



American Academy of Pediatrics



TESTIMONY

of the

**AMERICAN ACADEMY OF PEDIATRICS**

Submitted for the Record of the Hearing Before the  
Committee on Finance Health Care Subcommittee

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“CHIP at 10: A Decade of Covering Children”

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**Department of Federal Affairs**

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The American Academy of Pediatrics (AAP) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, who are deeply committed to protecting the health of the millions of children and adolescents who receive health care throughout the State Children's Health Insurance (SCHIP) program.<sup>1</sup>

The Academy would like to provide comments on the importance of the history of SCHIP and its impact on decreasing the number and percentage of children without insurance in the United States.

## **BACKGROUND**

The State Children's Health Insurance Program, enacted in 1997 as Title XXI of the Social Security Act, has achieved remarkable progress in its brief history. As a result of SCHIP, health insurance has been extended to millions of low-income children and rates of uninsurance among this population have declined by 2 percentage points, from 14% in 1997 to 12 % in 2004. Access to health care has been vastly improved. Specifically, SCHIP has resulted in more children having a usual source of care, receiving preventive care and immunizations, and reducing unmet need for dental care. Family satisfaction with care has also significantly improved under SCHIP as has a narrowing of income and racial/ethnic disparities in health insurance coverage and access to care. Importantly also, SCHIP has had positive spillover effects on the Medicaid program. As a result of SCHIP outreach, millions of potentially eligible but uninsured children have been enrolled in Medicaid. Eligibility determination processes have been simplified and coordination between these two public programs has become increasingly effective.

In 2005, SCHIP programs provided health insurance to 4 million children nationwide. 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 12 states created a Medicaid program. 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%, up to 300% FPL in 4 states and 350% FPL in one.

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 with an allotted time are redistributed to other states according to a specific formula. Unfortunately, in fiscal year (FY) 2007, 18 states are facing SCHIP funding shortfalls, amounting to about \$1B, according to the Center on Budget and Policy Priorities (<http://www.cbpp.org/3-9-06health.htm>). The Congressional Budget Office has concurred with this estimate. The current authorization levels, given the size of the uninsured children population, the growth in the low-income child population, and inflation are not sufficient to sustain existing programs.

In addition to the very serious federal budget shortfalls, states, since 2001, 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 (Cite).

The scope of coverage for SCHIP in the 39 states that are offering a non-Medicaid plan to some or all of its SCHIP enrollees, although not as comprehensive as Medicaid coverage, still (with few exceptions) far exceeds benefits in employer-sponsored health insurance. Similarly, although premium rates and co-payments and other dollar limits impose financial burdens for some families, they are still markedly less than in private health insurance plans and families, for the most part, consider them reasonable and affordable.

Provider payment rates, however, are generally low, well below commercial rates, and in many states at the same level as Medicaid's rates, which are on average only 70% of Medicare's rates. In fact, Medicaid professional fees were estimated to be about 70% of Medicare in 2004 according to the 2006 AAP Pediatric Medical Cost Model developed by actuaries at Reden & Anders, Inc. In comparison, commercial plans paid at 111% of Medicare.

The American Academy of Pediatrics has recommended the following improvements to strengthen SCHIP.

#### **1. Extending Eligibility and Enrollment**

- Expand SCHIP to include adolescents ages 19 through 21.
- Allow emancipated minors eligibility for SCHIP based on their own income.
- Encourage higher income eligibility levels (above 200% FPL) and discontinue asset testing to extend eligibility to more uninsured children.
- 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.
- Encourage CMS waiver application to expand SCHIP coverage to uninsured pregnant women and parents if states have already maximized comprehensive coverage and full enrollment of children.
- Extend 12-month continuous eligibility for SCHIP- (and Medicaid-) enrolled children.
- Adopt presumptive eligibility for all children, allowing health care providers and other designated agencies to grant eligibility for up to 60 days while a child goes through the enrollment process.

## **2. Supporting Comprehensive Coverage**

- Preserve Medicaid benefit coverage in states with Medicaid SCHIP programs.
- Expand the breadth of coverage in non-Medicaid SCHIP programs. This could be accomplished by adding an EPSDT-like provision to pay for services considered medically necessary or by creating wraparound programs for children meeting specific chronic condition or special-needs criteria.
- SCHIP benefit packages should cover the services defined in the AAP policy statement, “Scope of Health care Benefits for Newborns, Infants, Children, Adolescents, and Young adults through Age 21 Years,” including dental services and the full range of mental health services, including substance abuse treatment. Preventive care, immunization standards, and periodicity schedules should be consistent with current AAP requirements.
- Extend eligibility for the Vaccines for Children program to all children enrolled in non-Medicaid SCHIP programs.
- Adopt medical necessity standards that meet one or more of the following criteria: 1) the service is appropriate for the age and health status of the individual; 2) the service will prevent or ameliorate the effects of a condition, illness, injury, or disorder; 3) the service will aid the overall physical and mental growth and development of the individual; or 4) the service will assist in achieving or maintaining functional capacity.

## **3. Maintaining 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 providers and do not deter the use of medically necessary services. Point-of-service cost sharing holds the greatest risks for children failing to seek or receive needed care and preventive services. Deductibles and coinsurance should not be used; rather cost sharing in the form of income-adjusted premiums and copayments are more effective.
- Maintain policy stating that all preventive services under SCHIP are exempt.

#### 4. Improving Provider Payments and Network Capacity

- Establish reimbursement rates for pediatric services comparable to rates offered in private insurance plans or Medicare. Specifically, rates should be at least 90% of the usual, customary, or reasonable rates or equivalent to Medicare rates, whichever is higher.
- 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 the cost 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.

#### 5. Strengthening Quality Performance

- Adopt a consistent conceptual framework (such as the Institute of Medicine's framework) to assess health care quality across SCHIP programs. Performance goals should include 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.
- Involve pediatricians, pediatric subspecialists, pediatric mental health professionals, and other pediatric clinicians and families in continuously reviewing and evaluating each state's SCHIP program.
- Authorize more funding for SCHIP evaluations and allow greater access to state data for research.

### CONCLUSION

SCHIP has a proud history to build upon. To achieve continued success in reducing the number of uninsured children and assuring access to high quality pediatric care, the American Academy of Pediatrics commends the Subcommittee, the Finance Committee and Congress as a whole on its endeavors to internalize the history of SCHIP before the reauthorization debate begins in earnest.

We would be happy to provide any information or input the subcommittee might need as it considers changes to this critical program for children.

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<sup>1</sup> Medicaid Statistical Reports (MSIS/2028 Reports) for Federal Fiscal Year 2002. *Centers for Medicare and Medicaid Services.*