



POLICY STATEMENT

Children's Health Insurance Program (CHIP): Accomplishments, Challenges, and Policy Recommendations

COMMITTEE ON CHILD HEALTH FINANCING

KEY WORDS

Children's Health Insurance Program, CHIP, Affordable Care Act, health insurance, pediatrics

ABBREVIATIONS

AAP—American Academy of Pediatrics

ACA—Patient Protection and Affordable Care Act

CHIP—Children's Health Insurance Program

CHIPRA—The Children's Health Insurance Program Reauthorization Act of 2009

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abstract

Sixteen years ago, the 105th Congress, responding to the needs of 10 million children in the United States who lacked health insurance, created the State Children's Health Insurance Program (SCHIP) as part of the Balanced Budget Act of 1997. Enacted as Title XXI of the Social Security Act, the Children's Health Insurance Program (CHIP; or SCHIP as it has been known at some points) provided states with federal assistance to create programs specifically designed for children from families with incomes that exceeded Medicaid thresholds but that were insufficient to enable them to afford private health insurance. Congress provided \$40 billion in block grants over 10 years for states to expand their existing Medicaid programs to cover the intended populations, to erect new stand-alone SCHIP programs for these children, or to effect some combination of both options. Congress reauthorized CHIP once in 2009 under the Children's Health Insurance Program Reauthorization Act and extended its life further within provisions of the Patient Protection and Affordable Care Act of 2010. The purpose of this statement is to review the features of CHIP as it has evolved over the 16 years of its existence; to summarize what is known about the effects that the program has had on coverage, access, health status, and disparities among participants; to identify challenges that remain with respect to insuring this group of vulnerable children, including the impact that provisions of the new Affordable Card Act will have on the issue of health insurance coverage for near-poor children after 2015; and to offer recommendations on how to expand and strengthen the national commitment to provide health insurance to all children regardless of means. *Pediatrics* 2014;133:1–10

LEGISLATIVE BACKGROUND AND EVOLUTION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM

The Children's Health Insurance Program (CHIP) emerged as a consequence of previous policy experiences and political realities that characterized the late 1990s. The combination of successful Medicaid expansions in the late 1980s and early 1990s and the failure of the Clinton health reform proposals of the mid-1990s prepared the stage for both Democrats and Republicans to cooperate in fashioning an extension of health insurance for 10.1 million uninsured near-poor

children that would not establish a new entitlement program.¹ The resulting legislation, Title XXI of the Social Security Act (42 USC 7, §§1397aa–1397mm), inserted a provision into the Balanced Budget Act of 1997 (Pub L No. 105–33, 111 Stat 251) that encouraged states to establish programs to provide health insurance to noncovered children who lived in families with incomes up to 200% of the federal poverty level. The act incorporated specific design elements that made it more attractive to state governments, which would bear a large responsibility for its implementation. Using a level of federal matching funds in excess of that provided to the Medicaid program (70% of the cost of the program, on average, compared with 57% for Medicaid),² states were enabled to craft programs that were either extensions of their existing Medicaid programs or new stand-alone programs or a combination of both.³ The stand-alone programs were permitted to include cost sharing and premiums, and their benefit packages could differ from what was available in Medicaid, whereas the Medicaid extension programs were required to adhere to the traditional Medicaid package.

The new legislation budgeted \$40 billion for the 10 years of the program as a capped block grant to states rather than as an entitlement. To prevent states from shifting children from Medicaid to a program with greater federal cost sharing, the law mandated a maintenance-of-effort obligation and strict screening of Medicaid eligibility. To discourage crowd-out from the commercial insurance pool, the law also limited availability of the program to individuals without other forms of potential coverage and imposed waiting periods before patients could access the program after losing private coverage.⁴

As states were establishing their programs in the early years of CHIP, the

federal allotments exceeded state expenditures. By 2000, however, every state and territory as well as the District of Columbia had established its own program, so that by the middle part of that decade, states were beginning to find that their expenditures were outstripping the federal block grants allocated to them. To remedy such shortfalls in 2006 and again in 2007, Congress appropriated increased funds for the program above the original 1997 allocation.

At the 10-year mark, despite considerable progress in coverage for near-poor children, CHIP continued to confront 3 issues: provision of sufficient financing for the states to meet the needs of the intended population; adequate outreach, enrollment, and retention efforts for eligible children; and a perceived need to focus more on access and the quality of care for those covered.⁵ The 110th Congress attempted to reauthorize the program in 2007, but despite passage in both houses of Congress, the legislation was twice vetoed.⁶ In the absence of long-term funding, the Medicare, Medicaid, and CHIP Extension Act of 2007 (Pub L No. 110–173) was enacted to appropriate funds at the 2007 level to cover the costs of the program for 2008 through March 31, 2009.⁷

After the 2008 presidential elections, the new administration set the extension of CHIP as an important early legislative priority. President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA; Pub L No. 111-3) into law on February 4, 2009,⁸ with several specific policy goals in mind. The law increased appropriations for the program in acknowledgment of the shortfalls that states had been experiencing under the previous funding levels and extended the life of the program through 2013. In addition, it included a number of funding mechanisms, such as

Express Lane eligibility and state bonuses for reaching enrollment goals that were intended to extend Medicaid and CHIP coverage to millions of additional uninsured children and to increase outreach to many who lacked coverage despite being eligible for these programs. Finally, it improved benefits, enhanced data collection, and created a new emphasis on measuring the quality of care children received.⁹

One year later with the passage of the Patient Protection and Affordable Care Act (ACA; Pub L No. 111–148 [2010]),¹⁰ other modifications of CHIP came online: in particular, the ACA extended the funding for CHIP by another 2 years, through September 31, 2015. In addition, because the ACA enabled all citizens younger than 65 years with household incomes less than 133% of the federal poverty level (\$31 322 for a family of 4 in 2013, to which a 5% income disregard will be applied when considering eligibility)* to become eligible for Medicaid effective January 2014 (if, in view of the June 2012 Supreme Court decision, their state of residence agrees to participate in the Medicaid expansions),¹¹ the ACA anticipated that some children older than 6 years previously covered by a stand-alone CHIP plan would transition into Medicaid. In such cases, the ACA provides states the enhanced CHIP matching rates for those individuals. Furthermore, beginning in fiscal year 2016, the federal CHIP matching rate is slated to increase by 23 percentage points to an average of 93%. Finally,

*To determine income eligibility for Medicaid under the ACA, the statute references an individual's modified adjusted gross income and adds a standard 5% "income disregard," making the effective threshold for eligibility 138% of the federal poverty level. See "Determining Income for Adults Applying for Medicaid and Exchange Coverage Subsidies: How Income Measured With a Prior Tax Return Compares to Current Income at Enrollment" from The Kaiser Family Foundation Focus on Health Reform at <http://www.kff.org/healthreform/upload/8168.pdf>.

although the ACA extended authority for CHIP through 2019 and included maintenance-of-effort requirements for eligibility, identification, and enrollment of children in Medicaid and CHIP through that time period, it provided federal CHIP allotments to finance the program only through fiscal year 2015.¹²

ACCOMPLISHMENTS OF CHIP

Insurance Coverage

Incontrovertible evidence demonstrates that the CHIP program increased insurance coverage to its intended population above what it would have been in the absence of the program (see Fig 1). Although at the time of CHIP's enactment in 1997, states already had, under the existing Medicaid program, the option of expanding coverage for children in families up to 200% of the federal poverty level, only 6 states had availed themselves of this opportunity.¹³ From the enactment of CHIP in 1997 to 2011, enrollment has grown from under 1 million to 5.3 million children.^{14,15} Furthermore, the enactment of CHIPRA has had important spillover effects on the enrollment of eligible children into Medicaid so that the combined impact on the rate of uninsurance among children has been significant.¹⁶

Although the percentage of US children with private employer-sponsored health insurance decreased from 66.2% to 53.0% over this time, the proportion covered by public insurance, including Medicaid or CHIP, increased from 21.4% to 42.0% so that the total percentage of uninsured US children decreased from 13.9% to 6.6% at a time when the uninsurance rates among adults were increasing.^{17,18} Moreover, the reductions in uninsurance were concentrated among the population of children in families at or below 200% of the federal poverty level. The percentage of children covered by employer-sponsored insurance in this group fell from 34.4% to 24.9%, whereas the percentage of those on Medicaid or CHIP increased from 41.3% to 60.4% so that the uninsurance rate among these children decreased from 24.6% to 15.3% over this period.¹⁷ Beyond extending coverage to more children, specific provisions in CHIPRA made it mandatory for stand-alone CHIP programs to include dental coverage for children (section 2103[c]5)¹⁹ and to cover mental health services and substance abuse services on parity with medical and surgical coverage.

Even subsequent to the 2008 recession, CHIP continues to increase its enrollment, although at a slower rate than

before. Some have speculated that this slowdown is partially attributable to the migration of some children from CHIP to Medicaid as parents have lost employment.¹⁵ How much of the decline in private insurance coverage can be attributable to enrollment in the CHIP program has generated intense debate in the "crowd-out" literature, but a recent review of the evidence noted that only 4 of 22 pertinent studies examined found statistically significant crowd-out effects.²⁰ Among those who did find evidence of crowd-out, the magnitude of the estimates varied widely from 0% to 50% depending upon the underlying assumptions of their statistical model.²¹

Access to Care

For children enrolled in CHIP programs, most researchers, with occasional dissenting voices,²² have found that access to care and utilization of primary and preventive care appear to improve after enrollment.²⁰ Although methodologic challenges abound in trying to arrive at robust estimations in this regard,²³ evaluations conducted in individual states^{24–26} or across combinations of states^{16,27} have found, in general, that enrollees report improvements in having a usual source of care, in completing visits to physicians or dentists, and in having fewer unmet health needs after enrollment. Furthermore, some observers cite evidence indicating that racial/ethnic disparities in access and utilization detectable among new CHIP participants before they enrolled were either eliminated or greatly reduced after enrollment.²⁸ Other researchers have reported that the benefits of CHIP enrollment with respect to reductions in unmet needs are greater for children with chronic health conditions.²⁹ Finally, older children (older than 13 years) from low-income families who had not been eligible for public health insurance coverage before the enactment of CHIP appear to have had disproportionately greater increases in the

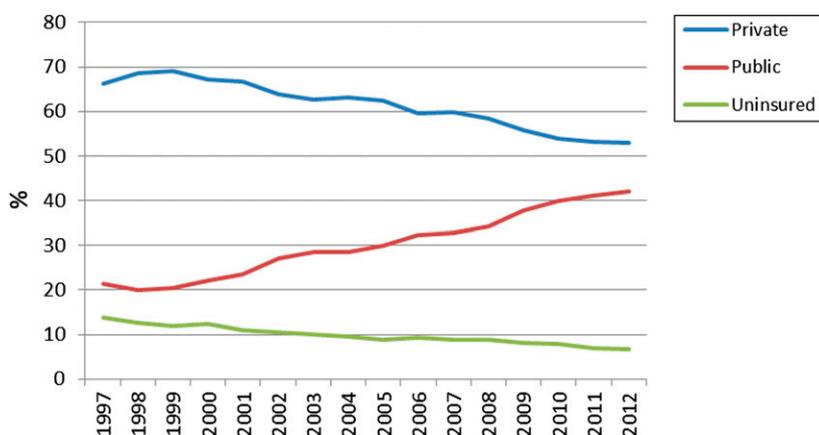


FIGURE 1

Health insurance rates for children in the United States, 1997–2012. Source: National Center for Health Statistics, 2013.¹⁸

likelihood of a physician visit and greater declines in rates of uninsurance as a result of the enactment of this program, when compared with younger children from poor and near-poor households.³⁰

Health Status and Quality of Care

Unambiguous evidence of the effects of CHIP on improvements in children's health status as measured either by mortality rates, morbidity, improved functional status, or parent-reported health assessment is more difficult to substantiate for a variety of reasons.²³ Some of the studies^{31,32} reported benefits of improved publicly funded health insurance lump effects of Medicaid with those of CHIP, even though they apply to different populations and may have been studied in different time periods. Despite these caveats, there are suggestions that enrollment in CHIP may have had positive effects on certain measures of health and well-being among participants.^{33,34}

Finally, over and apart from the direct effects that CHIP has had on the access, utilization, and health status of near-poor children, the provisions in CHIPRA that focus on the quality of care delivered to children are of signal importance. A major innovative element of CHIPRA was the incorporation of quality child health measurement standards, monitoring capabilities, and reporting requirements for states in section 401a of the statute.³⁵ The legislation established a mechanism by which the Centers for Medicare and Medicaid Services collaborated with the Agency for Healthcare Research and Quality to identify an initial core set of child health quality measures on which states could voluntarily agree to report.^{35,36} CHIPRA also allocated a total of \$100 million in awards to 18 states to encourage creation of quality demonstration projects. Since the law's enactment, the US Department of Health

and Human Services has been required to report on the quality of care received by children covered by Medicaid and CHIP.

PROBLEMATIC ISSUES FOR CHIP

CHIP and the ACA

Whereas it is important to acknowledge the signal achievements of the ACA in extending health insurance coverage, reforming practices in the health insurance market, and incentivizing opportunities to moderate health care costs, it is equally necessary to be alert to aspects of the new law that raise concerns regarding the future of CHIP. Many of these concerns emerge only from a detailed understanding of specific features of the legislation and are outlined as follows:

- First and foremost is the question of ongoing funding particularly in view of provisions of the ACA that preserve federal funding for CHIP only through 2015. After this date, it is not certain whether the program will be continued or whether some subset of children currently covered under CHIP who satisfy other eligibility criteria will be expected to transition into the new health insurance marketplaces, whereas others will be left without coverage entirely. This latter scenario may constitute an inferior outcome, even for children who do qualify to be covered by the marketplaces. At least 1 comparative analysis in 17 states found that the benefits and cost-sharing levels in existing CHIP programs were superior to those in the marketplaces.³⁷
- Second, initial experience with federal- and state-sponsored insurance marketplaces suggest that network restrictions limiting access to children's hospitals and certain subspecialists constitute a significant cost-containment strategy in many geographic areas. These restrictions

within the ACA framework are less beneficial to children compared with what they currently experience in CHIP.

- Third, the majority Supreme Court decision upholding the ACA but rendering state participation in the new Medicaid expansions optional¹¹ creates further inconsistencies that might leave certain poor older adolescents ineligible for any public funding in states that refuse to accept the new Medicaid expansions.³⁸ Even if the ACA is implemented such that all states opt to embrace the Medicaid expansions, a considerable number of children will find themselves in situations where their coverage is with a public plan, whereas their parents either have no coverage because they do not qualify for Medicaid under the proposed expansions or have different coverage from their children because they are in one of the marketplace plans, hence complicating coordination of benefits within the family.³⁹
- Fourth, another distinct disadvantage for children under the ACA involves the calculation of eligibility for premium tax credits under the law. The Internal Revenue Service has ruled that those whose premiums cost more than 9.5% of their gross adjusted income are eligible for tax credits from the federal government, but only the cost of an individual policy is taken into account in making this calculation. Because family coverage is more expensive than individual coverage, parents with children may find themselves paying more than 9.5% of their income to obtain coverage but being nevertheless ineligible for these credits (a feature known as the "kid glitch").
- Fifth, although the ACA permits children up to the age of 26 years

to remain on their parents' policies, this benefit does not extend to grandchildren (ie, children who might be born to these young adults).

- Finally, although provisions in the ACA have made redistribution of funds among states more responsive to the differential shortfalls in funding that emerge across different states over time, the block grant nature of the CHIP makes it difficult for all states to adjust their programs to the changing needs and numbers of near-poor children. This situation could become critical if future economic downturns render more families eligible for a program that has a cap on its total spending.

Enrollment and Retention

In addition to the concerns regarding future funding, the current program has yet to address other issues of enrollment and retention. There are now estimated to be 7.7 million children enrolled in the CHIP program, of whom 70% are in stand-alone programs.³ Despite the remarkable success of Medicaid and CHIP at reducing uninsurance among children from low-income families, an estimated 7.5 million children in the United States still remain uninsured, of whom 60% to 70% are thought to be eligible for public insurance of some kind.¹² Identifying those children and increasing the rate at which they enroll in CHIP is an ongoing challenge for the program. For children who do enroll, the rate of retention in the program is also lower than it might be. It was estimated in 2008 that 26.8% of uninsured children had been enrolled in public insurance the previous year, with 21.7% formerly enrolled in Medicaid and 5.1% enrolled in CHIP.³⁸ Understanding the reasons for and consequences of these dropouts, whether they result from

barriers associated with state enrollment and reenrollment policies, documentation and related concerns among immigrant parents of children born in the United States, changes in employment status, or other factors, should be a priority for the program. Part of the advantage of CHIP has been the built-in flexibility it has afforded states with respect to its implementation, particularly among stand-alone CHIP programs rather than pure Medicaid expansions. Because states have faced differential budgetary constraints in the aftermath of the recent recession, having some leeway in how to structure benefits and set eligibility for near-poor children has been a boon to policy makers facing difficult fiscal choices at the state level. This sanctioned flexibility in the rate of CHIP implementation, the degree of cost sharing, the generosity of benefit packages, and the extensiveness of outreach to those eligible but uninsured has, in turn, resulted in considerable state-to-state variation in retention rates and in the overall benefit of the program. Provisions of the ACA will do little to modify these operational aspects of CHIP.

Physician Participation

The rates at which pediatricians have been willing to accept children covered by public health insurance programs have declined in recent years as the payment rates in these programs have generally deteriorated relative to rates associated with commercial plans. A recent report by the Government Accountability Office summarizing a national survey of pediatricians indicated that although 47% of those surveyed reported that they would accept all new Medicaid or CHIP patients, the comparable figure for privately insured patients was 79%.⁴¹ In those states that have CHIP arrangements that are Medicaid expansions (and

some states with a stand-alone CHIP program use Medicaid plans and payment rates in CHIP), rates of acceptance of CHIP patients and Medicaid patients are highly correlated. To attempt to address this concern, at least in part, provisions of the ACA (§1202) require that, for primary care providers, Medicaid payment rates be increased to 100% of those available through Medicare.^{22,42} The federal government has issued a final rule, clarifying the following: (1) that this innovation applies to primary care evaluation and management (E&M) codes 99201–99499, including pediatric services that are not traditionally provided by Medicare practitioners; (2) that they apply to Medicaid managed care plans as well as traditional fee-for-service arrangements; and (3) that they apply to services administered by or under the direction of physicians in primary care specialties or subspecialties.⁴³ This ruling is important especially because three-quarters of CHIP patients are enrolled in managed care plans³ and the payment rates for participation in these plans vary considerably on a regional basis. Most pediatricians are in a disadvantageous position when it comes to negotiating payment rates with large insurance companies that can be the sole payers in a specific geographic locale. Less encouraging is the fact that the increase in the Medicaid fee structure to achieve parity with Medicare is time delimited and is due to expire after 2014.

Pediatric Providers and the Future of CHIP

How pediatricians and pediatric subspecialists respond to the incentives provided by CHIP is a critical consideration in evaluating the program's effectiveness over time. Because payments to physicians for patients enrolled in CHIP are generally lower than payments received from commercially

insured patients, the additional insurance coverage that CHIP achieves may result in access and utilization improvements for CHIP patients, which, although laudable, are smaller than they would be were payment rates in this program commensurate with commercial insurance. Indeed, some researchers examining physician response to the program found that, although participation on the part of pediatricians increased with CHIP's introduction, the hours devoted to patient care for all patients decreased,⁴⁴ and the visits to physicians remained unchanged.⁴⁵ These empirical findings indicate that rates of physician payment for CHIP participants will continue to influence how successfully the program achieves its articulated aims. To what extent these developments have implications for the growth of the pediatric workforce in the future is also a matter of considerable importance in the medium- to long-term. Disadvantageous payment rates covering greater proportions of pediatric patients may influence the decisions of those emerging from medical school with significant financial obligations of their own to preferentially consider alternative fields of specialization.

CHIPRA and the ACA have made important contributions to the advancement of health care delivery to near-poor children in recent years and have the potential to accomplish more so in years to come. Going forward, there is a series of issues that the pediatric community must continue to monitor to preserve the advances that have been made and to expand on them where possible. The ACA has mandated that income thresholds for CHIP are to remain constant through 2019 (although the federal government has yet to appropriate funds for the program beyond 2015), but state-by-state variability in cost sharing in the form of premiums, deductibles, and

coinsurance for CHIP stand-alone programs will need to be minimized to maintain true access to health care services, especially to subspecialty care. Pediatricians and families must continue to assess vigilantly the comprehensiveness of benefit packages available under the program, because these features will also vary from state to state. Policy makers will need to set payment rates at adequate levels if a significant proportion of the pediatric community is to engage actively in the care of CHIP enrollees. All those with an interest in advancing child well-being must monitor closely eligibility and benefits for emancipated minors, for children up to 26 years of age, for foster children once they reach the age of majority, for children of undocumented immigrants, and other vulnerable populations. Finally, the relationship between CHIP and the new health care marketplaces must be clearly delineated to ensure that the benefits for children are maintained at least at the present level and that the needs of children are not overlooked as these new structures are being created.

RECOMMENDATIONS

In view of the accomplishments of the CHIP program and the changing dynamics in the health care landscape, the American Academy of Pediatrics (AAP) makes the following recommendations with respect to this program:

1. Fully fund CHIP through 2019.
 - Extend the current appropriations formula beyond the 2015 date to continue comprehensive funding of CHIP through 2019.
 - Support maintenance of effort for eligibility thresholds and enrollment and renewal procedures for children in CHIP through 2019.
 - Maintain the enhanced federal matching rate for CHIP to

encourage states to take advantage of these funds.

- Continue the performance bonuses program beyond fiscal year 2013 to encourage states to innovate with respect to enrollment and retention policies.
 - Maintain contingency funds for states that experience funding shortfalls.
 - Strongly consider transforming CHIP from a block grant program to an entitlement for children in families with incomes less than 300% of the federal poverty level with sliding scale subsidies to eliminate the possibility of denial of coverage because of state caps on spending.
2. Expand awareness of CHIP among eligible families.
 - Encourage state and local departments of health to develop culturally appropriate written and Web-based outreach materials focused on families with incomes that meet CHIP eligibility criteria, concentrating particularly on children with special health care needs.
 - Expand the availability of AAP-generated resources using plain language principles,⁴⁶ and partner with other public and private organizations to produce resources that individual pediatricians can use in their offices to encourage families to enroll in CHIP programs, when applicable.
 3. Facilitate access to CHIP by eligible children.
 - Mandate all states to adopt automatic coverage for newborns, and require or incentivize multi-year (5-year) continuous eligibility in Medicaid/CHIP for newborns/infants.
 - Mandate all states to adopt 12-month continuous eligibility

for children and pregnant women in CHIP and Medicaid.

- Mandate all states to automatically enroll all children participating in the Supplemental Nutrition Assistance Program into Medicaid or CHIP.
- Streamline CHIP enrollment and renewal procedures by allowing self-declared income, using passive renewal procedures, eliminating face-to-face renewal encounters, and improving communication with families regarding renewal procedures.
- Coordinate CHIP enrollment efforts with community-based programs that work to enroll uninsured patients in Medicaid, new insurance exchanges, or other appropriate sources of health insurance.
- Expand the use of technology to facilitate enrollment and renewal by the use of prepopulated forms and the expansion of Express Lane eligibility that coordinates enrollment in CHIP with eligibility or enrollment in other public support programs, such as Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), etc.
- Decrease or eliminate enrollment fees and eliminate “lock-out” periods after disenrollment from CHIP for failure to pay premiums.
- Eliminate waiting periods for enrollment into CHIP after loss of employer-based insurance.
- Encourage states to take advantage of the provision in ACA that enables state programs to offer CHIP enrollment to children of

state employees who qualify for the program.

- Maintain eligibility levels and performance bonuses for states that exceed CHIP enrollment targets.
 - Eliminate the discrimination against undocumented children by allowing them access to the CHIP program if they meet other eligibility criteria.
 - Encourage all states to take advantage of the option to cover documented immigrant children through provisions in the Immigrant Children Health Insurance Act provisions of the CHIPRA legislation.
 - Allow youth who are considered “lawfully present” under the Deferred Action for Childhood Arrivals (DACA) program to qualify for Medicaid, CHIP, or tax credits in the marketplace.
 - Strongly consider allowing all children, “under color of law,” regardless of citizenship status to enroll in CHIP.
 - Extend Medicaid/CHIP coverage to age 21, and extend coverage to age 26 for children with special needs.
 - Extend age-appropriate coverage to infants of mothers who are covered under the “age 26” provision.
 - Auto-enroll youth leaving the juvenile justice system into Medicaid or CHIP, and extend coverage for former juvenile justice youth up to age 26 to align with available coverage for children aging out of the foster care system.
4. Work to reconcile stipulations in CHIPRA and the ACA.
- Eliminate “premium stacking” for families in states with separate CHIP programs in which

parents are eligible to enter the newly created marketplaces so that families whose adult members enter the marketplaces are not paying separate uncoordinated premiums for children and adults.

- Require the use of family, rather than individual, premiums for calculating the percentage of income devoted to employer-sponsored health care insurance in determining who is eligible for premium tax credits under provisions of §32B(c)2(C) of the ACA; or alternatively, enable these families to choose CHIP to cover their children.
- Eliminate the 4-week gap in coverage for children transitioning from CHIP to marketplace coverage.
- Work with states to address churning of children between plans by continuing 12-month continuous enrollment and requiring insurers to allow continuation of a child’s medical home irrespective of payer (see recommendations on churning in the Medicaid and CHIP Payment and Access Commission’s March 2013 Report to Congress, pages 26–43⁴⁷).
- Encourage all states to opt into the Medicaid expansions available through the ACA to cover more parents, thereby increasing the likelihood that their children will acquire health insurance.
- Allow special consideration to be given to families with unique custody circumstances, such as those with parents who are enrolled in marketplaces but whose children are eligible for CHIP, families of foster children, or those with joint custody, nonparental guardianship, or undocumented

parents where knowledge of potential coverage options for children may be limited.

5. Maximize comprehensive coverage and affordability for children in CHIP.

- Require the adoption of state-level requirements that insurance packages contracted by stand-alone CHIP programs meet essential health benefits packages that also adhere to *Bright Futures* guidelines⁴⁸ with respect to the provision of primary preventive, screening, diagnostic, interventional, subspecialty, dental, surgical, mental health, and palliative care and include all benefits outlined in the AAP policy statement “Scope of Health Care Benefits for Children From Birth Through Age 26.”⁴⁹
- Require/reinforce a defined dental, vision, mental health, and habilitative service benefit for children.
- Require the National Association of Insurance Commissioners (NAIC) definition of habilitation as a required benefit for all plans.
- Collect information on compliance with parity in mental health benefits in CHIP plans.
- Consider the extension of eligibility for the Vaccines for Children Program to all children in non-Medicaid CHIP programs in all states.
- Maintain the prohibition against any cost sharing for preventive care services, including immunizations, in stand-alone CHIP programs.
- Prohibit the use of any cost-sharing arrangements in CHIP that shift costs to pediatricians, hospitals, or other health care providers.

- Strengthen and clarify tracking of all out-of-pocket payments across medical and dental benefits in CHIP to ensure that families do not pay beyond 5% of household income.

6. Support the quality measurement provisions incorporated into CHIPRA.

- Establish incentives to encourage states to report on the full core measure set, and eventually require standardized reporting by states of all quality measures in the pediatric core set.
- Establish an advisory panel regarding pediatric quality.
- Sustain and extend support for CHIPRA-funded Centers of Excellence to develop pediatric measures.
- Analyze effectiveness of the pediatric electronic health record format and work to support the development of a unified pediatric electronic health record that could be widely adapted in multiple practice settings.
- Encourage the development, dissemination, monitoring, and reporting on a set of child-specific quality measures beyond the initial core set of 24 metrics that will enable policy makers, practitioners, patients, and families to compare outcomes across practice settings, regions, and insurance plans.
- Allow CHIP case-mix calculations for HITECH Act electronic health records incentive payments.⁵⁰
- Support ongoing funding at the National Institutes of Health and other federal agencies for the development, dissemination, implementation, and evaluation of these pediatric-specific quality measures.

- Encourage specifically, direct comparisons wherever possible in quality measures, outcome evaluations, and cost-effectiveness between CHIP enrollees and children who end up enrolled in marketplace insurance plans.

- Build on existing state demonstration grants to continue and expand a focus on quality outcomes at the state level.

- Work to sustain the Medicaid and CHIP Payment and Access Commission (MACPAC) to advance policy analysis and health services research as they apply to CHIP.

7. Ensure adequate payment for practitioners who care for CHIP patients.

- Require plans that contract with stand-alone CHIP programs to cover full costs of all new vaccines effective on the publication date of recommendations by the AAP or the Centers for Disease Control and Prevention in the *Morbidity and Mortality Weekly Report (MMWR)*. Coverage and payments must cover the costs of the vaccine adequately such that they include the total direct and indirect vaccine expense overhead as well as the related immunization administration service. Payment for the vaccine product should be at least 125% of the current Centers for Disease Control and Prevention vaccine price list. Payment for immunization administration must be at least 100% of the current Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule.
- To improve the adoption of effective medical home strategies by primary care pediatricians, require CHIP payers for

stand-alone programs to include payments for care coordination, telephone consultation, case management, hospital transition planning, and subspecialty care coordination.

- Create and maintain funding mechanisms to award achievement of recognized, evidence-based, outcome-driven quality-of-care standards for CHIP enrollees.
- Extend Medicaid payment parity permanently and extend parity to all billable services, including specialists and subspecialists.

CONCLUSIONS

Near-poor children in the United States have derived enormous benefits from

CHIP since its inception 16 years ago. The reauthorization of this landmark social insurance program in 2009 strengthened many of its most important elements and added innovative features that broadened its reach. With the passage of the ACA, the approach that the United States will adopt for this vulnerable segment of the pediatric population after 2015 is now subject to some uncertainty. Whether CHIP proves to have been an interim approach that is ultimately replaced by universal coverage through a combination of Medicaid, employer-sponsored health insurance, and insurance exchanges or by adoption of a single-payer system or whether CHIP endures in its current form even after full implementation of the ACA, it is vital for the health of near-

poor children that the principles of expanded access, affordable coverage, generous benefits, and quality monitoring be essential elements in the provision of health care services now and into the future.

LEAD AUTHOR

Andrew D. Racine, MD, PhD, FAAP

COMMITTEE ON CHILD HEALTH FINANCING, 2012–2013

Thomas F. Long, MD, FAAP
 Mark E. Helm, MD, MBA, FAAP
 Mark Hudak, MD, FAAP
 Andrew D. Racine, MD, PhD, FAAP
 Budd N. Shenkin, MD, FAAP
 Iris Grace Snider, MD, FAAP
 Patience Haydock White, MD, MA, FAAP
 Molly Droge, MD, FAAP
 Norman "Chip" Harbaugh, Jr, MD, FAAP

STAFF

Edward P. Zimmerman, MS

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COMMITTEE ON CHILD HEALTH FINANCING

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