A Child Health Advocate's Guide to Essential Health Benefits:

Eight Questions to Raise

Charles Bruner, Child and Family Policy Center

September 2012

DRAFT

About the Guide

Children's healthy development is critically important to the country's future. Both the Child Health Insurance Reauthorization Act (CHIPRA) and the Affordable Care Act (ACA) offer opportunities for states and communities to improve children's healthy development, generally starting with ensuring children have health insurance coverage. Certainly, children need health coverage, but they also need primary and preventive health services which respond to their needs as growing and developing beings, in the context of their families and communities.

Charles Bruner, Director of the Child and Family Policy Center and author of this guide, has described the opportunities available within the CHIPRA and the ACA to improve children's healthy development, particularly young children where social determinants of health can negatively impact their development (see Center for the Study of Social Policy. March 2012. Going Beyond Coverage to Improve Community Health. *Health Reform Implementation: Opportunities for Place-Based Initiatives.* Also see Build Initiative. September 2009. Federal Funding and Young Children: Directions, Opportunities and Challenges to States in Building Early Childhood Systems). He also has described exemplary practices which have demonstrated their efficacy in improving children's healthy development and their core principles (see Child and Family Policy Center. January 2011. The Healthy Child Storybook: Policy Opportunities to Improve Children's Healthy Development). State activities around developing Essential Health Benefits afford an additional opportunity to strengthen child health practice. This report draws upon the excellent reports for advocates from the Georgetown Center for Children and Families on Essential Health Benefits by specifically discussion how "evidenced-informed guidelines" (*Bright Futures*) can be drawn into this debate. These documents are worth reviewing, in addition to this guide. For ease of access, the url's for all these documents are provided below.

Charles Bruner and the Child and Family Policy Center produced this guide through generous funding from the Annie E. Casey Foundation, but all views are those of the author and Center and not the foundation. CFPC thanks Dr. Edward L. Schor, Dr. Paul Dworkin, Joe Touschner, and Robert Hall for reviewing earlier versions of this paper.

Resources

Federal Funding and Young Children: Directions, Opportunities and Challenges to States in Building Early Childhood Systems
http://www.buildinitiative.org/files/Federal%20Funding.pdf

Going Beyond Coverage to Improve Community Health
Health Reform Implementation: Opportunities for Place-Based Initiatives
http://www.cssp.org/publications/health-reform-and-place-based/Health-Reform-Implementation-Opportunities-for-Place-Based-Initiatives_Going-Beyond-Coverage-to-Improve-Community-Health_Issue-Brief-1.pdf

The Healthy Child Storybook: Policy Opportunities to Improve Children's Healthy Development
http://www.cfpciowa.org/uploaded/Issues/Child%20Health/HealthyChildStoryBookJan2011.pdf

Child Health Advocates' Guide to Essential Health Benefits
http://ccf.georgetown.edu/wp-content/uploads/2012/08/EHB-Guide.pdf

Pediatric Dental Benefits Under the ACA: Issues for State Advocates to Consider
http://www.cdhp.org/system/files/REVISED%20Pediatric%20Dental%20Benefitsf.pdf

A Child Health Advocate's Guide to Essential Health Benefits: Eight Questions to Raise

Executive Summary

State responsibilities in developing essential health benefits. One of the Affordable Care Act's important features for health insurance consumers is the establishment of a package of essential health benefits (EHB's) that will assure that certain insurance plans—including those purchased through insurance exchanges—provide adequate benefits to their enrollees. The EHB package will define the minimum set of benefits that new health plans must offer for private market individual and small group plans as well as for newly eligible Medicaid enrollees and those covered by state Basic Health Programs.

Section 1302 of the ACA sets out the requirements for these EHB's. An HHS Bulletin published in December 2011 advises that states will have the responsibility to select the EHB plan based upon an existing employer-based health plan in the state.

While states are charged with selecting a benchmark plan, their responsibilities do not end there. Certain benefits must be part of the EHB's, whether or not they are included in the benchmark plan a state chooses. The ACA lists ten categories of benefits, which include some potentially requiring child-focused benefit definitions, including in particular: maternity and newborn care; mental health and substance use disorder services; rehabilitative and habilitative services and devices; preventive and wellness services; and pediatric services, including oral and vision care. If the selected benchmark plan lacks coverage for one of the ten categories of services required by the ACA, the state must add coverage from one of the other benchmark plan options. The state's benchmark plan also must comply with the ACA's non-discrimination provisions.

Within Section 2713, the ACA also requires that group health plans and health insurers offer, with no cost sharing requirements, certain preventive services. Included are "with respect to infants, children, and adolescents, evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration." This is a reference to *Bright Futures*, a national health promotion and disease prevention initiative that addresses children's health in the context of family and community, providing detailed guidelines developed by the American Academy of Pediatrics.

This all provides child advocates with an opportunity to work in their states to ensure that the development of the state EHB gives due attention to child health coverage. Fortunately, child advocates do not need to start from scratch in this work – nor necessarily become the experts on all matters related to child health coverage benefits. Child advocates can play an important role simply by raising questions about the provisions for comprehensive child health benefits in their state's EHB.

The need for child-specific provisions within benchmark plans. Child advocates should be prepared to see that their state's selection process does not identify a benchmark plan that covers all important child health benefits. That is because most private health insurance plans have been written with adults and not children in mind, as children are not high cost users of health systems. Tailoring the benchmark to adequately address the more frequent preventive care needs of children who are growing and developing is a high priority. While preventive care for adults focuses on maintaining health, the concern for children is on promoting "healthy

development." Moreover, and particularly for young children, the focus in providing "patient-centered" care involves "anticipatory guidance" and counseling to the family, where parents must be partners in ensuring that recommended health activities are completed.

In short, children's need for adequate benefits is particularly important due to their continuous growth and development. Children require different health services than adults, including appropriate preventive health screenings and health promotion education that involves their parents.

Eight questions for child advocates to raise in reviewing benchmark plans. Clearly, there are many issues and nuances in any health insurance plan, with "the devil in the details" regarding whether children get the services they need. The adequacy of a plan is not only whether it covers a procedure or activity, but how much it requires co-payments or imposes conditions for receiving care and how much it provides in compensation to providers for delivering that service. These all are issues which can impact how much a service is available and used.

The first step, however, is ensuring that services essential to children are included within the EHB plan. The following are eight questions child advocates can raise specifically about child health coverage under a benchmark plan.

1. How will the benchmark plan provide adequate and complete coverage for the anticipatory guidance and well child care that is essential to children's healthy development?

2. How will the benchmark plan provide coverage for developmental screenings to identify developmental, behavioral, and mental issues or conditions which need to be addressed?

3. How will the benchmark plan provide coverage for services to address developmental, behavioral, and mental issues or conditions that children may face and, specifically, provide family-centered responses to ensure children's parents and guardians can play their necessary role in the child's supervision and treatment?

4. How will the benchmark plan provide coverage for habilitative services (services designed to enable patients to develop skills they do not now possess, rather than rehabilitative services designed to enable patients to regain skills they have lost) and, in particular, respond to risk factors and social determinants of health which jeopardize and adversely impact the acquisition of skills and healthy behaviors?

5. How will the benchmark plan provide coverage for care coordination, including intensive case management for children with complex needs, as well as appropriate referrals and scheduling of services needed to support children's healthy development?

6. How will the benchmark plan provide coverage to meet the oral health needs of children?

7. How will the benchmark plan provide coverage to address the vision needs of children?

8. How will the benchmark plan provide coverage for the audiological needs of children?

Some of these services (particularly mental and oral health services) require adequate panels of providers and may require defining provider eligibility accordingly. In the longer policy brief, background information on each of these questions is provided. There is a rationale for including each as part of comprehensive child health benefits.

Beginning ideas for child advocacy involvement in EHB development. Entering into the discussion of benchmark selection and modification can be a daunting task. The questions provided above are just questions – and they easily can be ignored or dismissed. In their efforts to select a benchmark plan, states may have little initial incentive to give detailed attention to these issues.

Fortunately, however, the state's work does not end with selection of a benchmark plan. That plan must be modified if it does not meet the requirements of the law. States will need to construct a process for reviewing the selected benchmark plan and securing public input. Child advocates can be up front in calling for such action and calling for specific attention to the child health benefits in the benchmark plan.

Child advocates are not the only stakeholders concerned about the benchmark plan and its benefits as they apply to children – and child health advocates do not need to become experts on all child health coverage issues and provisions. In every state, there are pediatric child health practitioners who are champions in promoting clinical practice adhering to *Bright Futures* guidelines and who recognize how child health coverage systems need to change.

Where child advocates can be helpful is in helping these and other champions navigate the policy world. Child advocates also often can support consumers in showing the need for such coverage. Advocates can find ways that stories of children who need specific services (such as hearing aids, timely diagnoses of and responses to autism) can be enlisted to encourage inclusion of these services in coverage. By raising these questions and calling upon state policy makers to respond to them, child advocates offer an additional aura of credibility in promoting the coverage children need.

Children represent 24% of the population but assume a very small share of current health costs. Their interests easily can be lost in implementation activities which focus upon those with the most costs and the most apparent immediate health needs. At the same time, children will become adults and their healthy development is key to the future health of society and the degree to which health care must deal with future preventable chronic health conditions. Child advocates play a critical role in raising child health issues in the implementation of all aspects of the ACA. Selecting and developing an EHB benchmark plan represents one of those levers to raising child health issues to the prominence they deserve.

A Child Health Advocate's Guide to Essential Health Benefits:

Eight Questions to Raise

One of the Affordable Care Act's important features for health insurance consumers is the establishment of a package of essential health benefits (EHB's) that will help assure that certain plans—including all exchange plans—provide adequate benefits to their enrollees. The essential health benefits package will define the minimum set of benefits that new health plans must offer for private market individual and small group plans as well as for newly eligible Medicaid enrollees and those covered by state Basic Health Programs.

Section 1302 of the ACA sets out the requirements for the essential health benefits. An HHS Bulletin published in December 2011 advises that states will have the responsibility to select the essential health benefits plan based on an existing employer-based health plan in the state. The ten plans available for states to choose as benchmarks are:

- The largest plan in any of the three largest small group market insurance products
- The three largest federal employee health plans
- The three largest state employee health plans
- The largest non-Medicaid HMO in the state.

In order to allow time for insurers to roll out the plans for coverage beginning January 1, 2014, the Bulletin specifies that states select a benchmark plan by October 1, 2012, using enrollment data from the first quarter of 2012 to determine which plans qualify as benchmark choices. If a state does not choose a benchmark plan by this deadline, the default plan is the largest plan in the largest product in the small group market. Once chosen in 2012, the benchmark will be effective in a state for 2014 and 2015. HHS intends to reassess the benchmark approach for 2016.

While states are charged with selecting a benchmark plan, their responsibilities do not end there. Certain benefits must be part of the essential health benefits, whether or not they are included in the benchmark plan a state chooses. The ACA lists ten categories of benefits that must be part of the EHB package. These are shown below, with **bold-faced** attached to those for which there are particular features which require child-specific approaches or focus upon children specifically:

(A) Ambulatory patient services;

(B) Emergency services;

(C) Hospitalization;

(D) **Maternity and newborn care**;

(E) Mental health and substance use disorder services, including health treatment;

(F) Prescription drugs;

(G) Rehabilitative and **habilitative services and devices**;

(H) Laboratory services;

(I) **Preventive and wellness services** and chronic disease management; and

(J) **Pediatric services, including oral and vision care**.

The law itself provides no further definition of what specific services the "pediatric services" should include, but, within Section 2713, the ACA requires that group health plans and health insurances offer, with no cost sharing requirements, certain preventive services. Included in these requirements are "with respect to infants, children, and adolescents, evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration" [e.g. *Bright Futures*]. This provision applies to health exchanges.

Section 1302 also establishes some specific guidelines in defining the EHBs. Benefits may not be designed "in ways that discriminate against individuals because of their **age**, disability, or expected length of life" and are required to "take into account the health care needs of **diverse segments of the population, including** women, **children**, persons with disabilities, and other groups." (bold-faced added]

If the benchmark plan lacks coverage for one of the ten categories of services required by the ACA, the state must add coverage for that category from one of the remaining benchmark choices. The benchmark plan also may need to be altered to comply with the ACA's non-discrimination provisions.

This all provides child advocates with an additional opportunity/responsibility to work in their states to ensure that the development of the state benchmark plan gives due attention to these issues.

Fortunately, child advocates do not need to start from scratch in this work – nor necessarily become the experts on all matters related to child health coverage benefits. Child advocates can play an important role simply in raising these questions in the policy arena – and helping to connect those with expertise in their state on children and their health coverage needs to this benefit plan development. The federal law is on their side in promoting development of a benchmark plan which includes provisions covering essential services for children, "including oral and vision" (and audiological and behavioral/development, etc.) services and "evidenced-informed preventive care and screenings."

This Brief next describes the need for child-specific provisions in health insurance coverage. It follows by posing eight questions child advocates can raise that focus attention on some of the most significant areas where child-specific attention is needed in developing such plans and concludes with a discussion of some steps child advocates can take in their own states (and as part of a national network) on these issues.

What's at stake for children? The need for child-specific provisions within benchmark plans (and all insurance coverage for children).

Most private health insurance plans have been written with adults and not children in mind. In general, children are not high cost users of health systems, but children are growing and developing and require more frequent routine, well-child visits than do adults. While the concern with adults may be on "health maintenance," the concern for children is on "healthy development." Moreover, and particularly for young children, the focus in providing "patient-centered" care involves "anticipatory guidance" and counseling to the family, where parents must be partners in ensuring that recommended health activities are completed and must identify conditions which could require health interventions. The ACA recognizes this by requiring insurers to provide coverage for "evidenced-informed" guidelines (*Bright Futures,* which offers very complete and detailed, and age-specific, guidelines regarding the content of well-child visits and follow-up services and address social and emotional, environmental, and behavioral health as well as bio-medical health).

Children's need for adequate benefits is particularly important due to their continuous growth and development. In short, children require different health services than adults, including appropriate preventive health screenings depending on their age and development stage. Children's growing bodies may also necessitate new durable medical equipment (like wheelchairs or hearing aids) on a more frequent schedule than adults.

In its Scope of Health Care Benefits for Children policy statement, the American Academy of Pediatrics (AAP) outlines services which are essential for children and need to be covered under health plans. Illustrative of these benefits (which may not be part of the benefit plan that a state selects) are the following:

- *Preventive educational and counseling services like anticipatory guidance, tobacco cessation, and services related to maintaining healthy weigh*
- *Corrective audiology and speech therapy services, delivered by those trained in the care of children*
- *Special diets, infant formulas, nutritional supplements, and delivery (feeding) devices for nutritional support and disease-specific metabolic needs*
- *Physical, occupational, speech (including speech-generating devices), and respiratory therapy*

To meet the needs of children, the EHBs should include such pediatric services. Research released by HHS has shown that, overall, benefits covered by the benchmark choices are broadly similar—that plans vary more in cost-sharing than in covered benefits. *Importantly, however, the HHS study also found limited coverage by potential benchmark plans in some types of coverage that are important for children, including behavioral health treatment, habilitative services, and pediatric oral and vision services, even apart from those described above.*

Therefore, child advocates should be prepared to see an initial benchmark selection process identify a benchmark plan that does not cover some, if not all, of important (and it is argued here, "essential") child health benefits. Fortunately, even if the initial selection of a benchmark plan is made which does not cover these benefits, states have a responsibility to add in

additional requirements – provided they recognize the need and are encouraged to do so. In addition, state Medicaid plans, because of their Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) provisions, provide coverage for many services for children that other plans may not – and reviewing Medicaid child coverage can be helpful in determining what children in private and EHB's should receive.

How can child advocates enter the dialogue? Eight questions for child advocates to raise in reviewing benchmark plans and recommending selection or proposing modifications.

Clearly, there are many issues and nuances in any health insurance plan, with "the devil in the details" in whether children get what they need in health services. The adequacy of a plan is not only whether it covers a procedure or activity, but how much it requires co-payments or imposes conditions for receiving care and how much it provides in compensation to providers for delivering that service. These all are issues that can impact how much a service is actually available and used, even if when is part of the coverage.

At the same time, the first step is ensuring that a service is included within the benchmark plan in the first place. The following are eight questions that child advocates can raise specifically about child health coverage under a benchmark plan.

9. How will the benchmark plan provide coverage for the anticipatory guidance and well child care that is essential to children's healthy development?

10. How will the benchmark plan provide coverage for developmental surveillance and developmental screening that can identify developmental, behavioral, and mental issues or conditions that need to be addressed?

11. How will the benchmark plan provide coverage for services to address developmental, behavioral, and mental issues or conditions and, specifically, provide family-centered responses to ensure children's parents and guardians can play their necessary role in the child's supervision and treatment?

12. How will the benchmark plan provide coverage for habilitative services and, in particular, respond to risk factors and social determinants which jeopardize and adversely impact the acquisition of skills and healthy behaviors?

13. How will the benchmark plan provide coverage for care coordination and appropriate referrals and scheduling of services needed to support children's healthy development?

14. How will the benchmark plan provide coverage to meet the oral health needs of children?

15. How will the benchmark plan provide coverage to address the vision needs of children?

16. How will the benchmark plan provide coverage for the audiological needs of children?

Anticipatory guidance and well-child care. The American Academy of Pediatrics' *Bright Futures* guide both sets a schedule for well-child care (with the number of well-child visits varying by child age) and establishes age-specific instructions to or discussions with parents or children around the child's development – known as "anticipatory guidance." This anticipatory guidance includes both queries about bio-medical health conditions and about developmental ones,

relating to cognitive, emotional, and behavioral development. For very young children, for example, this includes discussions with and guidance to parents about nutrition and exercise, prevention of exposure to second- or third-hand cigarette smoke, and expectations regarding children's cognitive and social development.

Child health coverage within benchmark benefits should adhere to providing for well-child visits according to the periodicity schedule established in *Bright Futures*, with recognition of the time involved in providing anticipatory guidance. Because some children do not meet all scheduled well-child visits but see practitioners for specific health needs, there also should be provision, if practitioners are able to do so, to conduct well-child visits at the time children come in for other services but have not had those well-child visits.

Under Section 2712, plans are required to provide well-child visits without co-payments or deductibles which meet the guidelines of *Bright Futures.* Ensuring that benchmark plans do provide such coverage may require more detailed definitions of what constitutes a well-child visit in the benchmark plan.

Developmental surveillance and screening. In addition to and as part of the process of providing anticipatory guidance, child health practitioners also are engaging in "developmental surveillance," checking for signs that the child is developing – socially, cognitively, behaviorally, and emotionally as well as physically – without cause for particular concern. This can include "developmental screening," administering a specific age-specific tool (such as Ages and Stages or Ages and Stages SE) to assess whether there is need for further assessment and possible treatment to address developmental delays or emotional concerns. In many state Medicaid programs, there are separate billing codes which cover the cost of administering such screening tools. Again, the guidelines from *Bright Futures* require such developmental surveillance and, if there are any concerns detected, follow-up screening and appropriate referrals for treatment. Again, benchmark plans should have explicit recognition of the need for such surveillance and provide coverage for developmental screening. While not expensive to provide, such screening still has costs to providers and needs to be recognized in health insurance coverage if it is to be performed.

Developmental health services. Developmental surveillance and screening are designed to identify conditions which can be treated or addressed through further activities and treatments – simply identifying a concern and not addressing it can be considered "malpractice" on the part of the health practitioner. Research indicates, even for very young children, that the prevalence of developmental delays and behavioral and emotional concern which are subject to remediation and response is significant. For instance, research indicates that about one in eight children six months to two years of age have an identifiable developmental delay that would qualify them for early intervention services under most state's Part C programs. Research indicates that one in six children two to five years of age have a DSM-IV mental condition that could be diagnosed. Research also shows that early identification and response is very important to eliminating or reducing the severity of the condition and avoiding secondary complications. These follow-up services need to be part of the benchmark plan.

Again, in particular when young children are considered, effective responses and treatments usually also require support and often training and counseling for the parents and guardians of the children. While the goal of such services is to ensure the healthy development of the child, the services often need to be family-centered and may include individual training, counseling

with the parent and even respite services for the parent to maintain the parent's ability to provide the regimen of care and treatment the child needs.

Benchmark plans need to recognize and provide coverage for developmental services and be clear that such services include family-centered services and counseling and training to parents, where those are essential to meeting the child's care and treatment needs.

Habilitative services. The term "habilitative services" is one of that has special applicability to children, as children are in the process of developing and acquiring a whole set of skills and behaviors related to their development. Habilitative services are services that help individuals acquire skills which they do not now have. Rehabilitative services help individuals re-acquire skills they have lost. In general, adults may require rehabilitative services to regain functions after a stroke or trauma or injury; but there are likely to be limited instances where they can benefit from habilitative services. Children are just the opposite.

Moreover, many of the factors which lead to children acquiring skills and behaviors relate to social environment and require responses which extend beyond bio-medical treatment. To prevent "developmental delays" in young children often requires habilitative services which support parents in creating an overall environment which offers nurturing and developmentally appropriate supports and activities. While the ACA and additional federal guidance do not provide additional detail on providing habilitative services, the legislation is clear on its required inclusion in benchmark plans. In fact, state Medicaid programs, through EPSDT provisions, may serve as some model for providing coverage for these services, although state Medicaid programs vary in the degree to which they effectively offer those services.

Care Coordination and Referrals to Needed Services. Once a developmental or behavioral of habilitative concern is identified by a child health practitioner, there must be a protocol or process for making referrals to needed services and scheduling and performing them. Particularly for children and particularly when the needed services and supports require parental involvement, the actual connection of the child to services often goes beyond what a child health practitioner can do within a well-child or other visit. In terms of services which go outside the medical field of specialties and sub-specialties, there also is a need to access services with which the child health practitioner may not be familiar. Generally, in order for child health practitioners to ensure that children needing such services receive them, there needs to be an additional "care coordination" component to make those linkages to services. Whether, in the case of larger practices which employ social workers and care coordinators and behavioral health specialists on staff, or in the case of smaller practices and family practitioners who do not, coverage of such care coordination is necessary and needs to be built into the benchmark plan.

Oral health. The oral health services component of pediatric services may be a particular concern for child advocates. Coverage for pediatric dental benefits is uneven among potential benchmark plans, since most dental coverage today is offered separately from medical insurance. The ACA further allows dental plans to be offered separately from benchmark health plans in the exchange. When a benchmark plan does not include coverage for pediatric dental benefits, a state will have the option of supplementing its benchmark with either the largest federal employee dental plan or the state's separate CHIP dental benefit. (The eleven states and the District of Columbia without a separate CHIP program may establish a benchmark benefit that is consistent with CHIP standards.) Advocates should check their state's CHIP dental benefit to determine whether it is a good choice for use in the EHBs. It should be compared to the

alternate choice, the Federal Employees Dental and Vision Insurance Program (FEDVIP) MetLife High option.

Securing adequate coverage for children's oral health services may require special attention from advocates. Many existing dental benefit plans rely on relatively low annual dollar limits on coverage. The ACA prohibits dollar limits, so these plans will have to be restructured to comply. Advocates should push for benefits that meet children's needs and oppose those that establish strict limits on coverage that could serve as a dollar limit by another name. One promising model that assures children can access the care they need while limiting expenditures for unnecessary care is known as a risk-based pediatric dental benefit. For more see the December 21, 2011 memo from the Children's Dental Health Project. Georgetown CCF intends to develop more materials on this issue as well.

Advocates should also note that while pediatric dental benefits are required to be part of the EHBs, in exchanges they may be offered through stand-alone plans separate from the plans that provide medical benefits. When stand-alone pediatric dental plans are offered in an exchange, the medical exchange plans need not provide the pediatric dental EHBs. While beyond the scope of this guide, this provision raises important questions around how benefits and cost-sharing will be coordinated across separate plans each providing part of the EHBs.

Securing adequate coverage for children's oral health services may require special attention from advocates. Many existing dental benefit plans rely on relatively low annual dollar limits on coverage. The ACA prohibits dollar limits, so these plans will have to be restructured to comply. Advocates should push for benefits that meet children's needs and oppose those that establish strict limits on coverage that could serve as a dollar limit by another name. One promising model that assures children can access the care they need while limiting expenditures for unnecessary care is known as a risk-based pediatric dental benefit. For more see the memo from the Children's Dental Health Project. Georgetown CCF intends to develop more materials on this issue as well.

In addition, and particularly for very young children (birth to three), most parents do not take their children to a dentist although there are recommended oral health activities, including providing sealants for baby teeth. In fact, parents may have difficulty, depending upon their insurance coverage, in finding dentists to provide this care. Child health practitioners can provide at least some of these services, but require coverage systems to do so. While there are "scope of practice" issues involved in offering such coverage, preventive oral health is part of the requirements under the ACA, and child advocates can press for that such coverage in ways that actual service provision is maximized either under dental care benefits or under benchmark health plans.

Vision. The ACA is explicit in including vision services as a pediatric benefit under a benchmark plan. Vision services certainly include checking for any astigmatisms and needs for corrective lenses (e.g. optometric or opthamalic visits and screening), but they also include the corrective treatments, including ongoing exercises and therapies for training the eye, providing guidance to parents, and for corrective lenses and implants. Again with respect to young children, vision is being developed and "hand-eye coordination" may require additional habilitation if it is to become developed – including so children are going to be prepared to track letters and words across a printed page and learn to read. Where parents have no discretionary income, purchasing corrective lens for their children, particularly if those need to be frequently replaced,

can be a significant burden – the reason that Medicaid programs do cover the cost of corrective lenses. While benchmark plans may not need to provide coverage for most corrective lenses, they do need to recognize higher cost vision services which some families experience, and at least establish co-payments and deductibles for vision services than help ensure that parent costs in providing for their children's vision needs are realistic in terms of their ability to pay.

Audiological services. The same need to recognize costs in relation to ability to pay (truly the reason for insurance) applies to audiological services. Benchmark plans not only should cover screening for hearing problems and needs, but also for corrective treatments and equipment to respond to them. While Medicaid programs do cover hearing aids and an increasing number of states require private insurance plans to cover pediatric hearing aids, not all states have such mandates and benchmark plans may not provide for such coverage. Even parents of substantial means may find that their ability to pay for such equipment and services, which require replacement and refitting as a child grows, difficult. Again, without good hearing or responses which help children respond to the lack of hearing, the child's habilitation is seriously jeopardized. Child advocates can press for coverage of audiological services within benchmark plans which do ensure coverage of both screening and follow-up services and equipment.

What can child advocates do to get these questions addressed? Beginning ideas for action.

Entering into the discussion of benchmark selection and modification can be a daunting task for child advocates. The questions provided above, which offer a little context for their importance, are just questions – and they easily can be ignored or dismissed. In their efforts to select a benchmark plan and the timeline involved in doing so, states may have little initial initiative to give detailed attention to these issues.

Fortunately, however, the state's work does not end with a selection of a benchmark plan. That plan must be modified if it does not meet the requirements of the law. States will need to construct a process for reviewing the selected benchmark plan and securing public input. Child advocates can be up front in calling for such action and for specific attention to the child health benefits in the benchmark plan.

In addition, child advocates are not the only stakeholders concerned about the benchmark plan and its benefits – not do child health advocates need to become the experts on all child health coverage issues and provisions. In every state, there are pediatric child health practitioners (pediatricians, nurse practitioners, and physicians assistants) who are champions in promoting clinical practice adhering to *Bright Futures* guidelines and who recognize how child health coverage systems need to change.

Where child advocates can be helpful to these champions is in helping them navigate the political and policy world in which such decisions are made. Child advocates also often have the capacity to support consumers in showing the need for such coverage. Advocates can find ways that stories of children who need specific services (such as hearing aids, timely diagnoses of and responses to autism) also can be forceful advocates for inclusion of these services in coverage.

Child advocates also offer an additional aura of credibility in promoting coverage that cannot be attributed to the self-interest of the provider community – but that is based solely upon promoting the child's interests and needs.

Children represent 24% of the population but assume a very small share of current health costs. Their interests easily can get lost in implementation activities which focus upon those with the most costs and the highest immediate health needs. At the same time, children will become adults and their healthy development is key to the future health of society and the degree to which health care in the future must deal with chronic and high-cost health conditions which could have been prevented. Child advocates can play a very significant role simply in raising child health issues in the overall implementation of all aspects of the ACA. Selecting and developing a benchmark health plan represents one of those levers to raising child health issues to the prominence they deserve.

Child and Family Policy Center
505 5th Avenue, Suite 404
Des Moines, IA 50309
515-280-9027
www.cfpciowa.org