



Policy Statement—Principles of Health Care Financing

abstract

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The American Academy of Pediatrics advocates that all children must have health insurance coverage that ensures them access to affordable and comprehensive quality care. Access to care depends on the design and implementation of payment systems that ensure the economic viability of the medical home; support and grow the professional pediatric workforce; promote the adoption and implementation of health information technology; enhance medical education, training, and research; and encourage and reward quality-improvement programs that advance and strengthen the medical home. Health insurance plans must be portable from state to state, with administrative procedures to eliminate breaks and gaps in coverage to ensure continuous coverage from year to year. Plans should ensure free choice of clinicians and foster coordination with public and private community-based programs for infants, children, and adolescents through the age of 26. The scope of services provided by all health plans must include preventive, acute and chronic illness, behavioral, inpatient, emergency, and home health care. These plans must be affordable and have cost-sharing policies that protect patients and families from financial strain and are without risk of loss of benefits because of plan design, current illness, or preexisting condition. *Pediatrics* 2010;126:1018–1021

INTRODUCTION

All children must have coverage that ensures them access to affordable and comprehensive quality care. Appropriate and adequate payment is essential to ensure the viability of the pediatric workforce to provide such care. Coverage and payment must provide access to pediatric primary care and comprehensive and coordinated medical subspecialty and surgical specialty services; developmental, behavioral, and mental health services; inpatient and emergency department care; home health care; dental care; and other specialized pediatric services within a medical home model of care. The principles outlined in this statement should be used to evaluate national and state health insurance reform proposals and to make ongoing improvements to private and public financing of health care for children and adolescents.

ACCESS TO HEALTH INSURANCE

All children and adolescents, from birth to 26 years of age, regardless of income, must have access to comprehensive health insurance. Quality health insurance should be guaranteed for every child, pregnant woman, family, and, ultimately, all individuals. Such coverage should be portable from state to state and continuous

COMMITTEE ON CHILD HEALTH FINANCING

KEY WORDS

pediatric health insurance benefits, payment, insurance premiums, affordability, medical home, health information technology, pediatric training, vaccines

ABBREVIATIONS

AAP—American Academy of Pediatrics
CPT—Current Procedural Terminology
HCPCS—Healthcare Common Procedure Coding System

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www.pediatrics.org/cgi/doi/10.1542/peds.2010-2182

doi:10.1542/peds.2010-2182

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.

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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from year to year with streamlined administrative procedures. It must ensure free choice of clinicians and foster coordination with public programs for children and adolescents. Ensuring access to health insurance must be a shared responsibility of parents, employers, and state and federal government agencies.

Recommendations

- All children up to 26 years of age in families with incomes up to 133% of the federal poverty level should have access to Medicaid or, at higher eligible incomes, the Children's Health Insurance Program (CHIP).
- Dependent children must not be denied coverage because of a preexisting condition, and their coverage should not be terminated because of illness.
- There must be no annual or lifetime limit on insurance benefits.
- For children whose families lose employer-sponsored health insurance, COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) premiums should remain at employer-sponsored rates. If the former employee is not able to afford that premium, there must be other health insurance options that will reduce the cost of coverage.
- For children ineligible for public coverage, national and state outreach efforts should be undertaken to educate their families on health insurance options and how to access care through the various public or private health care entities in their community.
- For children who remain uninsured despite access to public or private insurance, a safety-net system of care should be subsidized and offered through office-based practices in addition to

community health centers and hospitals. For children whose families have access to employer or other group health insurance, financial incentives should be extended to employers to offer and maintain dependent coverage up to 26 years of age.

- Dependent premium contributions for family coverage should be a responsibility shared between the employer and employee. Employers should be encouraged to provide access to family coverage to all employees.
- When employers offer insurance coverage for dependent children, the premium rate calculations must be based on the requirements of the March 2010 Patient Protection and Affordable Care Act.

HEALTH INSURANCE COVERAGE

All children and adolescents must have a comprehensive age-appropriate benefit package. The health insurance package should cover all pediatric services including preventive and wellness services, acute, inpatient, and chronic care services, including developmental, pregnancy-related and other reproductive health, newborn care, mental and behavioral health, substance abuse disorders, emergency services, facilitative, habilitative, and rehabilitative services and devices, palliative, home health, and hospice care services, prescription drugs, vision care services, and oral health services reflecting the scope of benefits recommended by the American Academy of Pediatrics (AAP)¹ and the National Business Group on Health.²

Recommendations

- Preventive benefits for children and adolescents must be consistent with *Bright Futures*³ recommenda-

tions, not the US Preventive Services Task Force recommendations.

- All benefits must be sufficient in amount, duration, and scope to achieve the best clinical outcome.
- Health insurers must work from a common definition of medical necessity so that health care services:
 - reflect the need to promote normal growth and development and prevent, diagnose, treat, ameliorate, or palliate the effects of physical, developmental, mental, behavioral, genetic, or congenital conditions, illness, injuries, or disability;
 - are in accordance with generally accepted standards of medical practice based on credible scientific evidence as would be published in peer-reviewed medical literature⁴ or are evidence-informed by clinical experts in pediatric care when insufficient studies are available; and
 - reflect the appropriate type, frequency, duration, and setting for effective care for that particular condition and patient.
- Health plans must provide information about how they determine medical necessity, including how they use clinical evidence that supports coverage of interventions, how they incorporate the opinions of experts in child/adolescent medicine, how they assist families who seek to appeal a medical-necessity decision, and how and when coverage decisions will be made.
- All public and private payers should establish cost-sharing policies that ensure affordable health services. Cost-sharing policies should not shift cost to physicians, hospitals, and other health care providers and should not deter the use of medically necessary services.
- Cost-sharing must not be applied to

preventive care, including recommended immunizations, for children and adolescents.

- For children whose family income is below 133% of the federal poverty level, cost-sharing, premiums, and other fees should be prohibited. For children whose family income is between 133% and 200% of the federal poverty level, deductibles and cost-sharing should be nominal and only applied to nonessential services.
- There should be no deductibles for children whose family income is below 133% of the federal poverty level.
- Annual and lifetime out-of-pocket limits must be established to protect families from significant medical debt.
- The impact of cost-sharing, premiums, and other out-of-pocket expenses on access to care should be regularly assessed by state insurance commissioners or another appropriate state agency that governs health insurance to ensure access and affordability of coverage.

PAYMENT POLICIES TO SUPPORT FAMILY- AND PATIENT-CENTERED MEDICAL HOMES

There should be cooperation between payers, employers, physicians, and patients and their families so that medical home payment reforms are implemented in ways that ensure quality care, financial viability, and fairness for payers and providers so that children and adolescents receive all AAP-recommended services. These reforms should be based on the medical home principles adopted jointly by the AAP, American Academy of Family Physicians, American Osteopathic Association, and American College of Physicians.⁵ The payment structure for comprehensive care should encompass recognition of relevant Current Procedural Terminology (CPT) and

Healthcare Common Procedure Coding System (HCPCS) codes, optimal community-based care coordination, current quality-improvement activities, and up-front investments and support for medical home infrastructure, including health information technology.

Recommendations

The following should be required by all health plans:

- All private and public payers should adopt a comprehensive set of medical home payment reforms that include 3 components:
 1. Encounter-based fee component that recognizes and values evaluative/cognitive services, preventive counseling, telephone and e-mail communication, collaborative consultation, and team care as defined by CPT or HCPCS codes. These items should be paid as fee-for-service or integrated into enhanced capitation payments.
 2. A community-based care coordination fee, which recognizes the work of clinical and administrative staff who provide medical home services. Payment for these services should be as a per-member-per-month fee, with adjustments based on the complexity of the patient panel.
 3. A performance (pay-for-performance) or quality-improvement fee for evidence-based or evidence-informed process, structure, or outcome measures. Payment should be as a bonus, either on a per-member-per-month basis or as a fee-schedule increase.
- Payment for vaccine products must exceed the acquisition cost of each vaccine and the overhead expense associated with them.

Any increase in a specific vaccine cost or new vaccine recommendation must be updated in a timely fashion, with retroactive compensation if there is any lag time to implement such change.

- Payment for vaccine-administration codes must cover costs of office overhead for scheduling, coordinating, educating patients and their families, pain management, staff time, supplies, and billing and should be, at minimum, 100% of the Medicare rate for each vaccine-administration CPT code.
- Payments for encounter-based visits should be closely tied to evidence-based or evidence-informed clinical decision-making. Methods used to determine payment should consider the child's age, symptom chronicity, severity of underlying health, and behavioral, social, and other problems and include a geographic adjustment.
- Payment policies should recognize and reward clinicians who provide population-based prevention and who promote continuous and coordinated care, including care coordination between generalists and specialists. Payment should be discouraged for clinics that provide episodic care for minor conditions.

SUPPORT FOR CLINICAL CARE, PAYMENT-SYSTEM REFORMS, AND TRAINING INNOVATIONS

At both national and state levels, expert pediatric advisory groups should be established to monitor progress related to health insurance access, comprehensive and affordable coverage, medical home implementation, payment reforms, and investments in innovation. There should be a federally funded pediatric-specific entity to support innovations in medical home implementation, education/training, quality im-

provement, health services research, and population-based prevention.

Recommendations

- Payment systems should be developed that reward high-quality, coordinated care.
- Care should be coordinated through collaborative practice involving primary care physicians and pediatric subspecialists.
- Access to pediatric medical subspecialists and surgical specialists should be improved. Concerted efforts should be aimed at recruitment, scholarship, loan support, and development of telemedicine technology for remote or physician-underserved locations.
- Clinical, community-based prevention programs that support population health, including but not limited to obesity and mental health, should be expanded.
- Clinical and population research should be supported with expanded efforts focusing on care coordination, self-management, preventive care, immunizations, behavioral health, children and adolescents with special health care needs, diabetes, depression, medication management, pregnancy and childbirth, and obesity.
- Transition planning from pediatric to adult health care should be promoted and implemented and should include training, consultation, and financial incentives to encourage early transition planning and the use of AAP recommendations.⁶
- Health care professionals should be trained to use advanced health information technology to support continuity of care and continuous quality improvement.
- Health literacy should be promoted for parents, children, and adolescents. A particular focus should be on low-income and non-English-speaking populations.
- Vaccine registries should be established at the local, state, and national levels with requirements

that registries link providers and vaccine manufacturers so that practice-management systems, including electronic health records, contain recipient as well as vaccine product and administration details and ensure interoperability between vaccine registries and personal health records.

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Principles of Health Care Financing
Committee on Child Health Financing
Pediatrics 2010;126;1018

DOI: 10.1542/peds.2010-2182 originally published online October 25, 2010;

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PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

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Pediatrics 2010;126;1018

DOI: 10.1542/peds.2010-2182 originally published online October 25, 2010;

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

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