



October 2, 2026

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

Dear Senator Wyden,

The Children's Hospital Association (CHA) is the nation's leading advocate for children's health, uniting children's hospitals to improve care and amplify impact. On behalf of the more than 200 children's hospitals and the millions of children and families we serve, we appreciate the opportunity to respond to your request for information (RFI) on policy proposals to improve access, quality, and affordability of health coverage in the United States, especially for children. We appreciate your leadership in examining opportunities to improve the nation's health care system and urge you to ensure that any future reforms prioritize the unique needs of children and the children's hospitals that serve them.

Children's hospitals are dedicated to advancing child health through innovations in the quality, cost, and delivery of care—regardless of payer—and serve as a vital safety net for commercially insured, underinsured, uninsured, and publicly insured children. **On average, more than 50% of their patients are covered by Medicaid or the Children's Health Insurance Program (CHIP).**<sup>1</sup> Children's hospitals play an essential role in their communities by providing specialized clinical care for infants, children, and adolescents, including treatment for complex and rare conditions. They also act as major referral centers at the state and regional levels, supporting smaller providers and ensuring access to high-level care across broad geographic areas. Additionally, children's hospitals serve as hubs for training the next generation of pediatric clinicians and advancing research that drives innovation in child health.

Beyond clinical care, children's hospitals also lead community health programs that focus on prevention, early intervention, and addressing community conditions that contribute to preventable childhood illnesses and increased health care costs, often partnering with schools, local organizations, and public health agencies. These hospitals provide critical mental and behavioral health services and outreach to underserved and vulnerable populations, helping ensure that children have the opportunity to grow, learn, and thrive. Through these efforts, children's hospitals play many roles in their communities, strengthening health systems, improving outcomes, and promoting healthier lives for children and families.

CHA is committed to improving care for children by supporting policies that strengthen access to high-quality pediatric health care and support the specialized providers and hospitals that serve children. When children face chronic, complex, or serious health conditions, they require specialized equipment and treatments designed specifically for their unique needs, including tiny tubing for premature infants and medications and dosing tailored to children of different

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<sup>1</sup> CHA, "Annual Benchmark Report (ABR), Fiscal Year 2023," (2023).



ages and sizes. They also need pediatric providers with expertise to use that equipment to treat conditions from infancy through adolescence, while supporting families and caregivers in navigating difficult medical decisions. CHA is at the forefront of innovation to ensure that all children have access to the specialized care they need, including through our work with policymakers to advance key priorities. Those priorities include protecting and strengthening Medicaid and CHIP as the foundation of coverage for approximately 35 million children in the United States,<sup>2</sup> addressing the youth mental health crisis, strengthening the pediatric workforce, and supporting investments in research and programs that promote healthy development.

**To protect and meet the needs of children, future reform efforts must prioritize reversing the Medicaid cuts enacted through H.R. 1. These cuts threaten access to care for all children.** New limits on state directed payments and provider taxes threaten children's access to care and the ability of children's hospitals to sustain essential pediatric services. As major Medicaid providers, children's hospitals rely on these resources to deliver comprehensive, high-quality care to all children, regardless of their coverage status. CHA is also concerned about the impact of Medicaid community engagement requirements on adults with complex medical needs and the families who depend on them for care and support.<sup>3</sup> If Congress does not reverse these provisions, the Centers for Medicare & Medicaid Services (CMS) should use regulations and subregulatory guidance to maximize state flexibility and encourage implementation approaches that minimize harm to children, families, and the pediatric health care delivery system.

Future reform efforts should also consider the broader context of financial and operational pressures facing children's hospitals, including chronic Medicaid underpayment, persistent workforce shortages, rising pharmaceutical and supply costs, and growing demand for highly specialized pediatric services. At the same time, policymakers continue to pursue policies that will threaten the ability of children's hospitals to expand the reach of their care through their outpatient departments. Children's hospital outpatient departments are uniquely important for children and their families because they provide specialized pediatric care that often cannot be replicated in a typical physician office or adult-focused outpatient setting. These sites bring care closer to home, reducing travel burdens and improving timely access to care, particularly in rural communities where families may lack access to pediatric specialty care and would otherwise have to travel long distances to a hospital's main campus. In addition, changes to the 340B Drug Program are shifting financial and administrative burdens onto safety-net providers and diverting critical resources from pediatric care. Together, these headwinds threaten the ability of children's hospitals to provide highly specialized, resource-intensive care that is often unavailable elsewhere in a community.

Policymakers should recognize that pediatric care is delivered through a highly specialized and regionalized system that differs fundamentally from adult care. Children's hospitals serve as regional centers for children's health, providing access to pediatric subspecialists and advanced services that may not be available in every community. As a result, many children, especially those with complex or rare conditions, must travel significant distances, often across state lines, to access appropriate care.

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<sup>2</sup> Centers for Medicare & Medicaid Services (CMS), "**February 2026: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot**," (May 2026).

<sup>3</sup> CHA's comments concerning the interim final rule on Medicaid community engagement requirements can be found [here](#).



We welcome the opportunity to work with you to improve the U.S. health system in a way that prioritizes children's health. Our comments below bring an important pediatric lens to many of the topics discussed in the RFI. Only by putting children first can we ensure that every child has access to the services they need to grow, thrive, and reach their full potential.

## Section I: Making Coverage More Affordable and Accessible

Private coverage reform should ensure meaningful access to needed care, including comprehensive, pediatric-appropriate benefits, meaningful parity for behavioral health services, and in-network pediatric providers with the expertise to provide that care. Families must be protected from coverage policies and plan designs that leave important health needs unmet, undervalue behavioral health care, or create financial barriers to medically necessary care.

### Consideration of New Coverage Pathways

The RFI seeks input on opportunities to fill persistent coverage gaps, including through the expansion of existing programs and the establishment of new, Medicare-type choices. CHA wants to be a partner as you develop children-specific proposals to improve children's coverage and access to needed care. We are working on our vision for children's health care and look forward to a future opportunity to share more specific feedback as this effort progresses.

### Coverage and Payment Policies Must Reflect the Unique Needs of Children

When it comes to health care, children are not little adults; they need coverage that is tailored to their developmental, behavioral, physical, and social needs. Federal policies designed to strengthen the existing coverage framework must establish a strong foundation of comprehensive, age-appropriate pediatric benefits and protect families from coverage products that expose them to significant financial risk. Just as benefit and coverage standards must account for the unique needs of children, payment policies must recognize that Medicare methodologies designed around an adult population are not appropriate benchmarks for pediatric care.<sup>4</sup> These protections are particularly important when changes elsewhere in the coverage and payment landscape are already placing additional strain on families and the pediatric providers that serve them.

### Defining Affordability

The RFI asks whether affordability standards should be expanded beyond premiums alone to account for families' total health care costs, including deductibles, copayments, and other out-of-pocket expenses. **CHA strongly supports this broader approach and urges Congress to evaluate affordability based on whether coverage provides meaningful financial protection and access to needed care.** A plan is not affordable when a lower premium is offset by cost-sharing that causes families to delay treatment or pay for medically necessary care out of pocket. This is true for children with complex, chronic, and serious conditions that

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<sup>4</sup> Manatt Health, "*Medicare Payment Methodologies and Pediatrics*," (2026).

may require ongoing care, but also for otherwise healthy children who need treatment for common illness or injury, an unexpected specialist visit, or diagnostic testing that a plan does not adequately cover.

Cost-sharing is a well-documented deterrent to timely care for children: Families facing higher out-of-pocket burdens are significantly more likely to delay or forgo needed medical care and prescriptions, and those effects are most pronounced for lower-income families and children with activity limitations.<sup>5</sup> For children, delayed care can result in missed developmental windows, avoidable hospitalizations, and higher costs later. Coinsurance is particularly a confusing concept for many consumers, which does not allow them to accurately determine their costs of care and can result in a higher financial burden, leaving families to decide whether to seek care without knowing what it will cost them. Plans should therefore use copayments rather than coinsurance for specialty visits and specialty drugs, so families can anticipate what they will owe for the services their children use most.

Predictability alone, however, is not sufficient for care children should receive as a matter of course. **Consistent with our prior comments on the Notice of Benefit and Payment Parameters, deductible exemptions should apply to the full range of pediatric preventive services, including those provided by a pediatric specialist.** Children with chronic or complex medical conditions visit their specialists more frequently and may rely on them for well-child and other preventive screenings, including immunizations—care that should not be subject to a deductible simply because of who delivers it. Plans should also delineate which specialist visits are exempt from the deductible and whether any limits apply to the number of visits allowed under the exemption.

Recent data on underinsurance among children underscores the need for a broader approach to defining affordability when it comes to health insurance. The share of children experiencing underinsurance increased from 30.6% in 2016 to 34% in 2019, representing an additional 2.4 million children.<sup>6,7</sup> In 2021, 33% of commercially insured children had inadequate coverage because of gaps in benefits, provider access, or protection from out-of-pocket costs, compared with 12.2% of publicly insured children. Children with disabilities or special health care needs experienced underinsurance at an even higher rate—40% compared with 30.8% among other children.<sup>8</sup> Underinsurance is also particularly prevalent among children with complex physical or behavioral health needs and among middle-income families that may not qualify for public coverage but still face unaffordable costs in private plans.<sup>9</sup>

Behavioral health care illustrates how underinsurance can lead to cost barriers. Pediatric mental health and substance use treatment is often ongoing, requiring frequent visits over months or years, and families may face per-visit copayments, separate deductibles, or out-of-network

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<sup>5</sup> Wisk et al., "Predictors of Delayed or Forgone Needed Health Care for Families With Children," *Pediatrics* (2012).

<sup>6</sup> Yu et al., "Underinsurance Among Children in the United States," *Pediatrics* (2022).

<sup>7</sup> In this study, "underinsurance" is defined as lacking continuous and adequate health insurance. Coverage was considered inadequate if it did not usually or always meet a child's needs, allow the child to see needed providers, or provide reasonable protection for out-of-pocket medical expenses.

<sup>8</sup> National Academies of Sciences, Engineering, and Medicine, "Launching Lifelong Health by Improving Health Care for Children, Youth, and Families," (2024).

<sup>9</sup> Validova et al., "Underinsurance Among Children With Special Health Care Needs in the United States," *JAMA Network Open* (2023).

costs where in-network pediatric behavioral health providers are unavailable. Cost-sharing structures designed around occasional adult utilization can make an otherwise covered benefit financially inaccessible at the point when early intervention would be most effective. **Deductible exemptions and cost-sharing limits should therefore extend to pediatric behavioral health services, as well as to habilitative services and devices**, which are critically important for children with a condition present at birth—such as cerebral palsy, autism, or spina bifida—or an illness or injury that prevents normal skills development and functioning.

**Standardized cost-sharing structures for these services should also be incorporated into plan designs**, both to inform families' plan choices and to convey the potential financial impact of relying on these therapies.

### Payment Must Reflect the Unique Characteristics and Long-Term Value of Pediatric Care

Policymakers often look to Medicare payment rates as a benchmark for health care payment policies outside of Medicare. For pediatric care, however, benchmarks derived largely from adult utilization and cost data may not accurately reflect the cost and complexity of caring for children, particularly for specialized and complex services. Medicare covers only a limited pediatric population, and its payment methodologies were developed primarily around the health care needs and utilization patterns of adults. This can result in payment benchmarks that do not fully account for the way pediatric care is delivered.

For example, Medicare uses relative value units, or RVUs, to help determine payment for physician services based on factors such as the work, time, and practice expenses associated with providing a service. Because these values are largely informed by care delivered to adults, they may not fully capture pediatric services that are uncommon in adult medicine, more complex when provided to children, or unique to pediatric care.<sup>10</sup> Caring for children often involves additional time communicating with and educating patients and families, greater care coordination and case management, and specialized equipment and supplies for children at different ages and stages of development. When these differences are not adequately reflected, adult-oriented benchmarks can undervalue pediatric services and the resources required to provide them.

Some states that use Medicare rates as a reference point have recognized this mismatch and adopted exceptions, conversion factors, or separate payment approaches for pediatric services. These adjustments reflect the practical difficulty of applying adult-focused Medicare benchmarks uniformly to care delivered to children.

**Payment reforms should also recognize that investments in children's health often produce benefits over a longer time horizon than are typically measured through traditional value-based arrangements.** Preventive services, early intervention, care coordination, and developmental supports can improve a child's health and functioning well into adulthood, but plans may have limited incentives to make those investments when families frequently change coverage and savings accrue outside the plan's measurement period. Pediatric providers can also be disadvantaged when shared savings or capitated payment

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<sup>10</sup> Manatt Health, 2026.



arrangements rely on adult-oriented measures or historical spending levels that do not reflect the cost and value of pediatric care. Value-based models should use pediatric-appropriate measures, recognize longer-term outcomes, and establish payment benchmarks that do not perpetuate existing underpayment.

As policymakers consider reforms to health care payment, they should avoid treating Medicare rates, adult-oriented measures, or historical spending as default benchmarks for pediatric care. **Payment policies should reflect the unique clinical and resource needs of children, account for the additional considerations associated with specialty and complex care, and recognize the long-term value of prevention, early intervention, and developmental supports.** These principles are essential to establishing sustainable payment models for pediatric providers and improving health outcomes for children.

### State Variation and the Need for Federal Guardrails

CHA recognizes the need for state flexibility across Marketplace plans and other state-regulated private coverage, including fully insured individual and group markets, to address the unique needs of their populations and health care markets. **However, that flexibility should operate within clear federal guardrails that protect children's access to age-appropriate, comprehensive, and medically necessary care and pediatric providers with the expertise to deliver that care on a timely basis.** Federal standards should establish a clear pediatric standard across private coverage while allowing states and plans to tailor benefit design and implementation to differences in population needs, provider availability, and patterns of care. Federal agencies should also require comparable public reporting of pediatric benefit limitations, exclusions, and coverage gaps so regulators can identify where additional guidance, oversight, or corrective action is needed.

**Congress should direct federal agencies to work with pediatric clinical experts and providers like children's hospitals to establish network adequacy standards that reflect pediatric patterns of care and apply across all types of insurance products, including ERISA plans.** A federal standard is essential because pediatric specialty care is regionalized and children routinely travel long distances and across state lines to reach the providers equipped to treat them. State-by-state variation leaves that access dependent on where a family lives and what type of coverage their employer or plan offers. Federal agencies can advance this work by partnering with the National Association of Insurance Commissioners to strengthen its existing model network standards and by supporting states implementing them.

**Federal policy should also promote consistent and transparent plan administration, including provider contracting, reimbursement, and claims payment practices.** Children's hospitals report that substantial variation in reimbursement levels and processes across plans and markets can make it difficult to sustain specialized pediatric services, particularly services that treat small numbers of children or require highly specialized clinical capacity. To address these challenges, Congress should direct federal agencies to examine how variations in payment, contracting, and tiering practices affect the adequacy of pediatric networks and access to covered services, and implement targeted protections where those practices create barriers to care. Such protections should account for clinical complexity, low service volume,



provider availability, and geographic differences while preserving state flexibility and opportunities for value-based arrangements.

## Pediatric Benefit Adequacy

Private health insurance does not provide children with comprehensive benefits tailored to their developmental, behavioral, physical, and social needs. Benefit packages are often designed with adults in mind, resulting in gaps, limitations, or exclusions for services that are essential to children's health and development, including habilitative therapies and devices, behavioral health care, home health services, durable medical equipment (DME), and care coordination. Research has identified employer-sponsored plans that did not cover pediatric dental services, applied behavior analysis therapy, or other autism services, illustrating how variation in state benefit rules can leave children without services that support their development and functioning.<sup>11</sup> Similar gaps can arise in coverage of essential health benefits (EHBs), which are tied to the scope of benefits provided under a “typical employer plan.”

The EHB framework illustrates the importance and the limitations of existing pediatric benefit protections in the private market. EHBs establish a pediatric benefit category coverage standard for individual and small-group market plans, but neither the statute nor implementing regulations define pediatric services beyond oral and vision care. As a result, there is no pediatric standard for the benchmark plans that serve as models for issuers in every state. **To address this gap, Congress and CMS should encourage states to benchmark their pediatric benefits against the Children’s Health Insurance Program (CHIP) coverage—either by adopting the CHIP benefit package as a pediatric benchmark option or by comparing their selected benchmark against the state’s CHIP package. Congress should also require that benchmark plans be assessed for gaps in pediatric coverage, including the inappropriate use of coverage limits, exclusions, cost-sharing, and medical necessity criteria.** States should identify and supplement gaps, and any benefit substitution should be clinically appropriate for children rather than merely actuarially equivalent.

States developed CHIP benefit packages with children in mind, making them a better reference point than adult-oriented commercial plans for ensuring adequate pediatric benefits. Comparative analyses have found that CHIP generally provides more consistent coverage of child-specific services and lower cost-sharing than qualified health plans in the Marketplace, although benefits vary across plans and coverage sources.<sup>12</sup> Similarly, Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement is a comprehensive benefit that encompasses prevention, diagnostic, and treatment services as well as well-child visits and mental health, dental, vision, and hearing care.<sup>13</sup> **CHA recommends allowing states to use CHIP as a pediatric EHB benchmark or supplemental standard, with EPSDT principles informing the identification and correction of pediatric coverage gaps.** Together, these programs would give states a practical basis for assessing benchmark plans and supplementing coverage when they fail to meet children’s needs.

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<sup>11</sup> NASEM, 2024.

<sup>12</sup> Wakely Consulting Group, “**Comparison of Benefits and Cost Sharing in Children’s Health Insurance Programs to Qualified Health Plans**,” (July 2014)

<sup>13</sup> CMS, “**Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements**,” SHO #24-005, (September 2024)

However, even the most comprehensive pediatric benefit package cannot ensure meaningful coverage if the medical necessity criteria used to determine access to services are not tailored to children's unique health care needs. Just as benefit packages based on a “typical employer plan” may reflect the needs of working adults, the medical necessity criteria used to administer those benefits are also grounded in adult populations and models of care. Even when a pediatric service is included as a covered benefit, a plan may apply medical necessity criteria to determine whether it will cover that service for an individual child. Children's hospitals report that payer policies and clinical criteria often rely on evidence developed from adult populations or otherwise fail to account for pediatric needs, requiring hospitals to negotiate pediatric-specific medical necessity language or repeatedly explain why adult-oriented standards are inappropriate for children.

For example, adult-oriented criteria may focus on treating acute illness or restoring a prior level of function. Pediatric care must also help children progress along a healthy developmental trajectory, including acquiring skills, maintaining function, and preventing or slowing deterioration. Medical necessity criteria should therefore consider whether a service is likely to support a child's trajectory toward the healthiest possible adulthood, including the child's physical, behavioral, cognitive, developmental, and social health. **Congress should require medical necessity criteria used across private coverage to reflect pediatric clinical evidence and expertise and recognize care needed for prevention, early intervention, growth, development, and the attainment, maintenance, or improvement of age-appropriate functioning.**

## Habilitative Services and Devices

Habilitative services and devices are those that are provided in order for a child or adult to **attain**, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. We were very pleased that Congress established habilitative services and devices as a separate EHB and supported the adoption of a standard definition of the benefit by CMS in 2015 given the importance of this benefit for children, particularly those with congenital conditions.

However, coverage of these services is often inadequate both within plans that must comply with the EHB requirements and in the large group market, which is not subject to a habilitative services coverage requirement at all. Private plans may restrict habilitative care through age or visit limits, therapy caps, narrow medical necessity criteria, diagnosis-based exclusions or delayed authorization, and may omit or narrowly define DME and other assistive technologies. These adult-oriented limits are inappropriate for children with congenital conditions, developmental disabilities, chronic illnesses, or serious injuries who may need support to acquire skills, maintain existing function, or slow deterioration as they grow and their needs change. For these children, habilitative therapies and assistive devices can determine whether they can participate at home, school, and in the community.

**CHA urges Congress and federal regulators to establish a pediatric standard for habilitative coverage based on functional need.** Medical necessity criteria should recognize attaining, maintaining, and preventing deterioration of function as appropriate outcomes; reflect

pediatric clinical expertise; and prohibit limits or exclusions not grounded in medical necessity.<sup>14</sup> CMS should implement this standard through the EHB framework by specifying a minimum set of covered therapies and devices and applying the federal definition of habilitation: services and devices that help a person keep, learn, or improve skills and functioning for daily living. EPSDT's correct-or-ameliorate standard can help identify gaps because pediatric habilitation is not limited to restoring prior function.<sup>15</sup> CMS should also monitor whether covered services and devices are actually available in practice and are age-appropriate. Unlike an adult who may use the same device for years, a child will outgrow it as they develop. Children need frequent replacement for assistive devices such as wheelchairs, glasses, hearing aids, orthotics, prosthetics, and augmentative communication devices, and coverage should not impose arbitrary restrictions on those replacements.

### Coverage Products with Limited Benefits or High Upfront Costs

Insurance marketed as lower-cost coverage may expose families to high upfront costs, benefit gaps, or limited consumer protections. When these products leave necessary care unpaid, families bear the consequences first. They may face medical bills they cannot pay, mounting debt, and in some cases bankruptcy, alongside the emotional strain of managing a child's illness while navigating unexpected costs and coverage denials. The consequences also extend to the providers who care for those children: children's hospitals may face greater uncompensated care and difficulty maintaining services for patients with intensive needs. **To address these challenges, CHA urges Congress and federal regulators to require minimum standards, clear disclosures, and oversight that reflect each product's risks and distinguish comprehensive insurance from temporary or noninsurance arrangements.**

Short-Term, Limited-Duration Insurance (STLDI). STLDI was originally intended to bridge a temporary gap between sources of comprehensive coverage, not to serve as a long-term substitute. These plans may use medical underwriting; exclude pre-existing conditions; impose benefit limits; and omit prescription drugs, behavioral health services, or pediatric therapies. The risks for consumers grow when coverage can be renewed, extended, or repeatedly repurchased, when prices or terms can change, or when plans can exclude a condition that arose during a prior term. **CHA supports limiting STLDI to a temporary period, maintaining prominent consumer notices, addressing misleading marketing, and ensuring families receive clear information about excluded benefits, network limitations, renewability, and pathways to comprehensive coverage.**

Health Care Sharing Ministries. Health care sharing ministries are not insurance and generally do not guarantee payment of medical claims. They may limit sharing for pre-existing conditions, prescription drugs, behavioral health care, habilitative services, or other pediatric needs, without providing the appeals, network, solvency, and other protections that apply to regulated insurance. **CHA urges stronger oversight, clear disclosures that payment is not**

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<sup>14</sup> Giardino et al., "Considerations in the Determination of Medical Necessity in Children: Application to Contractual Language," *Pediatrics* 150, no. 3: e2022058882 (September 2022).

<sup>15</sup> CMS, 2024.

**guaranteed, and prohibitions on marketing that presents these arrangements as insurance or allows them to avoid standards intended to protect children and families.**

Catastrophic Plans. Catastrophic plans generally offer lower premiums in exchange for very high deductibles and limited coverage before the deductible is met. Families may therefore bear the full cost of diagnostic testing, specialty care, behavioral health services, and treatment for common childhood illnesses, discouraging timely care and creating significant exposure for children who require ongoing services. Expanding eligibility may also draw healthier enrollees away from more comprehensive coverage. **CHA urges Congress and CMS to limit expansion of catastrophic plans, preserve annual cost-sharing protections, and ensure that multi-year contracts do not lock families into inadequate coverage or delay the point at which a plan begins paying claims.**

High-Deductible Health Plans (HDHPs). Although HDHPs are comprehensive insurance products, their lower premiums can expose families to substantial upfront costs and delay needed care. HDHP enrollment among privately insured children increased from 18.4% in 2007 to 48.6% in 2018, and families enrolled in these plans report greater barriers to care, medical debt, and difficulty paying bills than those in traditional plans.<sup>16</sup> The burden is particularly significant for lower-income families and those managing chronic conditions, whose recurring pediatric services create predictable expenses before the deductible is met.<sup>17</sup>

## Section II: Making Health Care Simpler for Families

Children and families should be able to obtain needed care without navigating unnecessary barriers created by insurance networks, coverage policies, or administrative requirements. When coverage policies make care harder to access, the burden falls not only on families but also on children's hospitals and other pediatric providers already facing workforce, capacity, and financial pressures. Private coverage should support timely access to appropriate pediatric providers and services by strengthening pediatric networks, reducing administrative barriers to care, and ensuring timely access to behavioral health services.

### Network Adequacy Standards Must Reflect How Children Access Specialized Pediatric Care

Children's hospitals frequently serve as regional referral centers for services unavailable in every community or state. As a result, pediatric subspecialists and other specialized pediatric providers are often concentrated around these centers rather than distributed evenly across health plan service areas. This means that children, particularly those with rare, complex, or chronic conditions, may need to travel beyond their local community or even across state lines to obtain medically necessary care. Adult-oriented network adequacy standards, which often assume that providers can be evaluated using local time-and-distance measures, can therefore

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<sup>16</sup> Larson et al., "High-Deductible Health Plans for US Children: Trends, Health Service Use, and Financial Barriers to Care," *Academic Pediatrics* (2021).

<sup>17</sup> Galbraith et al., "Nearly Half of Families in High-Deductible Health Plans Whose Members Have Chronic Conditions Face Substantial Financial Burden," *Health Affairs* (2011).

overstate access to pediatric care and fail to capture whether children can actually reach appropriate pediatric specialists and hospitals, which may result in families being more likely to seek necessary care out-of-network. Compared to Medicaid and other public insurance, research has found higher rates of out-of-network care and associated cost-sharing among commercially insured children with chronic conditions, including those with complex needs and those who use behavioral health services.<sup>18</sup> These standards should apply across all types of insurance products, including self-funded ERISA plans, which currently fall outside federal and state network adequacy requirements.

**Federal standards should require networks to demonstrate access to primary, preventive, dental, and behavioral health care and separately document pediatric specialty, subspecialty, and ancillary capacity.** Networks should include appropriately trained pediatric providers and at least one pediatric hospital provider capable of furnishing comprehensive specialty services. Standards must also be developed for the full range of board-certified pediatric specialties and subspecialties. Appropriate pediatric standards should:

- Ensure that networks are capable of providing pediatric services, both physical and mental health, for all levels of complexity, including for rare conditions, without administrative or cost barriers for children and families
- Only allow out-of-network arrangements as an exception for extremely rare services or when timely access to the type of provider a child needs cannot be assured
- Prohibit health plans from penalizing families through extra cost sharing or administrative hurdles in the rare circumstance when that child must use an out-of-network provider

**Regulators should also strictly limit a plan's opportunity to justify an inadequate network in lieu of assuring an adequate one.** Such justifications should be accepted only in very rare circumstances and for very rare health conditions; plans must not be allowed to secure exceptions solely because the appropriate provider is in another state. Plans must be required to design networks that ensure access to appropriate in-network providers for all covered services, and must not rely on out-of-network arrangements, exceptions processes, or other mechanisms that create barriers and burdens for sick children in need of care.

**Additionally, federal and state reviews of network adequacy should use pediatric-specific measures rather than relying on adult-oriented time-and-distance standards, which do not account for regional referral patterns or the concentration of tertiary and quaternary services at children's hospitals.** Research applying adult-oriented distance standards to pediatric specialty hospitalizations found that nearly half would fall outside those standards.<sup>19</sup> Reviews should consider appointment wait times, provider ratios by pediatric specialty, population dispersion, cross-state access, and the availability of providers equipped to serve children with complex needs. When appropriate pediatric specialty care is concentrated in one or two settings, tiered networks should place those providers in the lowest-cost tier.

**Plans should also maintain stable pediatric networks and protect continuity of care for children in active treatment.** When a family changes plans or a plan changes its network,

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<sup>18</sup> NASEM, 2024.

<sup>19</sup> Colvin et al., "Hypothetical Network Adequacy Schemes for Children Fail to Ensure Patients' Access to In-Network Children's Hospitals," *Health Affairs* (2018).

children receiving ongoing treatment should be able to remain with their current providers for a defined transition period of sufficient length to complete a course of treatment or transition safely to a new provider. This protection is especially important for children with complex or chronic conditions who have established relationships with highly specialized providers, particularly where only a few providers have the necessary expertise. Plans should provide advance notice of material network changes so families can plan for them.

**Finally, federal agencies should consult closely with a spectrum of pediatric provider and facility types, caregivers, child health advocates, and health plans to develop workable and effective pediatric standards and review processes.** That expertise can help design a framework that accounts for the full range of children's physical health, mental health, and developmental needs, geographic challenges, and the regionalization of pediatric specialty care. Because there is currently no state-of-the-art knowledge regarding network adequacy metrics for pediatrics, the standards development and implementation processes must be nimble enough to adapt as health care delivery and population needs change.

## Reporting and Enforcement

Plans should report pediatric specialty access in network filings, including appointment availability, location of care, use of noncontracted providers, and denials or exceptions related to unavailable pediatric providers. Regulators should review these data throughout the coverage year and require corrective action when persistent barriers emerge.

## Essential Pediatric Community Providers (ECPs)

Under the Affordable Care Act (ACA), providers that qualify as ECPs help ensure that low-income, vulnerable individuals and those in medically underserved areas have timely access to a broad range of primary and specialty care providers, including children's hospitals. Children's hospitals are recognized as ECPs because they play a particularly important role in caring for low-income children and children with serious, complex, or chronic conditions who rely on specialized pediatric services that may not be available elsewhere. However, the current federal standards for plans to contract with ECPs do not ensure that they actually include the children's hospital or specialized pediatric providers needed to meet the full range of children's health care needs.

**ECP standards should require that plans contract with a children's hospital that furnishes comprehensive specialty and supporting services.** Under current rules, a plan must contract with at least one provider in each ECP category, but the overall participation percentage applies across all categories combined. Children's hospitals fall within the hospital category, so a plan can meet the threshold by contracting broadly with other types of ECPs while leaving out the regional children's hospital that underserved children in its service area depend on. **Federal regulators should require plans to meet the participation standard within each ECP category, rather than across all categories combined, and consider raising the minimum participation percentage.** Applying the threshold category by category would make it far more likely that a plan contracts with the children's hospital serving its area, and a higher standard is warranted because most plans meet the established minimum and go

no further. **Furthermore, regulators should monitor, identify, and address gaps in ECP contracting, assess the validity of "good faith" offers, and review provider directories for accuracy.** Networks without a sufficient number and scope of ECP types can leave children without access to needed care, and delays in care are particularly detrimental to children—resulting not only in poor health outcomes but in additional costs to the health care system and long-term costs to the nation's economy.

### Out-of-Network Care and Coverage

When a network cannot furnish a covered service within a clinically appropriate timeframe, the plan should cover care from a capable out-of-network provider at in-network cost-sharing and provide reasonable payment. Because single-case agreements must be negotiated individually between the plan and the provider before care is delivered, they can delay treatment while a child waits for the parties to reach terms, and they leave families uncertain about whether care will be approved or what they will owe. Single-case agreements may therefore be appropriate for extremely rare services but should not substitute for a generally adequate pediatric network.

### Prior Authorization and Other Utilization Management Requirements Should Not Delay Medically Necessary Pediatric Care

Complicated prior authorization processes delay treatment, create additional stress for families, and burden providers. Children's hospitals report that prior authorization requirements are particularly challenging for children who need recurring therapies, medications, DME, behavioral health services, or specialty care. Repeated authorization requests for ongoing treatment often create administrative burden without improving care, while delays in obtaining equipment and home-based supports can prolong hospital stays and hinder safe discharge. Hospitals also report significant operational costs associated with maintaining staff and infrastructure needed to navigate varying payer requirements. At a time when children's hospitals are managing workforce and financial pressures across the care continuum, avoidable administrative work further fragments care and diverts scarce clinical and operational resources from patients.

### Standardized, Timely, and Limited Prior Authorization Processes

Prior authorization should be limited to circumstances in which review is necessary to promote appropriate care. Requirements should be minimized for routinely approved, evidence-based pediatric services, and pediatric services should be included in gold-carding programs. Moreover, children receiving ongoing treatment should not be subject to repeated reviews within an approved course of care.

**It is critical that coverage determinations and prior authorization reviews reflect pediatric-specific standards of care and recognize services that support healthy development, prevent deterioration, and help children attain, maintain, or improve age-appropriate functioning.** Payers should allow reasonable coding flexibility, honor requirements in effect when a request was submitted, and expedite review of DME and other home- and community-based supports needed for safe discharge. Prior authorization should not apply to emergency transport, stabilization, or transfer to an appropriate pediatric facility.

Prior authorization policies must also account for gaps in the pediatric evidence base. Many therapies approved for adults have not received pediatric indication from the Food and Drug Administration, even when their use in children is supported by pediatric clinical expertise and consistent with the standard of care. Payers should not treat the absence of a pediatric indication as evidence that a treatment is inappropriate or use adult-focused coverage criteria to deny or delay medically necessary pediatric care. Reviews involving such treatments should be conducted by clinicians with relevant pediatric expertise and consider the available evidence, the child's individual clinical circumstances, and accepted pediatric standards of care.

**Congress should continue supporting efforts to expand the evidence base for pediatric treatments. This includes maintaining incentives for pediatric clinical research and investing in federally supported research that values the safety, effectiveness, and appropriate use of therapies in children.** Strengthening the pediatric evidence base can improve clinical decision-making and inform coverage policies, but children should not be denied access to appropriate care while that evidence continues to develop.

**CHA urges Congress to establish consistent prior authorization processes across private coverage, particularly for children who need recurring therapies, medications, equipment, or specialty services.** Private plans should use common data elements, standardized documentation requirements, and interoperable electronic systems that clearly display authorization requirements and request status. Timely decisions are particularly important for children, whose health, development, and functioning can be affected by delays in care. Payers should be required to issue a final approval, denial, or request for additional information within 48 hours for standard requests and 24 hours for urgent requests, with shorter timeframes when delay could jeopardize a child's health or function. These standards should apply across payer types to medical services, prescription drugs, and biological products.

## Continuity, Denials, and Plan Accountability

**Coverage changes should not restart clinical review of a previously approved service or device.** When a child moves between plans—whether because a family changes coverage, a plan changes its network, or the child transitions between commercial coverage, Medicaid, and CHIP—a previously approved service or device should not be subject to a new round of clinical review. The patient's plan should receive pending and active authorizations and honor them for an appropriate transition period, particularly for extended treatment courses and specialty care obtained across state lines. Requiring a family to restart the authorization process interrupts care that a clinician has already determined the child needs and that another plan has already approved. Plans should remain accountable for delegated review and provide consistent requirements, real-time status information, and a reliable point of contact across vendors.

When denials occur, notices should provide families and providers with the clinical rationale, any covered alternatives, and clear instructions for resubmission or appeal. Expedited peer-to-peer review and appeals should be available with a reviewer who has relevant pediatric expertise, and ongoing services should continue while a timely appeal is pending. Plans should disclose when automated tools influence a decision, ensure review by a qualified clinician, and distinguish denials based on clinical review from requests closed for administrative reasons, such as missing documentation or procedural requirements.



## Transparency and Enforcement

Children's hospitals report that payers can take up to 14 days to render a prior authorization decision. One children's hospital found that 99% of prior authorization denials were ultimately overturned because the payer agreed the services were appropriate. That same hospital increased frontline prior authorization staffing by 33% over four years, at a cost of \$4 million.

**Congress can begin to address these challenges by requiring consistent, centralized reporting across payer types on decision times, denials, appeals, overturns, and third-party vendor use.** Federal agencies should publish comparable data, establish performance benchmarks, and intervene within the same plan year when patterns indicate excessive delay, denial, or reversal.

## All Health Plans Should Support Access to the Full Continuum of Pediatric Behavioral Health Services

Children and adolescents must be able to access mental health and substance use disorder services as readily as medical and surgical care. The EHB framework already requires individual and small group plans to cover mental health and substance use disorder services, yet coverage is frequently limited in scope, leaving significant gaps across the continuum of care. Narrower networks, inadequate reimbursement, restrictive utilization management, and inconsistent payment processes can delay early intervention, prolong emergency department boarding, and impede safe transitions from crisis or inpatient care. These barriers also strain the limited providers sustaining pediatric behavioral health capacity.

**CHA urges Congress and federal regulators to require that plans cover the full pediatric behavioral health continuum, including prevention, early intervention, outpatient and integrated care, intensive outpatient and partial hospitalization programs, residential and inpatient treatment, crisis services, and home- and community-based supports.** Intermediate levels of care should not be excluded from benefits or provider networks when they can prevent hospitalization or support timely discharge.

**Because a coverage requirement alone does not ensure that services are accessible in practice, CHA also urges Congress to call on the Departments of Labor, Health and Human Services, and the Treasury to restore and strengthen the 2024 final rule implementing the Mental Health Parity and Addiction Equity Act (MHPAEA).**<sup>20</sup> In May 2025, the agencies announced they would not enforce provisions of the rule that were new relative to the 2013 parity regulations; they have since indicated they will not defend the rule in court and intend to propose replacement regulations. Without those protections, parity reviews are substantially weaker for children.

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<sup>20</sup> Enacted in 2008 and amended by the Consolidated Appropriations Act, 2021, MHPAEA requires health plans that cover mental health and substance use disorder care to do so on terms no more restrictive than those applied to medical or surgical care. Rules issued in 2013 established that basic framework, and the 2024 rule further strengthened protections by requiring plans to analyze and document how their treatment limitations—such as prior authorization requirements and medical necessity criteria—affect access to behavioral health care.



CHA strongly supported the parity review requirements advanced in the 2024 rule while identifying opportunities to make those reviews more effective for children. Parity reviews should require pediatric-appropriate medical necessity criteria and comparable standards for authorization, approval duration, information requests, and appeals across behavioral health and medical or surgical care. Plans should remain accountable when review is delegated to a separate vendor. Our comments on the proposed MHPAEA rule offer more detailed recommendations on strengthening parity enforcement for children, and we welcome the opportunity to discuss them further.<sup>21</sup>

Finally, to strengthen behavioral health access for children, health plans should demonstrate adequate pediatric capacity at each level of care and report appointment wait times, out-of-network use, reimbursement levels, authorization timelines, denials, and appeals. Payment and credentialing practices should support integrated and team-based care models and intermediate levels of care. Reimbursement delays caused by burdensome utilization review and slow claims processing, combined with historically low reimbursement rates, contribute to pediatric providers declining to participate in private plan networks. Families should receive clear information about covered services, participating pediatric providers, and appeal rights, and regulators should require corrective action when data reveals material disparities in access.

## Monitoring and Enforcement

Congress should ensure that protections for children are more than promises on paper. New and existing requirements should be accompanied by strong monitoring and meaningful enforcement to ensure that children and families can realize the benefits these policies are intended to provide. Federal policymakers also should regularly assess the impact of any new policies using data and input from children, families, pediatric providers, and children's hospitals. Incorporating these perspectives will help identify unintended consequences, measure progress, and ensure that new policies effectively meet children's unique health and developmental needs.

Thank you for the opportunity to inform your efforts to improve health care coverage, access, and affordability. We stand ready to work with you to ensure that children's health and developmental needs and the unique nature of the pediatric delivery system are front and center as Congress contemplates future reforms. By putting children first, we can help ensure that every child has access to the timely, high-quality care they need to grow, develop, and thrive. Should you have questions or need further information, please reach out to Melinda Becker Roach at [melinda.roach@childrenshospitals.org](mailto:melinda.roach@childrenshospitals.org) or 202-753-5338.

Sincerely,

A handwritten signature in blue ink that reads 'Aimee Ossman'.

Aimee Ossman  
Vice President, Policy  
Children's Hospital Association

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<sup>21</sup> CHA's comments on the 2024 MHPAEA proposed rule can be found [here](#).