



POLICY STATEMENT

State Children's Health Insurance Program Achievements, Challenges, and Policy Recommendations

Committee on Child Health Financing

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

ABSTRACT

This policy statement reviews the impressive progress of the State Children's Health Insurance Program since its enactment in 1997 and identifies outstanding challenges and state and federal policy recommendations. The American Academy of Pediatrics urges Congress to reauthorize SCHIP to strengthen its historic gains. The following set of recommended strategies for reauthorization pertain to funding, eligibility and enrollment, coverage, cost sharing, payment and provider-network capacity, and quality performance.

INTRODUCTION

The State Children's Health Insurance Program (SCHIP), enacted in 1997 as Title XXI of the Social Security Act (Pub L No. 105–33), has achieved remarkable progress in its brief history. As a result of SCHIP, health insurance has been extended to millions of children from low-income families, and rates of uninsurance among this population have declined by 2.2 million, from 23% in 1997 to 14.4% in 2004.¹ Access to health care has been vastly improved.² Specifically, because of SCHIP, more children have a medical home, more children receive preventive care and immunizations, and fewer children have an unmet need for dental care.^{2–7} Family satisfaction and quality of care have also improved significantly under SCHIP.^{4,7} Income and racial/ethnic gaps in health insurance coverage and access to care have also narrowed.⁸ SCHIP also has had positive spillover effects on the Medicaid program.⁹ As a result of SCHIP outreach, millions of potentially eligible but uninsured children have been enrolled in Medicaid.¹⁰ Eligibility-determination processes have been simplified, and coordination between SCHIP and Medicaid has become increasingly effective.² The landmark SCHIP legislation allowed states to design their SCHIP programs as expansions of Medicaid, as separate non-Medicaid programs, or as combinations of the two. Unlike Medicaid, SCHIP is not an entitlement. It is capped at the amount that is funded by Congress and the states. States were able to pursue different approaches for offering the most comprehensive, affordable coverage possible for near-poor children and their families. SCHIP is important now more than ever because of concerns about the increased numbers of children with obesity, diabetes, mental health disorders, asthma, and other chronic conditions and the importance of ensuring that these children will be given timely and continuous access to health care services over the span of childhood and adolescence.

Despite the program's widely acknowledged success and popularity, several

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Key Words

SCHIP, Medicaid, reauthorization, uninsured, health insurance

Abbreviations

SCHIP—State Children's Health Insurance Program

AAP—American Academy of Pediatrics

FPL—federal poverty level

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outstanding challenges have been identified by SCHIP officials, enrolled families, participating pediatricians and other health care professionals, and health service researchers. These challenges pertain to (1) ensuring adequate funding, (2) extending the reach of SCHIP to all potentially eligible children and to more uninsured children and families at higher income levels, (3) improving benefit coverage in non-Medicaid plans, (4) maintaining affordable premiums and other forms of cost sharing, (5) providing adequate payments and strengthening provider-network capacity, and (6) improving quality performance. This policy statement identifies recommended strategies in each of these 6 areas, which the American Academy of Pediatrics (AAP) believes will further the program's success in the next decade.

BACKGROUND

In 2005, SCHIP programs provided health insurance to 4 million children nationwide.¹¹ States selected different approaches to provide health insurance under SCHIP; 21 states created a combination Medicaid and non-Medicaid program, 18 states created a non-Medicaid program, and 17 states and territories and the District of Columbia created a Medicaid program.¹² In 27 states and the District of Columbia, eligibility levels are established at the congressional target of 200% of the federal poverty level (FPL), and in 13 states, eligibility has been extended to children with family incomes above 200% of the FPL. Eligibility extends up to 300% of the FPL in 5 states (Connecticut, Maryland, Missouri, New Hampshire, and Vermont) and 350% of the FPL in 1 state (New Jersey).

The original funding-allocation formula for SCHIP, which will expire in 2007, is based on each state's share of low-income children, its share of low-income uninsured children, and the state's cost of providing health care services. Funds not spent by states within an allotted time are redistributed to other states according to a specific formula. Unfortunately, in fiscal year 2007, 17 states face SCHIP funding shortfalls that amount to approximately \$1 billion according to the Center on Budget and Policy Priorities.¹³ Shortfalls occurred because of the size of the population of uninsured children, the growth in the population of children from low-income families, the growing instability of employment-based health insurance, and inflation.

In addition to the very serious federal budget shortfalls, since 2001 states have experienced significant budget shortfalls that have adversely affected their ability to sustain their SCHIP programs. The most common cost-cutting response has been to limit outreach and enrollment; few states have actually lowered eligibility or benefits or imposed significantly higher cost-sharing requirements.¹⁴ These cost-cutting actions resulted in a first-ever dip in enrollment in 2003.¹⁵

The scope of coverage for SCHIP programs in the 39 states that are offering a non-Medicaid plan to some or

all of their SCHIP enrollees, although not as comprehensive as Medicaid coverage, still (with few exceptions) far exceeds benefits in employer-sponsored health insurance plans.¹⁶ Similarly, although premium rates, copayments, and other dollar limits impose financial burdens for some families, they are still markedly less than those in private health insurance plans, and families consider them reasonable and affordable.¹⁷

Provider payment rates, however, are generally low—well below commercial rates—and in many states are at the same level as Medicaid rates. Medicaid professional fees were estimated to be approximately 70% of Medicare rates in 2004 according to the 2006 AAP Pediatric Medical Cost Model developed by actuaries at Reden & Anders.¹⁸

The AAP recommends the following improvements to strengthen SCHIP:

1. Ensure adequate funding

- Establish a new funding-formula approach that relies on a combination of national and state data that does not penalize states for successfully enrolling uninsured children, that takes into account state variations in the costs of providing care, and that extends the period during which redistributed funds can be spent.
- Set the budget baseline for SCHIP at a rate significantly higher than the level set in law for the final year of SCHIP's initial authorization to avoid future budget shortfalls.

2. Extend eligibility and enrollment

- Establish a performance-based outreach fund that rewards states that are more successful in enrolling uninsured children who are eligible for public coverage.
- Continue to improve on administrative simplification to facilitate enrollment and reenrollment, including shortened forms, streamlined verification requirements, online enrollment, and renewal assistance. In addition, grant states the flexibility to automatically enroll children into SCHIP (and Medicaid) on the basis of findings of other means-tested programs such as the Supplemental Nutrition Program for Women, Infants, and Children (WIC), the National School Lunch Program, and the Food Stamp Program.
- Encourage presumptive eligibility for all children by allowing health care professionals and designated agencies to grant eligibility for up to 60 days while a child goes through the enrollment process. In addition, encourage states to adopt 12-month continuous eligibility for SCHIP-enrolled (and Medicaid-enrolled) children.

- Allow households with children in both Medicaid and SCHIP to enroll in the same program to ensure continuity among siblings with their pediatric medical home.
 - Encourage expansion of SCHIP to include adolescents 19 through 21 years of age and allow emancipated minors eligibility for SCHIP on the basis of their own income. In addition, eliminate eligibility restrictions for dependents of state employees if they qualify on the basis of income.
 - Encourage higher income eligibility levels (>200% of the FPL) and discontinue the practice of counting family assets to extend eligibility to more uninsured children.¹⁹
 - Offer SCHIP buy-in options for children whose family incomes are above their state's SCHIP eligibility level but who do not have access to or cannot afford comprehensive private health insurance.
 - Allow states to cover legal immigrant children who enter the United States on or after August 1996. These children, under the 1996 Welfare Law, are ineligible for Medicaid and SCHIP coverage during their first 5 years in the United States. Other complex rules restrict legal immigrant children from gaining public coverage until they are citizens.
 - Allow states to draw down Medicaid/SCHIP matching funds when employers pay for a share of the cost of coverage for children of low-income families enrolled in Medicaid or SCHIP.
 - Encourage waiver applications of the Centers for Medicare and Medicaid Services to expand SCHIP coverage for uninsured pregnant women and parents if states have already maximized comprehensive coverage and full enrollment of children.
3. Support comprehensive coverage
- Preserve Medicaid benefit coverage in states with Medicaid SCHIP programs.
 - Encourage states to adopt SCHIP benefit packages that are consistent with the AAP policy statement "Scope of Health Care Benefits for Children From Birth Through Age 21,"²⁰ including oral health services, the full range of mental health services, and substance abuse treatment. Preventive care, immunization standards, and periodicity schedules also should be consistent with current AAP requirements. In addition, definitions of medical necessity should adhere to AAP recommendations.²¹
 - Extend eligibility for the Vaccines for Children Program to all children enrolled in non-Medicaid SCHIP programs.
 - Eliminate the prohibition against partial benefit packages to allow states with non-Medicaid SCHIP programs to provide additional wrap-around coverage to children, especially those with special health care needs who have inadequate private health insurance.
4. Maintain affordable coverage
- Eliminate differences in copayments and coinsurance for physical and mental health services.
 - Adopt cost-sharing policies that do not shift cost to pediatricians, hospitals, and other health care professionals and do not deter the use of medically necessary services. Deductibles and coinsurance should not be used; rather, cost sharing should be in the form of income-adjusted premiums and copayments.
 - Maintain policy that requires all preventive services under SCHIP to be exempt from cost sharing.
5. Improve provider payments and network capacity
- Establish payment rates under SCHIP for pediatric services that are at least equal to the most current Medicare RBRVS (Resource-Based Relative Value Scale) rates.
 - Ensure adequate payment when new vaccines and other new technologies are introduced. Under capitated arrangement, states should ensure that provisions are made to reimburse physicians for all vaccine-related overhead costs (vaccine product-acquisition and administration costs) of the new vaccines until new contracts are negotiated. In addition, physicians should receive payment for the expenses associated with the administration of each vaccine.
 - Adopt financial incentives for medical homes, especially in the care of children with special needs, including chronic care management, child and family education, and coordination and consultation with pediatric specialists and other support services.
 - Provide financial incentives for pediatric practices that adopt quality-performance goals.
 - Recognizing the dearth of pediatric subspecialists nationwide, encourage the inclusion of pediatric subspecialists, and the academic medical centers in which they practice, in managed care plan networks, and encourage coordination and communication between pediatric subspecialists and primary care practitioners.
 - Identify new mechanisms to designate and support safety net providers, including office-based pediatric practices and hospitals that specialize in the care of children, who serve a certain proportion of publicly insured children.

- Ensure medical home and pediatric subspecialty network continuity in SCHIP and Medicaid when children switch managed care plans and when children switch between the 2 sources of coverage.

6. Strengthen quality performance

- Adopt a consistent conceptual framework (eg, the framework of the Institute of Medicine) to assess health care quality across SCHIP programs that takes into account the unique features of child health and health care.²² Performance goals for states and the plans with which they contract should consist of short-term and long-term health care outcomes, including monitoring eligibility thresholds and projected enrollment volume, program retention, access to medical care, assessments of process and outcomes of pediatric care, and family and provider satisfaction.
- Improve the collection and analysis of individual-level enrollment data and claims-based utilization data.
- Involve pediatricians, pediatric subspecialists, pediatric mental health professionals, pediatric dentists, and other pediatric clinicians and families, including those who represent special populations, in continuously reviewing and evaluating each state's SCHIP.
- Expand funding support for SCHIP evaluations and allow greater access to state data for research.
- Measures should be appropriate for children's health. Any effort to measure quality should take into account the unique features of child health and health care. In addition, pediatric and family representatives should be included in all measurement efforts at the national, state, and local levels.

CONCLUSIONS

SCHIP has a proud history on which to build. To achieve continued success in reducing uninsurance among children and ensuring access to high-quality pediatric care, the AAP recommends that Congress and state policy makers adopt these important recommendations.

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RESIDENTS' ATTITUDES ABOUT DUTY HOURS REGULATIONS

"To better understand the perspectives of residents on the effects of the ACGME duty hours restrictions, Jennifer S. Myers, MD, and colleagues performed a multi-site survey of internal medicine and surgery residents, focusing on residents who were in training both before and after implementation of the new regulations. The survey questions were designed to elicit opinions in three areas: quality of patient care and safety, residency education, and quality of resident life. . . . Medical and surgical residents' opinions of quality of care and medical errors were similar to each other. Both groups of residents felt that the quality of care had decreased slightly after implementation of the new regulations, but that the continuity of care had decreased a great deal. They also felt that errors attributable to continuity of care had increased, but that errors related to resident fatigue had decreased. Residents felt that the new rules had created a 'shift-work' mentality among housestaff, but did not believe that the quality of program graduates had changed. In addition, they felt that their quality of life had improved substantially since the implementation of the regulations. . . . The authors note that the survey results indicate that medical errors related to fatigue might have been replaced with errors related to discontinuity of care as a result of duty hours reform. Furthermore, duty hours reform has not resulted in significantly more hours of sleep per week for residents. Residents have also reported reductions in bedside teaching and in opportunities for mentoring from attending physicians. The authors state that these unintended consequences of duty hours reductions will need to be addressed as residency programs adapt their education programs to meet regulatory requirements."

Myers JS. *Academic Physician & Scientist*. February 2007

Noted by JFL, MD

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