

PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Principles of Child Health Care Financing

Committee on Child Health Financing

Pediatrics 2003;112:997-999

DOI: 10.1542/peds.112.4.997

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://www.pediatrics.org/cgi/content/full/112/4/997>

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2003 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



AMERICAN ACADEMY OF PEDIATRICS

POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Committee on Child Health Financing

Principles of Child Health Care Financing

ABSTRACT. Child health care financing must maximize access to quality, comprehensive pediatric and prenatal health care. This policy statement replaces the 1998 policy statement by the same title. Changes reflect recent state and federal legislation that affect child health care financing. The principles outlined in the statement will be used to evaluate the changing structure of child health care financing.

ABBREVIATIONS. AAP, American Academy of Pediatrics; SCHIP, State Children's Health Insurance Program.

INTRODUCTION

The American Academy of Pediatrics (AAP) advocates for universal and insured financial access to quality health care for all newborns, infants, children, adolescents, young adults (through 21 years of age), and pregnant women (hereafter referred to as children and pregnant women). The financing of such universal access should provide a comprehensive benefit package that should include but not be limited to preventive care services recommended by the AAP, acute and chronic care services, pregnancy-related services, mental and behavioral health services, and emergency care services without condition exclusions. Current financing systems must be improved to maximize access to quality, comprehensive pediatric and prenatal care. These systems should include ongoing, timely enhancement of coverage to ensure children's access to appropriate new technologies, such as improved immunizations and screening for genetic and metabolic diseases. Furthermore, reimbursement should be closely tied to quality of care as demonstrated by objective measures recommended by the Institute of Medicine.¹

Inequitable financing of health care contributes to the current level of preventable mortality and morbidity among children and pregnant women in the United States. There is growing evidence that access to comprehensive and continuous care, including preventive care and behavioral and mental health services, leads to positive health outcomes and decreased health expenditures.² Poor and near-poor children who were up-to-date on their well-child visits in the first 2 years of life had fewer avoidable

hospitalizations.³ Expansion of ambulatory care coordination and other supportive services led to decreased lengths of hospital stays and total inpatient expenditures among children with chronic conditions.⁴ Comprehensive follow-up care decreased the risk of life-threatening illness in the first year of life among high-risk inner-city infants without increasing costs.⁵ One analysis of mental health parity legislation found that the number of hospital days for all causes decreased by 70% and payments for mental health services as a portion of total health expenditures decreased from 6.4% to 3.1%.⁶ Although the establishment of the State Children's Health Insurance Program (SCHIP)⁷ (Title XXI of the Social Security Act⁸) has not created universal coverage for children, it has been an important opportunity to expand insurance coverage to a large portion of uninsured children. In addition, SCHIP partially addresses the current inequity of financing.⁹ Care must be taken to provide resources for the financial needs of children's health care even in the face of increasing adult health care expenditures. The AAP is concerned with the implications of state Health Insurance Flexibility and Accountability waivers, because the funds for new enrollee coverage will be derived only from cuts in existing benefits and increases in cost sharing for individuals, including poor children and their families. As the public and private sectors and the AAP work to expand the structure of health care financing, the following principles will be used to evaluate proposed changes. These principles will be integral in ensuring that SCHIP, regardless of whether states have established new programs or expanded Medicaid, provides access to quality health care.

1. Children's Rights to Access to the Health Care System

- All children and pregnant women have a right to comprehensive health care that is fully portable and ensures continuous coverage.
- Financial barriers should not prevent children and pregnant women from receiving comprehensive health care.
- One children's health care financing program without means testing and with uniform eligibility and benefits and simplicity of administrative procedures should be created.
- When families cannot be covered by private insurance, the public has an obligation to provide

health insurance for them, particularly for children and pregnant women.

- Health care financing should permit children and their families to choose health care professionals who will provide quality pediatric care.
- Children should be able to access pediatricians or family physicians whose offices will serve as medical homes¹⁰ providing continuity of care, and pregnant women should be able to access obstetricians, family physicians, and internists.
- All plans should be required to include in their panel of providers all pediatric medical subspecialties, pediatric surgical specialties, and inpatient facilities having designated pediatric units.
- Managed care plans should provide access to emergency care consistent with the “prudent layperson standard,” such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in 1) placing the health of the plan member in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.⁷
- Health care plans should ensure that access and referral processes for mental and behavioral health specialists are equivalent to those for physical health services. Health care plans should also recognize that pediatricians often provide mental health care in their offices and should be reimbursed for these services. Furthermore, health plans should also encourage improved communication and coordination between primary care physicians and behavioral health organizations.

2. Standards for Equity, Comprehensiveness, and Quality Improvement

Health care financing should:

- Support and fund health care that is provided in a culturally sensitive, family centered, flexible manner. Competition among health financing and delivery plans should be based on access, service, and quality and not solely on economics. Benefits and requirements for administrative efficiencies, such as uniform claim forms and payment, should be standardized among programs.
- Cover all health care needs of children as defined by the AAP statement “Scope of Health Care Benefits for Newborns, Infants, Children, and Adolescents Through Age 21 Years,”¹¹ *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*,¹² and *Bright Futures in Practice: Mental Health*.¹³
- Include incentives to promote continuity and coordination of care by primary care physicians whose practices serve as medical homes.
- Recognize that chronically ill children have special needs requiring appropriate reimbursement of evaluation and management, care coordination and case management, team meetings and conferences, and medically indicated interventions and surgeries.
- Be structured to encourage preventive care and screening for early detection and treatment of physical and mental illness. Such care has been

shown to improve quality of life and decrease the risk of psychosocial morbidities.^{14–18}

- Incorporate appropriate mechanisms for monitoring and reporting quality of care measurements specific to children. These should include assessments of process and outcome indicators, access to care, and patient satisfaction.

Additional recommended standards for health insurance policies include:

- Health care insurers should be prohibited from denying coverage after an appropriate waiting period through the use of preexisting condition exclusion clauses or severely restrictive medical underwriting practices.
- All private and public health insurance policies should fulfill the following requirements: 1) no limitation of coverage or reimbursement because of chronic or recurring illnesses; 2) no premium rate increases on the basis of experience; and 3) guaranteed renewability and portability of insurance coverage with no disruption as patients move between Medicaid, SCHIP, and commercial plans.
- The specifications and limitations of all health financing plans should be stated clearly and readily understood by all families and physicians.
- Regulations governing health care financing should encourage access to quality pediatric primary, medical subspecialty, surgical specialty, and mental and behavioral health care.
- Health insurers should define medical necessity as health and health-related services that: assist in achieving, maintaining, or restoring health and functional capacity; are appropriate for age and developmental status; and take into account the specific needs of the child.¹⁹
- Appropriate reimbursement should be available for medical care provided via telephone and e-mail and for telemedicine.

3. Standards for Cost Containment

- Cost containment is essential but must not impair the quality of care delivered. Physicians should play an important role in establishing principles of evidence-based medicine, validating the measurements used, and ensuring quality of care in any cost-containment process.
- Controlling costs should be the combined responsibility of families, clinicians, third-party payers, pharmaceutical companies, medical product/supply manufacturers and other manufacturers, employers, and administrators of health care delivery systems.
- Financial incentives should be used to encourage health care delivery systems to provide a medical home for all children and emphasize preventive care, early detection, and comprehensive diagnosis and treatment, thus promoting quality and efficiency.
- Health care financing should encourage delivery of services in the most medically appropriate and cost-effective settings.
- Health care insurers should recognize the unneeded extra cost involved with individualized

and nonstandardized requirements for provider participation. Standardization among programs for administrative efficiency, such as uniform credentialing, claim forms, referral processes, and payment systems will aid in achieving cost effectiveness.

- Cost sharing should not be applied to preventive or health supervision services, such as immunizations and well-child visits.
- The same cost sharing amounts and principles applied to physical health services should be applied to mental health and behavioral health services.
- Innovative models of health care financing should be carefully evaluated before assuming that they are relevant to the needs of children.

COMMITTEE ON CHILD HEALTH FINANCING, 2003–2004

Thomas K. McInerney, MD, Chairperson

Charles J. Barone, MD

Jeffrey M. Brown, MD, MPH

Richard Lander, MD

John R. Meurer, MD, MBA

Richard Y. Mitsunaga, MD

Mark S. Reuben, MD

Steven E. Wegner MD

*Mark J. Werner, MD

CONSULTANT

Margaret McManus, MHS

STAFF

Jean C. Davis, MPP

*Lead author

REFERENCES

1. Committee on Enhancing Federal Healthcare Quality Programs, The Institute of Medicine. *Leadership By Example: Coordinating Government Roles In Improving Health Care Quality*. Corrigan JM, Eden J, Smith BM, eds. Washington, DC: The National Academies Press; 2003
2. Christakis DA, Wright JA, Zimmerman FJ, Bassett AL, Connell FL. Continuity of care is associated with high-quality care by parental report. *Pediatrics*. 2002;109(4). Available at: <http://www.pediatrics.org/cgi/content/full/109/4/e54>
3. Hakim RB, Bye BV. Effectiveness of compliance with pediatric preven-

tive care guidelines among Medicaid beneficiaries. *Pediatrics*. 2001;108:90–97

4. Liptak GS, Burns CM, Davidson PW, McAnarney ER. Effects of providing comprehensive ambulatory services to children with chronic conditions. *Arch Pediatr Adolesc Med*. 1998;152:1003–1008
5. Broyles RS, Tyson JE, Heyne ET, et al. Comprehensive follow-up care and life-threatening illnesses among high-risk infants: a randomized controlled trial. *JAMA*. 2000;284:2070–2076
6. North Carolina Psychological Association. *Data on the Mental Health Benefit: Analysis Prepared by the NC Psychological Association From Data Supplied by the North Carolina State Health Plan Office*. Raleigh, NC: North Carolina Psychological Association; 1999
7. Balanced Budget Act of 1997. Pub L No. 105-33 §4704 (b)(2)(C) (1997)
8. Social Security Act. Pub L No. 74-271 (49 Stat 620), 42 USC 7 (1935)
9. American Academy of Pediatrics, Committee on Child Health Financing. Implementation principles and strategies for Title XXI (State Children's Health Insurance Program). *Pediatrics*. 1998;101:944–948
10. American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee The medical home. *Pediatrics*. 2002;110:184–186
11. American Academy of Pediatrics, Committee on Child Health Financing. Scope of health care benefits for newborns, infants, children, adolescents, and young adults through age 21 years. *Pediatrics*. 1997;100:1040–1041
12. Green M, Palfrey JS, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 2nd ed. Arlington, VA: National Center for Education in Maternal and Child Health; 2002
13. Jellinek M, Patel BP, Froehle MC, eds. *Bright Futures in Practice: Mental Health—Volume 1. Practice Guide*. Arlington, VA: National Center for Education in Maternal and Child Health; 2003
14. Homer CJ, Szilagyi P, Rodewald L, et al. Does quality of care affect rates of hospitalization for childhood asthma? *Pediatrics*. 1996;98:18–23
15. Yang JM, Shah AK, Watson M, Mankad VN. Comparison of costs to the health sector of comprehensive and episodic health care for sickle cell disease patients. *Public Health Rep*. 1995;110:80–86
16. Bindman AB, Grumbach K, Osmond D, et al. Preventable hospitalizations and access to health care. *JAMA*. 1995;274:305–311
17. Friedman B, Basu J Health insurance, primary care, and preventable hospitalization of children in a large state. *Am J Manag Care*. 2001;7:473–481
18. Patterson T, Higgins M, Dyck DG. A collaborative approach to reduce hospitalization of developmentally disabled clients with mental illness. *Psychiatr Serv*. 1995;46:243–247
19. Berman S. A pediatric perspective on medical necessity. *Arch Pediatr Adolesc Med*. 1997;151:858–859

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

Principles of Child Health Care Financing
Committee on Child Health Financing
Pediatrics 2003;112;997-999
DOI: 10.1542/peds.112.4.997

Updated Information & Services	including high-resolution figures, can be found at: http://www.pediatrics.org/cgi/content/full/112/4/997
References	This article cites 12 articles, 10 of which you can access for free at: http://www.pediatrics.org/cgi/content/full/112/4/997#BIBL
Citations	This article has been cited by 3 HighWire-hosted articles: http://www.pediatrics.org/cgi/content/full/112/4/997#otherarticles
Subspecialty Collections	This article, along with others on similar topics, appears in the following collection(s): Office Practice http://www.pediatrics.org/cgi/collection/office_practice
Permissions & Licensing	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: http://www.pediatrics.org/misc/Permissions.shtml
Reprints	Information about ordering reprints can be found online: http://www.pediatrics.org/misc/reprints.shtml

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

