

The EHB statute establishes 10 required benefit classes, significantly more than the required classes found in CHIP but well below the level of coverage under Medicaid. Because one of the EHB coverage classes is “pediatric” services, the secretary has the power to define coverage for children in a manner that exceeds the scope and depth of coverage for adults. To date, she has not exercised her power in this fashion. The ACA does specify that, in the case of children, EHBs include both oral and vision care,¹⁶ thereby somewhat broadening coverage for children as a matter of federal statutory law. Furthermore, the EHB statute specifies inclusion of some level of habilitation services. But without secretarial implementation of standards oriented to pediatric standards of necessity, insurers potentially retain the discretion to use coverage limitations that place limits on developmental treatments or exclude them entirely.

Preventive services under the ACA begin to approach levels found in EPSDT. The ACA requires coverage of preventive services without cost-sharing in the case of virtually all health insurance products, including those governed by the EHB statute. By law, covered preventive services consist not only of all recommended immunizations (a requirement applicable to both children and adults) but also “evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.”¹⁷ Thus, compared with CHIP, the ACA preventive coverage standard, when applied to EHB-governed products, offers a potentially broader range

of benefits. Furthermore, the ACA offers what arguably may be a more expansive vision of preventive coverage, requiring that preventive coverage be “evidence-informed” rather than resting on traditional concepts of “well baby” and “well-child” care.

At the same time, the ACA fundamentally operates as premium support for commercial insurance. Indeed, the EHB statute explicitly references “typical” employer plans as the coverage norm, thereby operating in a legal framework that, like CHIP, is distinct from that which governs Medicaid. For this reason, children enrolled in plans secured with government support through state Exchanges remain potentially subject to the limitations and exclusions found in the commercial insurance market, the hallmark of which is exclusion of developmental treatments for children with serious and chronic conditions and disabilities.

Despite its tethering to the commercial insurance markets, the ACA contains 2 important limits on insurer discretion to discriminate in coverage on the basis of disability. First, as noted, the ACA classifies habilitation services as a specific covered benefit, thereby potentially prohibiting insurers from entirely excluding developmental coverage for children whose need for treatment relates to physical and mental health conditions that affect development.¹⁶ Second, the ACA bars the HHS secretary, in implementing the EHB provisions, from making “coverage decisions, determin[ing] reimbursement rates, establish[ing] incentive programs, or design[ing] benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.”¹⁶ As of fall 2012, however, HHS had offered virtually no in-depth guidance to health plans or state Exchanges as to the meaning of these limitations on insurer discretion. The guidelines issued

in late 2011² reiterate the prohibition on discrimination in coverage design on the basis of disability but offer no illustrative examples of what types of insurer actions (such as medical necessity coverage standards that emphasize improvement and restoration rather than attainment and maintenance) would be considered discriminatory. Furthermore, while the bulletin reiterates the EHB coverage classes, including habilitation coverage, it also provides that insurers have the option to use an “actuarial equivalence” approach to coverage. Under this approach, as long as at least some level of coverage is offered for each required benefit class, an insurer would remain free to reduce its investment in habilitation services to offer enhanced benefits within another coverage class, such as additional substance abuse disorder services or additional levels of preventive services.

In sum, implementation of the ACA to date potentially signals pediatric coverage design pegged to the commercial insurance market rather than Medicaid’s unique pediatric coverage standard. Were the secretary to use her authority, however, to insist on greater scope and depth of coverage for children, such an interpretation certainly would be warranted by the terms of the ACA itself as well as by the overall goals of the act. On one hand, the ACA places special emphasis on improving health system performance through greater investments in prevention and primary care. This emphasis can be seen in its terms of coverage, in models of health delivery such as Accountable Care Organizations and health homes, and in investments in greater access to primary health care. On the other hand, the ACA simultaneously emphasizes health system performance improvement in the management of chronic physical and mental conditions and illnesses. By and large, adults are the primary focus

of this emphasis on the management of chronic conditions, chiefly because many of the chronic illness provisions are codified in the act's Medicare amendments as well as in the establishment of the Center for Medicare and Medicaid Innovation, the primary focus of which is on reducing the financial and health burden of chronic conditions among Medicare beneficiaries. Whether HHS will pursue the theme of reducing the burden of chronic conditions in a pediatric context remains to be seen. Such a step certainly would be consistent with the act's overall emphasis on quality under its National Quality Strategy.¹⁸

EPSDT VERSUS EHB: IS THE NEW COVERAGE STANDARD FAIR FOR CHILDREN?

The EHB statute has been widely hailed as a major step forward in improving the quality of coverage. Indeed, beyond a few specific mandates enacted under previous laws, federal law has never attempted to name the benefits that private insurance plans must cover, nor have states generally done so in a comprehensive manner.¹⁹ A critical question as implementation proceeds, however, is whether the new coverage standard will result in the fair provision of services to the millions of low- and moderate-income children to whom it will apply, especially children who experience serious health conditions.

Although EPSDT's emphasis on early, developmental, and ameliorative services might result in more comprehensive benefits for children, particularly those with special health needs, one might still describe EHB coverage as providing a basic minimal level of services from a distributive justice perspective. The questions underlying an assessment of EHB coverage as a new standard for children's health care, then, are what should comprise that basic minimum, and how is that level to be determined? An extensive

body of academic literature, of course, is devoted to these questions and the principles on which such decisions should be made.^{20,21} In the case of EHB coverage in particular, HHS asked the Institute of Medicine (IOM) to recommend a process through which the secretary could define and subsequently update the benefit. The IOM committee chose an ethics framework as 1 of 4 policy perspectives to use in analyzing the task of deciding what should be included in EHB coverage and how it should be implemented. Within this framework, the committee emphasized that public examination of clinical effectiveness and priority setting among benefits as well as the use of ethically guided benefit management processes are required to preserve access to benefits that are the safest and most effective.²² Furthermore, the committee relied on the extensive work of Norman Daniels and James E. Sabin in noting that an ethical framework requires consideration of both stewardship of shared population-wide resources and loyalty to the needs of the individual.^{23,24} Finally, the committee reviewed the content areas proposed by the American Medical Association's Ethical Force Program (which state that health care coverage should be transparent, participatory, equitable and consistent, sensitive to value, and compassionate) as "aspirational targets" directly related to the fairness of health benefits design and subsequent administration.²⁵ Ultimately, the committee concluded that there are no shared principles in our large, pluralistic society for assigning fixed weights to these aspirational targets and therefore gave central roles to a fair process and public deliberation to guide EHB coverage design and administration.²²

As Matthew K. Wynia and Susan Dorr Gould recently noted, ensuring public

deliberation and a fair process in establishing a "decent minimum" set of health benefits can inform and justify health financing choices as well as enhance public understanding of such policies. They describe the work in more than 20 states of states, employers, unions, insurers, community-based organizations, and researchers who have involved the public in health priority setting, including efforts to engage the public in deliberations about what counts as "essential," "core," or "basic" benefits. Published reports of this work state that participants have found such deliberations informative and fair, developed understanding of limited resources, recognized others' needs, and learned to appreciate "what we should do as a community," not just "what I want."²⁶

The ACA directs HHS to promulgate standards for EHB coverage after notice and an opportunity for public comment.¹⁶ This statutory plan has been criticized, however, as unlikely to produce standards that are both fair and in the public interest because of political considerations that could lead executive and legislative branch officials to mandate coverage of health benefits desired by the public and special interest groups, regardless of the merits of doing so.²⁰ As described earlier, HHS itself asked the IOM to devise an appropriate process for defining and updating the EHB, which recommended the preemption of state insurance law benefit mandates in favor of federal guidelines giving power to insurers to define the extent and limitations of coverage in relation to a tightly managed premium price increase model. HHS chose not to follow IOM's recommended process, instead giving the states discretion to define the range and scope of EHB coverage under broad federal direction.²⁷

It remains to be seen what particular processes the states devise for refining

EHB coverage standards and how state policymakers will approach the issue of public deliberation. As described earlier, HHS's decision has been criticized as allowing the perpetuation of geographic inequities and encouraging states to engage in discrimination against people with rare, severe, or costly health conditions by permitting products that limit coverage of expensive treatments and procedures.³ Some members of Congress have agreed, writing to Secretary Sebelius that the HHS policy invites "very lean" coverage, with "restrictive amount, duration, and scope limitations."²⁷ Alan Weil, however, has argued that the HHS policy allows states to act as laboratories in testing the capacity of the new markets created by the ACA through different approaches to coverage, even in the case of benefits such as habilitation services, which are not defined in a consistent way in existing commercial insurance plans. Weil argues further that the EHB statute is specific regarding the composition of coverage and any degree of variation among the states is likely to be small, concluding that any state differences must be viewed as representing "a modest

potential source of inequity relative to the overall direction of the law."⁴

As the states move forward in defining EHB coverage, policy makers will face a decision of great ethical import: how to balance the goal of broad access to basic insurance (the "decent minimum" represented by the EHB) against the need for access to deeper and broader coverage for children with elevated physical, mental, and developmental risks (traditionally represented by the EPSDT standard). In the case of child health, 2 additional factors become relevant to this balance. The first is the fact that children represent a population whose disabilities may stem from birth and who are unable to make the life choices that adults can make, thereby creating a singular dependence on adults for appropriate care. The second is the fact that the proportion of children who face a need for heightened health care is small, and their impact on the overall cost of health insurance coverage may be minimal, thereby lessening the imperatives that arise when limited resources must be broadly distributed across the population.

For the EHB to approximate a true "decent minimum," at least in the area of child health, a key consideration may be the preservation of EPSDT's unique focus on child development. In this regard, the ACA provides important tools for ensuring that children with disabilities covered through state Exchanges (and therefore exclusively reliant on EHB-level coverage) can continue to benefit from the full array of treatments and services falling within the EPSDT coverage standard. Not only does the EHB standard include habilitation services, but the fact that "pediatric" services is a distinct coverage class allows states to use their own regulatory powers to ensure that all Exchange health plans cover the full range of EPSDT treatments and to bar the use of medical necessity standards that discriminate against children whose need for treatment is tied to development rather than "restoration." How states use this authority to ensure that the highest-need children are as well served as children with more routine health needs can be expected to emerge as a major issue in child health advocacy in the coming years, with pediatricians leading the way.

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Pediatrics 2013;131;S142

DOI: 10.1542/peds.2013-0252e

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