Federally Facilitated Health Insurance Exchanges  
Key Issues for Children’s Health Care  
March 2013

It is critically important that federally facilitated Exchanges (FFEs), including state partnership Exchanges, meet the unique health care needs of children. Federal and state policymakers, local stakeholders, and pediatric health care providers can work together to make the FFEs work for children by ensuring that they:

- Provide comprehensive child-specific essential health benefits
- Have robust pediatric provider networks
- Include children’s hospitals as essential community providers
- Provide seamless coverage and care through strong coordination with Medicaid and CHIP
- Have effective consumer assistance programs
- Allow for robust public input from pediatric stakeholders into exchange planning and operations
- Require appropriate pediatric-focused quality measurement and improvement

Comprehensive Child-specific Essential Health Benefits

The essential health benefits (EHB) benchmark plans can be strengthened for children’s coverage through a strong medical necessity definition for health plans that is based on the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard and through a comprehensive definition of habilitative services that does not impose arbitrary limits on services.

The FFE will implement the state’s choice of an EHB benchmark plan, per final federal EHB rules. In the event a state did not choose a benchmark plan, the FFE will require health plans to offer the benefits offered through the largest plan by enrollment in the largest product in the state’s small group market. The FFE will be responsible for oversight of issuer compliance with the default benchmark and will review the state’s or the issuer’s defined habilitation benefit, as delineated below:

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<tr>
<th>Issue</th>
<th>FFE/Partnership Standards – HHS Reviews</th>
<th>State Standards</th>
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| Essential Health Benefits (EHBs) | HHS review of state choice of benchmark  
HHS review of state-determined habilitation benefit OR parity with rehab OR issuer-defined benefit | States choose benchmark plan OR default plan serves as benchmark  
State may determine habilitation benefits OR  
• Require parity with rehab |
HHS will monitor habilitation coverage

- Let plans determine benefits

Source: Children’s Hospital Association

The FFEs will work best for children when:

- States work with insurers to create a definition of medical necessity that is as close as possible to the Medicaid EPSDT standard

- As federal rules allow, states, not issuers, establish a definition of habilitation that ensures children access to all necessary services and devices to *attain and maintain* function. States should adopt a definition of habilitative services that is no more restrictive than the one put forth by the National Association of Insurance Commissioners¹ and does not impose arbitrary limits on services.

- States and HHS work together to monitor children’s access to needed care under the state’s EHB benchmark plan and address gaps in coverage

**Network adequacy**

Network adequacy standards for QHPs must ensure that children have reasonable and timely access to the full spectrum of pediatric providers they need.

The FFE will confirm that the state department of insurance has certified that health plans meet the minimum provider network standard that they contract with “sufficient number and types of providers to ensure that all services are available without unreasonable delay.” In the absence of state certification, the FFE will do its own review of health plan compliance with the minimum federal standards as delineated below:

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| **Network Adequacy** | Issuer attestation to HHS and HHS evaluation of state review of plans’ networks  
- YES, if ‘effective’ state review – HHS confirms state approval of network  
- NO, state’s review not effective – HHS accepts accredited issuers’ attestations, or access plan from unaccredited issuers | SUFFICIENT number & types of providers must be available without unreasonable delay |

Source: Children’s Hospital Association

¹ NAIC recommended to HHS this definition of habilitative services for inclusion in the *Glossary of Health Insurance and Medical Terms*: “Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”
• Provider networks include a full range of primary, specialty and ancillary pediatric providers based on standards developed with input from pediatric health researchers, providers and families. Those standards (related to timeliness, quantity and types of providers, and monitoring) must ensure that children have access to needed services without unreasonable delay.

• A child is able to obtain a covered service from an out-of-network provider at no additional cost if no network provider is accessible for that service in a timely manner.

• Adequate payment is provided for all components of patient-centered medical homes for high-need children, as well as primary care medical homes. The medical home model that encompasses a broad spectrum of services is particularly effective for children with complex and chronic medical conditions. QHP reimbursement for these programs would allow their expansion and replication.

• They develop and utilize pediatric-specific access standards to monitor adequacy of provider payment. The standards should be developed in consultation with pediatric providers and other pediatric experts and require QHPs to publicly disclose data related to the access measures.

**Essential community providers**

QHPs must be required to contract with all ECPs, including children’s hospitals eligible to participate in the federal 340B Drug Discount program that serve low-income and medically-underserved populations.

The FFE will confirm that the state has reviewed health plans’ compliance with the federal ECP standard that they contract with a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of ECPs. In the absence of state certification, the FFE will do its own review as delineated below:

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| **Essential Community Providers (ECPs)** | Network must have:  
• At least 20% ECPs in service area, at least 1 ECP of each type by county, OR  
• At least 10% ECPs with satisfactory justification OR  
• Neither, but satisfactory justification | SUFFICIENT number, geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of ECPs |

Source: Children’s Hospital Association

The FFEs will work best for children when:

• QHPs are required to contract with all ECPs as defined in the statute, which includes children’s hospitals, to assure children access to especially qualified providers with expertise in the care of critically or chronically ill and disabled children.

• QHPs are required to conduct meaningful negotiations for adequate payment rates for all necessary services, including ancillary services, provided by children’s hospitals and other ECPs.
Reimbursement for support services intended to address health care access barriers that are uniquely characteristic of ECPs, such as language services, social service interventions, outreach and others, is critical to ECPs’ ability to fulfill their mission of providing care to those with inadequate access.

**Continuity of Care**

Continuous care and coverage for children must be ensured even when a child's provider leaves a network or the child moves back and forth between subsidized Exchange coverage and Medicaid or the Children's Health Insurance Program (CHIP).

Children, especially children with special health care needs, can be greatly affected by even small gaps in care and coverage. Children with ongoing health concerns and their families often have a strong reliance on a particular provider and a change in provider networks or coverage can be catastrophic to their development and health.

The FFEs will work best for children when:

- QHPs are required to align provider networks with those in the state’s Medicaid and CHIP provider networks
- A broad definition of “primary care provider” is adopted to accommodate those pediatric specialists who are the main providers of primary health care services for the children with complex or chronic medical conditions who are in their care
- QHPs are required to adopt a definition of medical necessity that would cover all medically necessary services that are provided by ECPs. Unless QHPs cover all necessary services, children who move from Medicaid to a QHP will be at risk of losing coverage for critically needed services that they had received through the Medicaid EPSDT benefit.
- They allow children to remain on their health plan for 12 months and encourage states to adopt 12-month continuous eligibility for children covered by Medicaid

**Consumer assistance**

FFE consumer assistance and education efforts must take into account children’s unique health care needs and provide pediatric-specific information to families.

Families with a child with special health care needs will face particular challenges navigating health insurance options in the Exchanges. Effective consumer assistance (navigator and in-person assistance) programs will serve as a bridge between families, cost-effective medical assistance, and high quality care.

The FFEs will work best for children when:

- Their consumer assistance and public outreach programs connect children, especially children with special health care needs, to appropriate coverage
- They build upon existing efforts by children’s hospitals and other community-based organizations that have a proven track record of helping families connect with appropriate health coverage and navigate the health system

Public input from pediatric stakeholders
Pediatric providers should be included in Exchange policymaking entities and stakeholder consultations.

Pediatric providers, including pediatric specialists, offer a critical perspective on insurance coverage, health benefits, health plan purchasing, health care delivery, and important public health issues pertaining to children. Many pediatric providers also have valuable insights about the challenges of moving between public and private coverage. These perspectives are invaluable to the design and implementation of an Exchange structure that effectively meets the health care needs of children and their families.

The FFEs will work best for children when:

- They engage in open and transparent planning and implementation and ensure that all planning documents are publicly available to demonstrate their potential and real impact on children’s health and health care
- They provide appropriate opportunities for comment before policy decisions are finalized to ensure that concerns regarding the implications of policy options on child health are collected and addressed
- They collect data that document impacts on children, particularly children with special health care needs, of benefit packages, network design, cost sharing requirements, quality incentives and measures, and other plan design features
- They develop, with public input, a timely plan to address gaps in care and coverage for children

Quality

All health plans in the FFE should be required to report on a common set of federal pediatric quality measures and play an active role in health care quality improvements that address children's unique health care needs.

Under federal rules, there will be a two-year delay in the implementation of quality reporting requirements for health plan in the FFEs, which will result in limited quality oversight during that time.

The FFEs will work best for children when:

- They use the two-year delay to build the infrastructure to comply with nationally-developed standards for pediatric measure reporting, beginning with the 24 core quality measures already developed under the Children’s Health Insurance Program Reauthorization Act, as required in the ACA. The measures should be aligned with those in the state’s Medicaid program and the private insurance market outside the Exchange.
- They certify QHPs based on a set of high quality standards that address clinical, network adequacy and delivery reform models that can meet the health care needs of children, particularly those with complex and chronic conditions. The standards should reward plans that collaborate with pediatric providers in the design of innovative delivery and payment reforms and contract with pediatric providers that are participating in delivery models that promote coordinated care.
- They require QHPs to include providers in the design of payment and other contractual incentives aimed at encouraging continuous quality improvement and delivery innovation. The payment structures must cover the costs of the full spectrum of primary, specialty, and ancillary services, including care coordination and management.
• They collect consistent and regular data to assess the effectiveness of new delivery systems in controlling costs and improving health outcomes for children

• They include information about pediatric coordinated and integrated delivery systems in consumer and patient marketing materials