

PROPOSAL FOR

Children's Coverage

NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS

Children's Pathway to Health Coverage

Overview

A new approach to children's health coverage – the Children's Pathway to Health Coverage – would ensure that all children have continuous health coverage. Every child would be eligible for comprehensive health insurance offered through the Pathway program and automatically enrolled in the program at birth. Parents would have a choice of health benefit plans for their children under Pathway or the option to choose coverage through their employers or other creditable family coverage. However, the Pathway program would always be there to resume coverage in the event other coverage was lost.

Children's access to health coverage through Pathway or employer-sponsored insurance (ESI) would be guaranteed, without regard to their health status. Affordability of coverage would be guaranteed as well. Premium assistance would be provided for Pathway, ESI or other creditable family coverage, based on family income. The Pathway program would also provide uniform limits on cost sharing for children in low income families, in accordance with those provided under Medicaid and SCHIP.

SCHIP would be subsumed into the Pathway program, while Medicaid's coverage of children would continue, providing coverage for services not covered by Pathway including long term residential care, community based alternatives, and transportation. The Pathway program's comprehensive benefits would incorporate Medicaid's standard of preventive care and medical necessity (EPSDT), reflecting children's health and development care needs.

The program, administered by states under uniform federal standards, would provide the capacity and national leadership needed for system reform and advancements in the quality, performance and effectiveness of children's health care. Strong federal uniform standards would ensure the portability of coverage, simple streamlined eligibility and enrollment procedures and would provide children the same opportunity for health coverage across the country. Open to all children, Pathway would ensure that premiums and payments are sufficient for broad plan and provider participation and to recognize and reward excellence in delivering care.

Proposal Elements

A Mandate for Children's Coverage: Health coverage for all children would be federally required. Covering all children is difficult without a mandate, and mandatory coverage is particularly appropriate for children, given their dependency on the decisions of adults.

Continuous Health Coverage for All Children: All children would be guaranteed health coverage from birth through age 21 and automatically enrolled at birth in the Pathway program. Parents would have a choice of participating Pathway health benefit plans, or they could opt out for their ESI program or other creditable family coverage. Upon loss of ESI or other private coverage, a child's coverage under Pathway would automatically be reinstated. With automatic and continuous coverage, there would be no pre-existing condition exclusions or waiting periods for children's coverage in Pathway or ESI. Federal standards would ensure a seamless transition to coverage if children move from state to state, and would require streamlined enrollment to guarantee that children get coverage and keep coverage.

Available Coverage: The Pathway program would guarantee that all children have access to large group coverage through a state children's health insurance exchange. The connector would offer at least two private health benefit plans for children, and public plans could be offered as well. States could use an existing entity performing similar functions. States with one dominant insurer covering 80 percent of more of their market would be allowed to use a single insurer. The federal government would offer a plan, through multiple bidders, that would be available in any state lacking alternatives. Currently, most children covered by Medicaid and SCHIP are enrolled in private health plans.

Affordable Coverage: Premium assistance would be provided, on a sliding scale, for children in families with incomes at or below 300 percent of poverty (in accordance with current Medicaid and SCHIP standards), regardless of whether their coverage comes through Pathway, ESI or other creditable family coverage. Eligibility would be based on income not assets. Families with incomes above 300 percent of poverty would pay full premiums for no more than two children and would be limited to no more than 10 percent of adjusted gross income.

Comprehensive Coverage: A standard comprehensive benefits package would be required for all Pathway coverage. Coverage would include current Medicaid benefits for children - with the exception of long term residential care, community based alternatives and transportation, which would continue to be covered by Medicaid. Covered benefits - including vision, dental and mental health services - would provide a standard of preventive care and medical necessity (EPSDT), reflecting children's health and development care needs.

Coverage that Assures Access to Care: Cost sharing would be limited to co-payments of \$10 a visit or prescription. There would be no deductibles and no cost sharing for preventive care. Cost sharing for children below 150 percent of poverty would be nominal. A \$20 co-payment for non-emergent use of emergency rooms or non-preferred drugs would apply for all children.

Pathway program premiums and payments would provide a payment floor of no less than Medicare, adjusted for children's health care and risk. Payment incentives would be linked to quality, performance and participation in system reform. Payment adjustments for safety net providers would be as under Medicaid with federal standards, as would payments for the costs of graduate medical education, costs generally offset by spending reductions in other programs.

System Reform

The Pathway program provides an essential foundation for system reform for children's health care through continuous, comprehensive coverage and standards supporting adequate premiums and payment. The latter is particularly important to encourage medical homes and to sustain regionalized pediatric specialty care.

Ensuring that necessary care is delivered effectively, however, will require more. It will require linking payment incentives to participation in system reform, recognizing and rewarding high quality effective care, and investing in health information technology systems and measuring quality of care for children. The Pathway program will provide the authority for federal leadership and resources needed for national change.

Children's Health Care Quality Improvement Trust: One percent of Pathway's total program funding would be set aside to provide resources for system reform in children's health care that would accelerate improvements in care across all quality domains – safety, effectiveness, equity, timeliness, efficiency and family-centeredness. In determining areas of investment, the Secretary of Health and Human Services would consult with stakeholders involved in the provision of children's health care and the quality of that care. The "Trust" would support the infrastructure and investments needed for system reform, including innovations in the design and delivery of care through states and state connectors, health plans and providers and administrative costs. These investments would include, for example:

National quality measures and public reporting: States and children's health insurance exchanges would report on evidence-based indicators of performance and quality in their children's health care systems to the Secretary of HHS. Measures for participating health plans and providers would be evidence- and consensus-based to the fullest extent possible, and the process for selecting measures and reporting would be consistent with processes used in other federal efforts. The Secretary of HHS would assess the availability of current measures and the need for future measures through consultation with pediatric professional and provider organizations, health care quality organizations, states/connectors, parent consumers, and others. Funds would be provided for the development, testing and evaluation of pediatric measures across the domains of quality.

As the federal government moves forward with measures of quality and performance through Medicare, the infrastructure created should encompass pediatric as well as adult measures. Public reporting has been found to improve performance, particularly if it is combined with shared information and analysis of best practices.

Comparative effectiveness research (CE): The Secretary would establish a Center for Pediatric Medical Effectiveness Research, which could be incorporated into a center addressing CE broadly. The center would promote and fund research (new clinical trials and reviews of existing research) to determine the effectiveness of alternative processes for the treatment of children's illnesses and conditions, beginning with chronic illness. It would disseminate information that would help guide medical decision making toward the most appropriate care. Comparative effectiveness research and implementation is crucial to children's health. A study released in 2007 found that children receive only 68 percent of recommended care for acute medical problems, 53 percent of recommended care of chronic medical conditions, and 41 percent of recommended preventive care. The Lewin Group estimates that savings from these activities in combination with physician payment incentives would result in federal savings for the Pathway program of \$19.9 billion over 10 years. Private payers, families and states would also realize savings.

Health Information Technology (HIT): Funds would provide subsidies to providers to encourage adoption of HIT technology and promote the development of health information exchange networks. Funds would support the development of a model pediatric electronic medical record and standards to ensure that any electronic health record system used to care for children includes a level of functionality that will meet the needs of children – reducing the implementation costs of customizing adult-focused systems. Studies have estimated savings from the widespread adoption of HIT, and the Lewin Group estimated \$10.9 billion in federal savings for the Pathway program over 10 years, with an additional \$17.9 billion in savings for private payers, families and states.

Funds would also support initiatives, which can demonstrate improvements in the delivery of care, achieve savings, and be widely implemented through collaborative provider networks and pilots projects. For example,

Collaborative Improvement Initiatives: The Alliance for Pediatric Quality is working to spread proven collaborative improvement initiatives using evidence- and consensus-based quality measures, and benchmarking to bring about immediate, measurable change in the quality of children's health care. The Alliance includes four national pediatric organizations, bringing together hospitals and physicians to improve care for children. In the first phase of their efforts, the Alliance has had significant success, focusing on two priority areas – patient safety and chronic care. For example, the pediatric intensive care collaborative decreased catheter-associated blood stream infections rates by 70 percent; the improvement collaborative for pediatric inflammatory bowel disease increased compliance with best practices to over 90 percent; and the asthma initiative to improve performance in practice expanded to five new states, bringing quality improvement resources and coaching to primary care settings and state-based coalitions to sustain support.

Pilot medical home projects: Supported by a grant from the Agency for Healthcare Research and Quality, Community Care North Carolina is demonstrating how medical homes and community-based, physician-led networks can improve care, enhance access and decrease overall costs. The program, which began in 1998, saved the state about \$120 million in 2004. North Carolina Medicaid officials have urged their state to increase physician payment fees, which are now at 95 percent of

Medicare, and consider adequate physician payment a key to success. Medicare is supporting medical home pilots, and similar pilot projects should be funded for children.

Program Administration

The Secretary of HHS - in consultation with pediatric professional organizations, experts in pediatric quality, states, consumers and others -would establish nationally uniform standards and guidelines for the Pathway program and oversee the Children's Health Care Quality Trust. The federal government would assume additional governmental financing required for the Pathway program.

States would establish a state children's health insurance exchange through which to provide Pathway coverage. States would ensure the coordination of care for any child receiving services through Pathway and Medicaid or other program. State contributions to financing Pathway would be based on maintenance of effort of their current Medicaid and SCHIP programs for children, adjusted for inflation. A federal match would be provided for state administrative costs in the Pathway program, as well as a their continued residual financing of children's long-term residential and personal care services under Medicaid, including linkages to programs required by Individuals with Disabilities Act (which includes individualized education plans) and Title V, the Maternal and Child Health Block Grant.

Connectors would administer Pathway coverage and operations. They would be the point entry into the program for children, providing information on participating plans and determining subsidies for cost sharing for low income children. Parents would have the responsibility of self declaring income at enrollment. The Connector would select health plans, enroll children into participating plans, make payments to plans, provide automatic reinstatement of coverage for children upon loss of ESI or other creditable private coverage, and oversee continuous system improvement functions.

Premiums would be collected through the tax filing system, at point of payroll or through quarterly tax filings for the self-employed. To the extent that children are eligible for premium assistance, it will be provided at that time. Tax filings would include verification of children's health coverage and premiums paid.

Program Cost

The Lewin Group estimates that the program would result in increased federal spending of \$189.8 billion over 10 years for children age 21 and under. For children age 18 and under, current program requirements, the increase would be an estimated \$145 billion. If the CHIPRA bill were to be enacted for SCHIP reauthorization, this cost would be substantially reduced.



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