



Principles of Child Health Care Financing

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After passage of the Patient Protection and Affordable Care Act, more children and young adults have become insured and have benefited from health care coverage than at any time since the creation of the Medicaid program in 1965. From 2009 to 2015, the uninsurance rate for children younger than 19 years fell from 9.7% to 5.3%, whereas the uninsurance rate for young adults 19 to 25 years of age declined from 31.7% to 14.5%. Nonetheless, much work remains to be done. The American Academy of Pediatrics (AAP) believes that the United States can and should ensure that all children, adolescents, and young adults from birth through the age of 26 years who reside within its borders have affordable access to high-quality and comprehensive health care, regardless of their or their families' incomes. Public and private health insurance should safeguard existing benefits for children and take further steps to cover the full array of essential health care services recommended by the AAP. Each family should be able to afford the premiums, deductibles, and other cost-sharing provisions of the plan. Health plans providing these benefits should ensure, insofar as possible, that families have a choice of professionals and facilities with expertise in the care of children within a reasonable distance of their residence. Traditional and innovative payment methodologies by public and private payers should be structured to guarantee the economic viability of the pediatric medical home and of other pediatric specialty and subspecialty practices to address developing shortages in the pediatric specialty and subspecialty workforce, to promote the use of health information technology, to improve population health and the experience of care, and to encourage the delivery of evidence-based and quality health care in the medical home, as well as in other outpatient, inpatient, and home settings. All current and future health care insurance plans should incorporate the principles for child health financing outlined in this statement. Espousing the core principle to do no harm, the AAP believes that the United States must not sacrifice any of the hard-won gains for our children. Medicaid, as the largest single payer of health care for children and young adults, should remain true to its origins as an entitlement program; in other words, future fiscal or regulatory reforms of Medicaid should not reduce the eligibility and scope of benefits for children and young adults below current levels nor jeopardize children's access to care. Proposed Medicaid funding "reforms" (eg, institution of block grant, capped allotment, or per-capita capitation payments to states) will achieve their goal of securing cost savings but will inevitably compel states to reduce enrollee eligibility, trim existing benefits (such as Early and Periodic Screening, Diagnostic, and Treatment), and/or compromise children's access to necessary and timely care through cuts in payments to providers and delivery systems. In fact, the AAP advocates for increased Medicaid funding to improve access to essential care for existing enrollees, fund care for eligible but uninsured children once they enroll, and accommodate enrollment growth that will occur in states that choose to expand Medicaid eligibility. The AAP also calls for Congress to extend funding for the Children's Health Insurance Program, a plan vital to the 8.9 million children it covered in fiscal year 2016, for a minimum of 5 years.

abstract

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Advances in pediatric care have unquestionably secured dramatic improvements in the health of children,^{1,2} as evidenced by decreased infant mortality,³ increased immunization rates,⁴ and a decrease in the rate of preventable hospital admissions for children.⁵ Acknowledging that the cost of comprehensive health care for children is a small fraction of the cost for the adult population and adopting as an implicit national priority the mission to ensure that children will have reached their full potential at the time they transition to adulthood, the vast majority of industrialized nations have created systems that provide affordable, high-quality, accessible, and comprehensive health care for all children.

In the United States, federal and state governments have established Medicaid and the Children's Health Insurance Program (CHIP) and have facilitated access to marketplace insurance options through the Patient Protection and Affordable Care Act (ACA).⁶ These programs have significantly increased eligibility for and access to health insurance in the general population. As a result, by 2015, the percentages of uninsured children younger than 19 years and young adults 19 to 25 years of age had fallen to historic lows of 5.3%* and 14.5%, respectively.⁷ However, more progress can and should be

*In 2015, more than two thirds of the 3.5 million uninsured children younger than 18 years were eligible for enrollment in Medicaid or CHIP. Approximately 5% were eligible for assistance to purchase marketplace plans. The rest were ineligible for public funding because of family income level, because of an offer for employer-sponsored insurance within the family, or because of their status as immigrant or undocumented children (5%). More than half of uninsured children in 2015 lived in 7 states (TX, CA, FL, GA, AZ, OH, and PA). Hispanic and American Indian/Alaska Native children have rates of uninsurance that are double the rates for white and black children (see <http://ccf.georgetown.edu/wp-content/uploads/2016/11/Kids-ACS-update-11-Q2-1.pdf> and <http://kff.org/report-section/childrens-health-coverage-the-role-of-medicaid-and-chip-and-issues-for-the-future-issue-brief/>).

made to reduce uninsurance and underinsurance rates. The United States, the most prosperous country in the world by far, lags behind other industrialized nations. A significant number of children still face barriers to accessing necessary health care, whether they are insured or uninsured. Continued improvement in child health can be realized if the United States improves on its current patchwork of private and public insurance programs to create a system that ensures that all children have affordable access to essential high-quality and comprehensive health care.[†] Ensuring high-quality care and maintaining a robust pediatric care delivery infrastructure require that insurance and payment systems are designed and funded to offer comprehensive benefits at affordable rates and at the same time pay professionals sufficiently to retain the current workforce and encourage an adequate pipeline of newly trained pediatric providers.

Although intelligent fiscal reforms crafted to improve quality of care and outcomes among children and young adults can achieve some savings, reforms that solely aim to limit or

reduce expenditures for health care (for example, by using block grant, capped allotment, or per-capita capitation payment methodologies) will in the end harm children by reducing eligibility, scope of benefits, and access to care and will, hence, contract the future prosperity of this nation. The principles outlined in this statement can be used to evaluate the adequacy of current private and public health insurance plans and should guide both the reform of existing plans and the design of new plans. A national focus on improving the financing of health care for children, adolescents, and young adults through the age of 26 years (consistent with all of the principles outlined in this statement) will likely result in a high, long-term societal return on investment associated with the prevention, early detection, and comprehensive diagnosis and treatment of medical, behavioral, and mental health conditions in this population.

The design, financing, and payment policies of a comprehensive system of health care for children should accomplish 4 goals, as discussed in the following sections.

ENSURE UNIVERSAL COVERAGE WITH QUALITY, AFFORDABLE HEALTH INSURANCE

All children, adolescents, and young adults from birth to the age of 26 years who reside within our borders, regardless of income, family composition, or immigration status, should be covered by an affordable, quality health insurance plan that allows access to comprehensive essential care. Accessible health insurance coverage should pose minimal enrollment and renewal burdens, commence with the minimal waiting period needed to verify eligibility, offer continuous eligibility for a minimum of 12 months, and be portable across states. Insurance coverage options should ensure access to an adequate

[†]The AAP espouses the following principles related to access to health care by children: every child should receive care in a medical home with a primary care pediatrician and have access to pediatric medical subspecialists, pediatric surgical specialists, pediatric mental and dental health professionals, and hospitals with appropriate pediatric expertise; quality health care is a right, regardless of income, for all children, their families, pregnant women, and ultimately all individuals; every child must have quality health insurance; the concept of quality health insurance includes portability, continuous coverage, streamlined and simplified administrative aspects, choice of clinician(s), affordability for families, and coordination with existing maternal and child health programs; all health insurance plans should have a comprehensive, age-appropriate benefits package directed at the special needs of the pediatric population, as recommended by the AAP; and all health plans should have payment rates that ensure that children receive all recommended and needed services. See <http://downloads.aap.org/DOFA/AAP%20Access%20Principles.pdf>.

pediatric primary, specialty, and subspecialty network that includes dental, behavioral, and mental health services. Essential coverage also enables care coordination and care management by pediatric primary and specialty medical homes to ensure excellent outpatient management of children with chronic and complex conditions and to ensure linkages to age-appropriate public, community, and employer-based programs. Ensuring access to health insurance and providing timely access to and payment for necessary health care services for children should be a shared responsibility of parents and/or families, employers, and state and federal government agencies.

Recommendations Related to Universal Health Insurance Coverage

1. Children, adolescents, and young adults, irrespective of preexisting conditions, should be ensured access to affordable, quality, and comprehensive health insurance that meets their needs;
2. Medicaid is currently the single largest payer of health care for children and young adults, providing coverage for 37 million children. Fiscal and regulatory reform of the Medicaid program should maintain the program as an entitlement so that eligibility, scope of benefits, and access to health care are maintained for these enrollees.⁸ Reforms should instead focus on increasing access to care and improving quality of care, both of which can reduce short- and long-term costs;
3. CHIP is authorized indefinitely but only funded through September 2017.⁹ This vital program covered 8.9 million children in fiscal year 2016. Its funding should be extended for (a minimum of) an additional 5 years, as recommended by the Medicaid and CHIP Access and Payment Commission¹⁰;

4. The Centers for Medicare and Medicaid Services should use its regulatory authority to enforce the Medicaid equal access provision so that children insured by Medicaid truly have access to a high-quality medical home and both outpatient and inpatient pediatric specialty and subspecialty care^{‡,11};
5. Children in economically disadvantaged families should receive support to secure health insurance from publicly funded programs or receive public subsidies to aid in purchasing private insurance, including options now available under the ACA and employer-sponsored insurance;
6. Health insurance should be affordable for the whole family. Premium subsidies should take into account total family income. Stacked premium anomalies and related copays that make children's access to health insurance functionally unaffordable should be eliminated^{§,12};
7. For children, adolescents, and young adults who are eligible for health care insurance but who remain uninsured, national and state outreach efforts should be undertaken to inform their families about health insurance options and to guide families in how to access care through the various public or private health care options;

[‡]Throughout the statement, "pediatric specialty and subspecialty care" denotes care provided by both pediatric medical subspecialists and pediatric surgical specialists.

[§]For example, the "kid glitch" in the ACA is a requirement for employers to provide "affordable" insurance only for their employees, not for their families. Premiums for individual coverage must not exceed 9.5% of a worker's income. But there is no limit on the employee's share of premiums for family coverage, which typically costs close to 3 to 4 times as much as individual coverage.

8. For those who remain uninsured because they are currently ineligible for or cannot afford 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. Congress should ensure that documented and undocumented immigrant children have the same access to insurance coverage or to essential health care as children who are US citizens¹³;
9. The Department of Health and Human Services (HHS) should evaluate access to and affordability of care for children, adolescents, and young adults insured by federally subsidized plans and take steps to ensure that such plans are at least as robust as Medicaid and CHIP plans; and
10. Where employer-sponsored insurance coverage is an option, dependent premium contributions for family coverage should be a responsibility shared between employer and employee. In addition, employers should be incentivized to provide access to family coverage to all employees and to maintain dependent coverage to 26 years of age. Affordability of employer-sponsored insurance for all family members remains a concern. The effects of extending varying degrees of tax deductibility to employer- and employee-paid health insurance premiums on employer provision and employee election of this benefit should be explored as a means of increasing rates and adequacy of insurance coverage for the entire family.

ENSURE COVERAGE OF ESSENTIAL PEDIATRIC BENEFITS

Health insurance for all children, adolescents, and young adults should offer a comprehensive,

age-appropriate essential benefit package.¹⁴ The health insurance package should include the full range of essential pediatric services, including prenatal and newborn care; postnatal home visits; preventive and wellness services; urgent and emergency care; acute, inpatient, and chronic care services; developmentally appropriate habilitative and rehabilitative therapies and devices; dental services; behavioral and mental health services; transition to adult care services; reproductive health and pregnancy-related services; and treatment of substance abuse disorders. Insurance should include at least 1 children’s hospital as a network provider. Insurance should also cover oral health and vision care services; home-based care, including private duty nursing and personal care services; palliative and hospice care services; durable medical equipment; interpreter services; specialty formulas; and prescription drugs in formulations appropriate for children, consistent with the scope of benefits recommended by the American Academy of Pediatrics (AAP)¹⁴ and the National Business Group on Health.¹

Recommendations Related to Coverage of Essential Pediatric Benefits

1. Federal payers and regulators of health care services for children should exercise their full authority to ensure, insofar as it is possible, that children, adolescents, and young adults have access to a uniform standard of essential pediatric health care benefits across all geographies. If, and to the extent that, existing regulatory authority cannot achieve this goal, new legislative solutions should be enacted;
2. The HHS should provide clear regulatory guidance that identifies Early and Periodic Screening, Diagnostic, and Treatment

benefits as the standard for pediatric essential health benefits;

3. Preventive care and wellness benefits for children, adolescents, and young adults should be consistent with current recommendations in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.¹⁵ In accord with ACA provisions, preventive and wellness benefits, including immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the AAP, should be exempt from any cost sharing;
4. All health care benefits should be sufficient in the type, amount, frequency, duration, setting, and scope to enable care that achieves the best clinical outcome for the condition(s) under treatment; and
5. The HHS should provide guidance on medical necessity specific to the needs of children that allows medical professionals flexibility in prescribing health services in consideration of the evolving status of the individual child. Health care services that are medically necessary for children promote normal growth and optimal development; prevent, diagnose, treat, ameliorate, or palliate the effects of physical, developmental, mental, behavioral, genetic, or congenital conditions, illnesses, injuries, or disabilities; and are in accord with generally accepted standards of medical practice based on credible scientific evidence or on evidence-informed clinical expert recommendations.¹⁶

ENSURE THAT COST SHARING IS AFFORDABLE AND DOES NOT NEGATIVELY AFFECT CARE

The design of most health care plans delegates a number of expenses over and above basic premiums to

members. Copays, deductibles, and coinsurance charges represent “cost sharing” by the member. These payments should encourage wise use of appropriate care but not inhibit access to preventive or necessary care.

Recommendations Related to Cost Sharing

1. Public and private payers should establish cost-sharing policies that ensure affordability of health services for the entire range of family income. Annual out-of-pocket limits should be established at reasonable levels as a function of family income to protect families from significant medical debt;
2. Cost-sharing policies should not shift costs to health care providers and should neither deter appropriate comanagement of a child’s care with specialists nor deter economically disadvantaged families from seeking appropriate and necessary care;
3. Care should be exercised in developing cost-sharing policies so that these policies primarily focus on discouraging excessive, inappropriate, or abusive use of medical services. Primary care services delivered under the supervision of a medical home should be available without the imposition of cost sharing. Access to drugs necessary and appropriate to treat pediatric conditions should not be jeopardized by the levy of higher copays and coinsurance;
4. Health care providers should be protected from financial loss resulting from the family’s inability or unwillingness to pay their portion of costs, the health plan’s limitation of coverage for essential health care services, or the health plan’s inability to accurately inform the provider of the patient’s cost-sharing responsibility; and

5. The impact of cost sharing on access to care should be regularly assessed by federal and state agencies. The results of this monitoring should inform policies, regulations, and health insurance law to ensure access to and affordability of coverage.

ENSURE ADEQUATE PROVIDER PAYMENTS TO STRENGTHEN FAMILY- AND PATIENT-CENTERED MEDICAL HOMES

Reform of payment policies should enable achievement of the medical home principles adopted jointly by the AAP, American Academy of Family Physicians, American Osteopathic Association, and American College of Physicians.¹⁷ Patient-centered, physician-led medical homes can best ensure that infants, children, adolescents, and young adults receive all AAP-recommended services and appropriate, cost-effective, coordinated care for medical, dental, developmental, and mental health and behavioral concerns. The patient-centered medical home can help realize the objectives of the triple aim to provide better care and higher patient satisfaction at a lower cost.¹⁸ The payment structure for comprehensive care should recognize relevant billing codes and new technologies of care (eg, telehealth encounters), appropriately value care teams and expanded care management capabilities by paying adequately for necessary non-face-to-face time, and invest in and encourage acquisition and maintenance of health information technology infrastructure and the application of health information technology to quality improvement activities and population health initiatives. Migration from fee-for-service to population-based payment methodologies must account for the cost of comprehensive medical home services in risk-adjusted calculations

of per-member per-month (PMPM) payments.

Recommendations Related to Provider Payments

1. A guiding principle that should anchor all rapidly evolving alternate payment methodologies is that payments should be sufficient to fund 3 types of medical home services:
 - Traditional episodic care encounters (preventive and wellness, acute illness, telehealth, procedural, etc). Payments should reflect the complexity of service and be sufficient to underwrite the basic clinical and administrative costs of a practice;
 - Provision of specific medical home functions such as case management, care coordination, mental and behavioral health services, patient and family education, counseling, and social work or related community coordination services. Typical fee-for-service methodologies generally do not fully pay for these supplemental services that are vital for raising the caliber of the medical home; and
 - Maintenance of health information technology and the application of health information technology to quality improvement activities and population health initiatives;
2. A number of methodologies can achieve actuarial soundness. For example, fee-for-service payments can be structured to cover the basic costs of encounters, including maintenance of health information technology, and be supplemented by a PMPM care coordination fee titrated to the specific medical home services offered by a practice in consideration of the medical

and psychological complexity of the patient panel. Alternatively, PMPM capitation payments can be calculated to pay for both types of practice expense. Capitated payments should be risk adjusted to medical homes that have a significant number of children with complex and/or chronic diseases in their patient panels. Plans can offer additional incentive payments related to performance on pediatric-specific process or outcome metrics that have an evidence-based correlation with quality and improved health. Such payments enable and reward a practice's investment and accomplishments in quality improvement and other activities of value that might contribute to improving population health. Payments for pediatric health care services should be structured to achieve parity with payments for similar services for adults. In particular, Medicaid payments for services to children and young adults should be set at a minimum to Medicare payments made for the care of adults. A service provided to a child is not less complicated or time consuming than a similar service rendered to an adult because the child is younger or smaller; in fact, pediatric services not infrequently require greater effort because of a higher degree of medical complexity or procedural difficulty;

3. To address the challenges of care delivery to remote locations and existing local and regional shortages of pediatric specialists and subspecialists, payments should recognize the full range of telehealth encounters, including non-face-to-face encounters, and should also enable regionalization of pediatric subspecialty care¹⁹;

4. Payments for medications, vaccines, and other medical products administered in medical home settings should exceed the acquisition cost of the products and the overhead expense associated with the ordering, safe storage, and maintenance of documentation for these products. Changes in acquisition costs should be recognized by timely increases in payment. Retroactive payment increases should include interest and/or penalties to compensate for delays. Payment for treatment, medication, or vaccine administration codes should cover costs of office overhead for scheduling, coordinating, and educating patients and families; vaccine administration; management of postinjection pain or anxiety; supplies; staff time; and billing. Payment should be at least equal to corresponding Medicare rates for comparable procedure codes²⁰;
5. Payers should cover and pay for pediatric-to-adult health care transition services, as reported, with appropriate *Current Procedural Terminology* codes that recognize the added time of transition assessment, anticipatory guidance, care planning, and communication with adult providers;
6. “Shared savings” payment models should be carefully reviewed to understand which services are included in the shared savings calculation as well as the cost benchmarks against which performance will be evaluated;
7. “Withhold” payments should be avoided. Withholds to practices that have not yet achieved particular standards do not support building the capacity of a practice to achieve a relevant standard;
8. “Bundled or episode” payments should cover reasonable and expected average costs within a health care referral area for evidence-based and/or evidence-informed cognitive and procedural aspects of care and care coordination as well as for supplies, medicines, and other patient care costs. Only large health care entities that can control and coordinate most, if not all, of the dimensions of the health care encounter and that can also absorb the risk should be held fiscally accountable for “bundled” payments for procedures (eg, joint replacement and percutaneous coronary bypass procedures). Payers should not hold primary care providers fiscally responsible for limiting total payments for all diagnostic and treatment services associated with certain episodes of care (eg, community-acquired pneumonia) to a predetermined fixed maximum per episode. The primary care provider cannot assume this full risk if the plan allows a patient and family to access other care venues (eg, retail-based clinics or urgent care) outside the medical home that generate expenses over which the provider has no control;
9. All alternative payment models that support care of pediatric patients should be designed with the input of pediatricians and pediatric specialists and subspecialists with relevant expertise in practice and financing;
10. Measurement of patient satisfaction with a health care provider should not typically result in reduction of public funding to payers or in payment penalties exacted by payers on providers. The most helpful use of this information is to provide it to the practice as a potential area for quality or process improvement. Providers understand well that evidence-based counseling and recommendations for treatment can engender patient or family dissatisfaction, even when communicated in a contextually sensitive way;
11. Payment and delivery models that include pediatrics, such as integrated delivery systems and accountable care organizations, should include a sufficient number of pediatricians and pediatric specialists on their governing structures to address knowledgeably the breadth of most pediatric issues. In addition, accountable care organizations should engage a sufficient number and breadth of both general and specialty pediatricians to advise development of policies and procedures so that the needs of the pediatric and young adult populations (so different from those of older adults) are fully addressed²¹;
12. At both national (eg, the Centers for Medicare and Medicaid Services), state (eg, Medicaid agency), and regional (eg, private payer) levels, expert pediatric advisory groups should be established to monitor progress related to health insurance access, comprehensive and affordable coverage, medical home implementation, payment reform, and investments in innovation; and
13. There should be a federally funded, pediatric-specific entity to support innovations in new payment and care delivery models that address medical home implementation, transition from pediatric to adult health care, integration of mental and behavioral health and primary

care, shared management between pediatric primary and specialty and subspecialty care, transition from acute to postacute settings, and population-based prevention.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ACA: Patient Protection and Affordable Care Act
CHIP: Children's Health Insurance Program
HHS: Department of Health and Human Services
PMPM: per member per month

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Principles of Child Health Care Financing

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