ABSTRACT. A major provision of the Balanced Budget Act of 1997 established the State Children’s Health Insurance Program (Title XXI of the Social Security Act). This program is a historic milestone in the financing of health care for children. Not since the enactment of Medicaid has there been a greater investment in children’s health care. Title XXI does not create universal coverage for all children, but this program does offer an unprecedented opportunity to expand insurance to a large portion of uninsured children. Title XXI of the Social Security Act makes >$40 billion in federal grants available to states over the next 10 years to provide health insurance coverage, including Medicaid. However, states must contribute a defined share of funds to obtain federal matching funds. The legislation gives great flexibility to states in designing and implementing their programs, and it is critical that they do this in a timely manner. If states fail to use all State Children’s Health Insurance Program funds available, it is possible that future federal funding will be reduced. If this happens, a major opportunity to improve the health insurance coverage of America’s children will be diminished.

ABBR EVIATIONS. AAP, American Academy of Pediatrics; SCHIP, State Children’s Health Insurance Program; FPL, federal poverty level.

The purpose of this policy statement is to present a set of principles and implementation strategies recommended to states by the American Academy of Pediatrics (AAP) as they create and amend their SCHIPs. These principles address issues related to financing, eligibility, enrollment, benefits, cost-sharing, reimbursement, managed care, and accountability. Title XXI offers an opportunity for every state to develop an effective program to reduce the number of uninsured children, but this will require a strong public and private partnership of SCHIP lead agencies; pediatricians, and other physicians, business groups, advocacy groups, consumers, and other coalitions interested in the welfare of children.

BACKGROUND

Under Title XXI, states can select three different approaches to providing health insurance coverage to children. These approaches include 1) expanding Medicaid; 2) creating or expanding a non-Medicaid children’s health insurance program; or 3) implementing a combination of both options. Whichever approach a state chooses, it will receive an enhanced federal matching rate, above their Medicaid rate. In addition, states can request to provide coverage through direct service support. In certain circumstances, states also can subsidize the purchase of family coverage. The AAP recognizes that one approach will not be suitable for all states. Each state must select the approach that will ensure that the largest possible number of uninsured children receive comprehensive quality health care.

For many states, expanding Medicaid will be the best option, and for others a non-Medicaid health insurance program will be the best strategy. The choice will depend in part on the public and private resources and financing of child health services in each state. With Medicaid, the benefit package is comprehensive and includes the Early and Periodic Screening, Diagnosis, and Treatment program, as well as a range of specialized services for children with chronic or disabling conditions. Medicaid provides significant patient protection and entitles every eligible child to health insurance coverage at no cost, unless the state has an approved 1115 demonstration waiver program. A Medicaid expansion could be implemented more rapidly than a non-Medicaid state health insurance program and avoids the need to create a new entity with separate administrative systems. It also eliminates the need to coordinate enrollment between two insurance programs and reduces the problem of shifting children between insurance programs when family income levels change. Therefore, the Medicaid option may enhance continuity and result in a more seamless system of coverage. Expanding Medicaid may also place states in a stronger negotiating position with managed care organizations because, with a larger number of children’s health insurance program. When creating or expanding a non-Medicaid children’s health insurance program, the benefit package must reflect one or more of the following five basic options: 1) Blue Cross/Blue Shield standard preferred provider option offered to federal employees under the Federal Employees Health Benefits Program; 2) the state employee health plan; 3) the HMO product with the largest insured commercial, non-Medicaid enrollment in the state; 4) a benefit plan that is the actuarial equivalent to one of the previous options; or 5) a benefits package approved by the Secretary of Health and Human Services. Under Title XXI, the states of Florida, New York, and Pennsylvania are allowed to use their existing children’s health insurance benefits plans; however, they will still need to submit for approval a Title XXI plan.

Section 1115 of the Social Security Act grants permission to the Secretary of the Department of Health and Human Services to waive federal Medicaid provisions for states implementing experimental or pilot programs designed to advance the goals of the program.
crease in uninsured children is related to an enrollment. Research, Health Insurance Status of US Children

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to pay the premium contributions. Individual states

will vary with respect to changes in numbers of

uninsured children based on state economic condi-

tions, state Medicaid eligibility levels, outreach and

enrollment activities, welfare reform policies, and the

availability of other state health insurance programs.

AAP PRINCIPLES AND IMPLEMENTATION

STRATEGIES

As states begin to design and implement SCHIP, the following implementation principles and strategies should be incorporated into their plans.

1. State child health insurance programs should provide comprehensive quality health care coverage to the largest number of uninsured children as rapidly as possible.

a. State programs should include children younger than 19 years of age and use the highest income eligibility allowable. For states with Medicaid income eligibility thresholds at or below 150% of the federal poverty level (FPL), the income eligibility level should increase to 200% FPL. For states that already cover all children in families above 150% FPL or subgroups such as infants to 185% FPL, the income eligibility level should increase to 50 percentage points above the state’s current Medicaid income limit for children in any applicable age category. To reach even more children, states should be encouraged to use the income disregards allowed under Section 1902 (r)2 42 USC 1396a. States also should consider discontinuing asset testing to determine eligibility.

b. States should offer 12-month continuous eligibility for Medicaid and SCHIP children. States also should implement presumptive eligibility for all children, allowing health care providers and other designated agencies to grant eligibility for up to 60 days while a child goes through

THE HEALTH INSURANCE STATUS OF CHILDREN

The number and proportion of American children lacking health insurance increased in 1996 to the highest levels ever recorded by the Census Bureau’s Current Population Survey. In 1996, 15.1% (11.3 million) of children younger than age 19 were uninsured, up from 14% (10.3 million) who were uninsured in 1993 (AAP Division of Health Policy Research, Health Insurance Status of US Children Under Age 19, 1997). For 1998, the projection is that of the uninsured children younger than 19 years, 39.5% (4.4 million) will be Medicaid-eligible (AAP Division of Health Policy Research, Uninsured Children Before Title XXI, 1997). Nationwide, the increase in uninsured children is related to an enroll-

ment decline in Medicaid rather than to a decrease in the number of children with employer-based insurance. As of 1996, 21.6% (16.2 million) of children younger than age 19 were enrolled in Medicaid, down from 23.5% (17.2 million), who were enrolled in 1993. Although the reasons for this decrease are not clear, it is likely that the strong economy has raised income levels of many families above some current state Medicaid eligibility thresholds, and welfare reform policies have unintentionally reduced the number of Medicaid recipients. Many families leaving the welfare roles are unaware that their children continue to be Medicaid eligible. As of 1996, 63.3% (47.4 million) of children younger than 19 years had private employer-based insurance, up from 62.5% (45.7 million) in 1993. Despite this increase, most children without health insurance have an employed parent, who are either not offered health benefits by their employer or cannot afford to pay the premium contributions. Individual states will vary with respect to changes in numbers of uninsured children based on state economic condi-

tions, state Medicaid eligibility levels, outreach and enrollment activities, welfare reform policies, and the availability of other state health insurance programs.

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† Created by the 1988 Medicare Catastrophic Coverage Act (MCCA 1988, PL 100-360), Section 1902(r)2 42 USC 1396a allows states to expand Medicaid eligibility by using a more flexible methodology to determine family income and resources.
the enrollment process. By doing so, children will receive health services and insurance coverage as rapidly as possible. Continuity of care will be enhanced, and if the child should be determined ineligible, pediatricians and other caregivers still will be reimbursed for services rendered.

c. Public and private statewide and community-based outreach programs should be aggressively initiated to increase the prospects that all families with eligible children are informed and enrolled in the Medicaid or non-Medicaid SCHIP. Aggressive outreach will enable states to access all available federal funds and enroll the greatest number of uninsured children.

d. Simplified application forms and expedited eligibility determination processes for SCHIP should be used and coordinated with the state’s existing Medicaid program and other public assistance programs for children offered in the state. To develop a seamless system to process applications for both Medicaid and non-Medicaid programs, states should use community-based agencies, including offices where parents apply for government subsidized programs such as WIC and child care, resource and referral agencies for all types of services to families with young children, schools, community health programs and personnel, and Early and Periodic Screening, Diagnosis, and Treatment outreach workers to enroll potential applicants.

States also should implement proactive enrollment processes. For children who are found to be ineligible for SCHIPs because they are eligible for Medicaid (or vice versa), systems should be developed to expedite children’s enrollment in the appropriate program without requiring families to submit additional application forms.

e. States concerned about families or employers dropping private insurance coverage in favor of SCHIP, referred to as crowd-out, should establish policies that do not penalize families who do not have access to coverage or only have access to individually purchased health insurance plans.

f. States should offer a SCHIP buy-in option for families who are not eligible for SCHIP or whose private health insurance benefits are not comprehensive. States also should develop incentives to encourage employers who do not provide private health insurance and those whose private health insurance benefits are less comprehensive than those for SCHIP to subsidize family buy-in option.

2. States should obtain the full amount of Title XXI funds for implementation to serve the greatest number of children possible.

a. All states should submit their State Child Health Insurance Plan by July 1, 1998. Failure to expend the available federal funds over the 3-year allowable period will compromise the health of uninsured children in the United States and jeopardize the continued federal funding of this program.

b. States should provide sufficient funding flexibility (perhaps through the creation of a reserve fund) to meet the unforeseen challenges associated with either an underestimation of the number of enrollees or an inadequate amount of funds earmarked for a state’s program.

c. Because federal funding for SCHIP will decrease in years 4 and 5, states should be encouraged to extend any unexpended funds to the subsequent years.

3. All state children’s health insurance plans should include a comprehensive scope of benefits to provide quality health care for enrolled children. Because benchmark and benchmark-equivalent options offer limited coverage for many specialized or chronic care services, states should examine alternative strategies to supplement these benefit packages, such as coordination with Title V programs, school-based services, and the direct service option as a workaround for uncovered services.

a. Each benefit package should be evaluated in comparison to the AAP policy statement, Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years, which should serve as the benchmark. Preventive care, immunization standards, and periodicity schedules should be consistent with current AAP requirements.

b. States should carefully assess the adequacy of the non-Medicaid SCHIP benefit package as well as the level of cost-sharing for children with chronic or disabling conditions.

c. To determine medical necessity and approval of services, states should use consensus recommendations of recognized national professional organizations or of a professional peer review panel where evidence-based guidelines do not exist. Benefits should be included if they meet one or more of the following criteria: 1) the service is appropriate for the age and health status of the individual; 2) the service will prevent or ameliorate the effects of a condition, illness, injury, or disorder; 3) the service will aid the overall physical and mental growth and development of the individual; and/or 4) the service will assist in achieving or maintaining functional capacity.

4. Cost-sharing policies should be crafted carefully so that they are not simply a cost-shift to pediatricians, hospitals, and other providers. They should not deter the use of medically necessary services and should ensure that children with needs above and beyond the usual have access to necessary health care.

a. For families with one child, individual premiums should be charged. For families with two

a See footnote a for an explanation of benchmark and benchmark-equivalent options.
or more children, a single premium rate should be charged to cover all children. The AAP is not opposed to premium-sharing with families as long as the cost to families is moderate for their income and is based on a sliding scale.

b. Point-of-service cost-sharing presents the highest risks for children. The AAP opposes the use of deductibles and coinsurance for all SCHIP-eligible children. Copayments for all SCHIP beneficiaries should be limited to the nominal level legislated for children in families with incomes ≤ 150% FPL. Consistent with the Title XXI legislation and AAP policy, all preventive services should be exempt from copayments.

5. States should ensure that pediatricians, pediatric medical subspecialists, and pediatric surgical specialists are involved in developing and reviewing the state child health plans as well as annual reports and evaluations that are required under Title XXI.

a. Primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists should play an active role in developing performance measurements.

b. States should develop uniform quality performance measurements for children insured by Medicaid and SCHIP, and encourage the same standards among employer-based plans.

c. All health plans should provide access to pediatric primary care and pediatric medical subspecialty and pediatric surgical specialty services, as described in the AAP policy statement, Guiding Principles for Managed Care Arrangements for the Health Care of Infants, Children, Adolescents, and Young Adults.5

d. States, local communities, and managed care organizations should publish pediatric-specific quality data that allow consumers and purchasers to evaluate and compare quality performance, including pediatric provider network composition among competing SCHIP plans.

6. SCHIP plans should provide reimbursement for pediatric services that is comparable with rates offered in private insurance plans.

a. In states with low provider reimbursement rates for Medicaid services, SCHIP plans should be developed with concurrent efforts to raise Medicaid rates to levels that are comparable with rates offered in private insurance plans. States with higher reimbursement rates and better levels of physician participation should be used as benchmarks for states with historically low Medicaid reimbursement rates that have discouraged pediatricians and other physicians from full participation. New efforts should be made by states to base reimbursement rates for Medicaid and SCHIP on current market rates.

b. In states considering managed care models as a health delivery system, varied strategies should be evaluated, such as pediatric risk-adjusted capitation rates and/or enhanced case management payments and benefits for children with special health care needs. Reimbursement levels must ensure reasonable clinician compensation in relation to the increased time requirement expended in coordinating and providing care for children, particularly those with special health care needs.4

7. SCHIP plans should allow choice for patients and pediatricians.

a. Parents should have the ability, with proactive outreach and information from the state, to choose their child’s pediatrician and managed care plan. Securing a medical home and continuity of care should be encouraged when families choose or are assigned to managed care plans. Families should be allowed to disenroll for cause at any time. However, to support the medical home optimally, families should be required to adhere to their choices or assignments for 1 year unless there is due cause to change.

b. Pediatricians, pediatric medical subspecialists, and pediatric surgical specialists are encouraged not to accept exclusive contracts with a single managed care plan to provide care to newly insured children. They also should consider contracting with several plans to ensure that children have a choice among primary and specialty pediatric services.

8. SCHIP plans should establish simplified and efficient administrative systems.

a. States should streamline and simplify their eligibility determination and enrollment process, cost-sharing policies, and copayment collection procedures.

b. Health plans should simplify procedures for specialty referrals, previous authorization, second opinions, and methodologies to pay physicians.

CONCLUSIONS

Title XXI has the potential to increase the number of children with health insurance coverage dramatically. To maximize the benefits of this legislation, states have an obligation to implement programs created by Title XXI in such a way that the greatest number of children receive the most comprehensive health care services available. To do this, states must ensure that all children who are eligible for coverage are enrolled and have access to high-quality care. The ultimate success of these programs will depend on the number of previously uninsured children who will now be insured, and the resulting improvement in their access to health services. Although Title XXI does not create universal coverage for all children, it
is an important step toward the goal of ensuring that all children in the United States have health insurance.

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