American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

March 4, 2015

The Honorable Orrin Hatch
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Fred Upton
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Hatch and Chairman Upton:

On behalf of the American Academy of Pediatrics (the Academy), a non-profit professional organization of 63,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, thank you for introducing an SCHIP extension Discussion Draft (the "Draft").

Since its bipartisan beginning in 1997, the State Children's Health Insurance Plan (renamed CHIP in 2009) has worked hand-in-hand with Medicaid to lower the child uninsurance rate by half. CHIP has spurred this historic success by financing insurance for millions of children in working families that earn too much to qualify for Medicaid but too little to afford private insurance.

Funding for CHIP expires September 30, 2015. Without an extension of federal funding, millions of families will have to shift their insurance to new plans that may not include access to their children's pediatrician and medical home, and many children will lose coverage altogether. Unlike most private insurance plans, which are based on the health needs of adults, CHIP offers insurance with age-appropriate benefits that is affordable for middle-income families. CHIP plans also provide access to pediatric primary care physicians, pediatric subspecialists and pediatric surgical specialists who are experts at addressing their unique needs.

Pediatricians often interact with families to persuade insurers to finance what children need from the health system, regardless of whether the insurance is financed by families, employers, state, or federal tax dollars. Pediatricians have reported caring for families whose insurance is inadequate for different reasons. For employer- and family-sponsored insurance, access to care is generally good because physician payment rates are significantly higher than with publicly-financed insurance, but benefits are often inadequate to address the unique needs of children. For publicly-financed insurance, especially in Medicaid and with states that use CHIP dollars to grow their Medicaid programs, benefits are appropriate, but payment rates are so low that pediatric practices too often find it impossible to afford to care for every child with publicly-financed insurance in their catchment area.

The AAP has advocated for a pediatric health system that would sufficiently finance the best health and development outcomes for children. As part of this vision for all children, the first standard for such a system is insurance coverage for every child, followed closely by age-appropriate benefits and adequate payment to insure real access to care. Each of these issues is covered below in the context of the Draft.

AAP Headquarters
141 Northwest Point Blvd
Elk Grove Village, IL 60007-1019
Phone: 847/434-4000
Fax: 847/434-8000
E-mail: kidsdocs@aap.org
www.aap.org

Reply to
Department of Federal Affairs
Homer Building, Suite 400 N
601 13th St NW
Washington, DC 20005
Phone: 202/347-8600
Fax: 202/393-6137
E-mail: kids1st@aap.org

Pediatricians frequently confront the national embarrassment that in the wealthiest country in the world, millions of children – the least expensive population to insure – lack access to quality, affordable health insurance. Based on this perspective, the Academy believes that the Draft represents a critical and important step in the process of extending CHIP, but is – respectfully – a missed opportunity. The Academy has repeatedly urged federal leaders to pass strong policies that support the AAP's agenda for children by meeting children's most basic health needs: sound nutrition, nurturing relationships and safe environments. You and your colleagues in the House and Senate can play a vital role in meeting the basic health needs of our children by enacting a CHIP extension that would more adequately address the urgent needs of this vulnerable population.

Initially, the Academy notes that the Draft excludes important aspects of prior legislation that recognized that children have needs beyond simple insurance coverage. Any mention of quality improvement, as established by CHIPRA's Title IV, is absent from the Draft. The Academy would urge an extension of the components of CHIPRA's Title IV contained in section 2(f) of S. 522, the "PRO-CHIP Act," or Title IV of HR 919, the "CHIP Extension and Improvement Act of 2015." 'The Academy also notes that the Draft withdraws federal support for the currently-scheduled increase in FMAP effective October 1. While the increase will not immediately increase enrollment, the change will almost certainly increase access as more funding for children's care will be available to overwhelmed state-level CHIP and Medicaid systems. It is important to note that states have historically paid pediatricians serving Medicaid children 70% of what other physicians are paid for caring for the Medicare population. Additionally, a new NASHP survey reports that at least 18 states have budgeted for this change. Survey results available at http://www.nashp.org/sites/default/files/Quantitative.pdf.

Section 2 of the Draft requests comment on the length of an extension of CHIP. The Academy would respectfully request that a CHIP extension be funded by the federal government for at least 4 years. There is broad support for this length of an extension beyond the Academy. For instance, the majority of governors who responded to your letter requested an extension at least for this length of time. Additionally, MACPAC has suggested an extension long enough to address the following major issues: the failure of any state to choose an age-appropriate benchmark benefit package for exchange coverage, the significant disparity in cost sharing between CHIP and exchange coverage, the definition of what constitutes an adequate pediatric network, and the "kid glitch." The Academy recognizes these policy rationales but also wishes to add a clinical rationale to support the argument for a 4-year extension.

Children's care is different from adult care in that children's care has been designed around the medical home model of care for decades. One of the most important aspects of the medical home model is stability, and a short-term extension of funding for CHIP would undermine many families' connection to the medical home due to an unnecessary transfer of coverage between payers. A medical home is not a building, but is an approach to providing comprehensive primary care. In a medical home, the pediatric care team works in partnership with a child and a child's family to assure that all of the medical and non-medical needs are met. Through this partnership the pediatric care team can help the family/patient access, coordinate, and understand services that are important for the overall health of the child and family, including specialty care, educational services, out-of-home care, family support, and other public and private community

services. The Academy developed the medical home model for delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, including children and youth with special health care needs (CSHCN).

The Academy also urges you to act quickly to extend CHIP. From a clinical perspective, families need a stable connection to their medical home. But children and families are not the only interested parties depending on the federal government to provide an indication about its intentions regarding the CHIP; state governments, who have partnered with the federal government for almost two decades to establish and strengthen the program, need certainty now. Many states will end their legislative sessions soon and thus it is critical that the federal government extend CHIP before they conclude.

One other reason the Academy urges quick action to extend CHIP is due to the uncertainty caused by the Supreme Court's forthcoming decision to consider arguments in *King v. Burwell*. The case has important implications regarding the future of CHIP, but not purely because of current enrollees in states that have failed to establish their own exchange. As you may know, 42 U.S.C. §1397ee(d)(3)(B) requires that if CHIP is not extended, children must be transitioned to coverage in an exchange "established by the State." This is the same language that appears in the section directly at issue before the Supreme Court (See 26 U.S.C. 36B(c)(2)(A)). If the Supreme Court determines that tax credits may not be used to defray the cost of insurance in states that have failed to establish non-federal Exchanges, millions of children formerly in CHIP would become uninsured as options on the non-subsidized exchange or in the open market would be prohibitively expensive.[i] It should be noted that many states with large CHIP populations have failed to establish a non-federal exchange, and children whose care is currently financed by CHIP could find themselves without affordable coverage just eight months from now after federal funding for CHIP ends.

Please act quickly to extend this vital program for at least four more years.

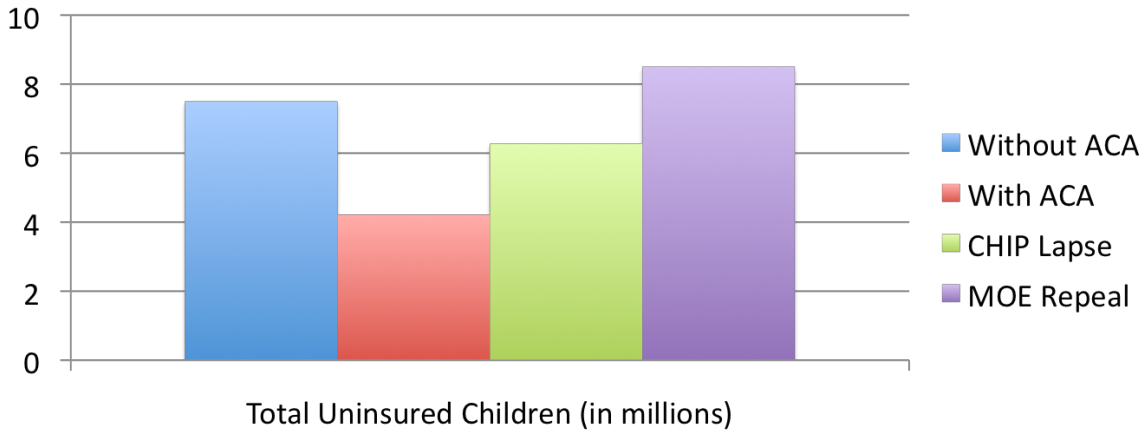
Coverage

All children and adolescents, from birth to 26 years of age, regardless of income, must have access to comprehensive health insurance.[ii] The Draft would reverse the historic improvement in child uninsurance through a number of policies, and the Academy would strongly oppose Sections 8, 5 and 9. First, Section 8 of the Draft has the potential to have the most negative impact on coverage, forcing millions of children off of coverage and exacerbating the impact of the "kid glitch." The Academy strongly opposes Section 8 because implementation of the policy would rob children of insurance by lifting the Maintenance of Effort (MOE) provisions in current law that require states to maintain eligibility and enrollment standards until 2019.

The MOE provision is extremely impactful for children's health coverage. If the MOE is rescinded, one Urban Institute study projected that fewer children would have health insurance than if the ACA were overturned in its entirety. Child uninsurance would rise to more than 8 million children (as compared to 7 million without the ACA).[iii] Thus, if Section 8 is enacted and the MOE repealed, children's uninsurance will spike.

The MOE provision is important to coverage and the health of the CHIP program because, without it, states are incentivized to move children from CHIP to tax-defrayed coverage in the exchange. This is because CHIP requires a state funding match while tax-defrayed coverage is fully federally financed. Recognizing this incentive, current law requires states to maintain standards, methodologies, and procedures for eligibility in Medicaid and CHIP for children through October 1, 2019.

Removal of the MOE will have a deep and deleterious impact on CHIP enrollment and precipitate a tragic unraveling of the nation's record-breaking success in covering children. The projected impact of the policy is illustrated in the chart below:



Source: Kenney, Genevieve, et al., *Improving Coverage For Children Under Health Reform Will Require Maintaining Current Eligibility Standards For Medicaid And CHIP*, Health Affairs Vol. 30, No. 12 (December, 2011), 2371-2381.

* The estimates provided for CHIP Lapse and MOE Repeal range depending on assumptions about high or low ESI and Exchange takeup rates – the value assigned here is an average.

The Academy also opposes Section 5. This section of the Draft would withdraw federal support for states beyond 300% of the federal poverty level (FPL) and shrink the federal commitment for children whose state governments have used their flexibility to draw down federal dollars for families with incomes above 250% of the FPL. This policy strikes at the core of the state flexibility of CHIP and its recognition that, for example, citizens in Rhode Island confront a different cost of living than citizens in Wyoming.

The following chart sets forth cuts in each state targeted by Section 5. The chart highlights the current State-established Federal Poverty Level CHIP cap as well as whether the state has chosen to rely on a "federally-facilitated marketplace" (FFM) or a "partnership" marketplace (P/S):

FPL CHIP Caps by State

Alabama (317%) [FFM]	Missouri (305%) [FFM]
California (266%)	Montana (266%) [FFM]
Colorado (265%)	New Hampshire (323%) [P/S]
Connecticut (323%)	New Jersey (355%) [FFM]
District of Columbia (324%)	New Mexico (305%)
Georgia (252%) [FFM]	New York (405%)
Hawaii (313%)	Oregon (305%)
Illinois (318%) [P/S]	Pennsylvania (319%)
Indiana (255%) [FFM]	Rhode Island (266%)
Iowa (380%) [P/S]	Tennessee (255%) [FFM]
Louisiana (255%) [FFM]	Vermont (317%)
Maryland (322%)	West Virginia (305%) [P/S]
Minnesota (288%)	Wisconsin (306%) [FFM]

The chart makes clear that implementation of Section 5, in conjunction with a decision in favor of the Petitioners in *King v. Burwell*, would usher in a precipitous increase in child uninsurance rates. This two-pronged attack on children's coverage would have the effect of eliminating the federal government's support for millions of children in middle class families across the country.

Additionally, the Academy opposes Section 5 because it is unclear why 250% and 300% of the FPL were chosen as proposed caps for federal support. It is unclear who is advocating for the demarcated cut-offs, or, perhaps more importantly, the rationale behind why these particular caps were chosen. Current law allows states to use CHIP block grant funds to address the needs of their population. Capping a federal commitment at 250% or 300% when a state may have chosen to use matched federal funds in a different manner seems arbitrary. In addition, there are clinical reasons to allow states to draw down federal support above 300% of the FPL. In particular, middle class families with children who experience special health care needs (CSHCN) may rely on CHIP for any number of reasons. Families may enroll their children in CHIP because states have structured CHIP to include benefits children may need but which are often not available through private insurance products in other plans offered in the state.

Section 9 would also have a deleterious impact on coverage. This section of the Draft would grant states the ability to impose waiting periods of up to twelve months for families with private insurance who wish to transition to CHIP coverage, purportedly to deter "crowd out", now known to be an unfounded concern. Concerns with crowd out have long been used as a specter to argue against establishing public coverage programs (even when private programs may be deficient). Anti-crowd out measures like waiting periods have been particularly unsuccessful in achieving their stated goals.[iv] Crowd out should no longer be a concern in the context of CHIP because of the near-universal public coverage system for children in families established by the Affordable Care Act. Simply put, with the availability of tax credit defrayed coverage available in Exchanges in every state, resurrecting the debate over displacement of private coverage by public coverage seems particularly antiquated. Additionally, a number of states have either completely eliminated or greatly reduced CHIP waiting periods, indicating that crowd out is not a concern that has come to fruition or has produced deleterious effects in the state.[v] Under current law, the policy issue confronting families, employers and governments is no longer

whether individuals will be incentivized to maintain (often inadequate) employer-sponsored insurance, but whether it is more desirable for public coverage subsidized by the federal government (tax-credit defrayed coverage through exchanges) to substitute for other public coverage whose cost is at least shared by state funds (CHIP).

While the rationale behind discouraging crowd-out is questionable as a threshold question, the Academy harbors deep concern regarding the impacts Section 9 would have in states who choose to implement waiting periods on two particularly vulnerable groups of children: the very young and the very sick. Infants need frequent access to well-baby services in the first year of life, and the Academy recommends that all children have coverage for eight such visits by the happy occasion of their first birthday.[vi] In the context of children with special health care needs (as well as those in danger of developing significant health issues), there may be critical clinical reasons why a family would be counseled by a pediatrician to enroll in CHIP coverage, especially in a state in which CHIP finances medically necessary services that other insurance plans may not.

Section 9 of the Draft would create a population of newborn and sick children who would be singularly discriminated against in the US health system: those who may not have access to employer-based or private coverage, but who, for no legitimate health reason, would be barred from federal and state support to access health services. There is no medical basis for this particularly noxious proposed discrimination, and, if enacted, the policy would create a situation in which health financing would be singularly unavailable for highly vulnerable populations of children whose developmental trajectory may have costly impacts on government-funded programs throughout their life course. It should also be noted that well-baby and well-child services are now required to be covered without cost sharing in all non-Grandfathered insurance plans. The Academy would strongly oppose section 9 because it would create a group of second-class child citizens who could not even benefit from this provision of the law available to every other American covered by a non-Grandfathered plan.

Benefits

Beyond coverage, pediatricians clearly recognize the value of age-appropriate insurance benefits.[vii] Academy policy reflects this informed opinion, and calls for all children and adolescents to have a comprehensive age-appropriate benefit package. The health insurance package should cover all pediatric services including preventive and wellness services, acute, inpatient, and chronic care services, including developmental, pregnancy-related and other reproductive health, newborn care, mental and behavioral health, substance abuse disorders, emergency services, facilitative, habilitative, and rehabilitative services and devices, palliative, home health, and hospice care services, prescription drugs, vision care services, and oral health services reflecting the scope of benefits recommended by the Academy and the National Business Group on Health.[viii]

Unfortunately, the unique needs of children are not adequately covered by most private insurance benefit packages. This is why the Academy would oppose Section 3 of the Draft that would limit access to medically necessary services for so-called “stairstep” children. The movement of stairstep children into Medicaid has provided millions of children newly-enrolled in Medicaid

(but financed by CHIP dollars) with the benefit package that the Academy considers to be the gold standard: Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT requires that children in Medicaid have access to all medically necessary services, and grew out of a recognition that the country's military readiness is impacted by the health of the pediatric population.[ix] Simply put, the future health of the nation and its workforce depend on real access to medically necessary services. Recognizing that many stairstep children only recently transitioned to Medicaid, and that a stable connection to a medical home is important to their care, it is unclear why children should be bounced back and forth between benefit packages and insurers. Implementation of section 3 would only exacerbate this retrogressive chaos.

Access

Closely behind coverage and benefits, pediatricians recognize that access to care depends on adequate payment, not because pediatricians are singularly concerned with their bottom line, but because pediatricians experience the frequent challenge of attempting to facilitate children receiving medically necessary care in a health system that is not adequately financed. In concrete terms, children are often "covered" by insurance with benefits including oral health, mental health, and subspecialty services, but their parents and the primary care practice are too often unable to locate providers for these services that will accept the family's insurance.

The original SCHIP legislation included a recognition that access to covered services was critical.[x] CHIPRA also recognized that access was an issue in public programs, and based partially on Academy advocacy, authorized the creation of MACPAC, which has become an important source of data on access and coverage for the Congress.[xi]

The Academy notes that the Draft contains no provisions designed to address access to services once coverage is achieved. Access challenges for children in the context of CHIP and Medicaid are significant, and result from the large state variation and historic underfunding of payment rates in Medicaid. In particular, the Academy strongly supports section 304 of H.R. 919, which would extend a successful program that helps states provide payment rates at least as high as Medicare for primary care services. An earlier provision containing a nearly identical policy has had documented success at improving access.[xii]

Conclusion

Your leadership in continuing the discussion regarding CHIP's future is worthy of the history of the program, which has financed quality, affordable health insurance for millions of children by granting states the flexibility to build upon Medicaid's foundational child health coverage. The strengths of CHIP are clear for the more than eight million children whose care has been financed by the program: CHIP finances superior benefits, affordability and networks for children's health insurance. CHIP also provides a solution for many children who would otherwise fall into the "kid glitch." We urge you to advocate with your colleagues to extend current CHIP law for at least four more years.

We are grateful for the wisdom you have shown on this important issue. The Academy thanks you for your courage in introducing this important legislation. If you or your staff have any questions regarding the Academy's support for CHIP, please contact Robert Hall at 202/724-3309 or RHall@aap.org.

Sincerely,

Sandra G. Hassink, MD, FAAP

Sandra G. Hassink, MD, FAAP
President

SGH:rth

---

[i] See Brief of Amicus Curiae American Academy of Pediatrics, et al., available at http://www.americanbar.org/content/dam/aba/publications/supreme_court_preview/BriefsV5/14-114_amicus_resp_aap.authcheckdam.pdf.

[ii] See Pediatrics. "AAP Principles of Child Health Financing." Committee on Child Health Financing, DOI: 10.1542/peds.2010-2182, originally published online October 25, 2010.

[iii] See Kenney, Genevieve, et al., *Improving Coverage For Children Under Health Reform Will Require Maintaining Current Eligibility Standards For Medicaid And CHIP*, Health Affairs Vol. 30, No. 12 (December, 2011), 2371-2381.

[iv] See generally, Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau of Economic Research Working Paper 12858; January 2007, available at http://www.nber.org/papers/w12858. For a more targeted discussion appropriate to the population at issue, See Dague, Laura, et al., "Estimates of Crowd-Out from a Public Health Insurance Expansion Using Administrative Data," National Bureau of Economic Research Working Paper 17009; May 2011, available at http://www.nber.org/papers/w17009.

[v] For more information regarding the antiquated nature of waiting periods in the context of children's coverage, please See http://ccf.georgetown.edu/wp-content/uploads/2013/12/Making-Kids-Wait-for-Coverage-Makes-No-Sense-in-a-Reformed-Health-System1.pdf.

[vi] See Bright Futures Periodicity Schedule available at http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf.

[vii] Pediatricians responded to an Academy Periodic Surveys in 2008 designed to determine whether, in a system in which all children have insurance coverage, certain aspects of that insurance may be more important than others. Benefits were rated as the most important insurance aspect after coverage. See http://www.aap.org/en-us/professional-resources/Research/pediatrician-surveys/Pages/Periodic-Survey-List-of-Surveys-and-Summary-of-Findings.aspx.

[viii] See Pediatrics. "Scope of Health Care Benefits for Children From Birth Through Age 21," Committee on Child Health Financing, March 2006; 117:3 979-982; doi:10.1542/peds.2005-3204.

[ix] See Rosenbaum, S., Mauery, D. R., Shin, P., & Hidalgo, J. (2005). National security and U.S. child health policy: The origins and continuing role of Medicaid and EPSDT. Washington, D.C.: Department of Health Policy, School of Public Health and Health Services, The George Washington University.

[x] See §2102(a)(7), which required that state plans set forth, "methods (including monitoring) used … (B) to assure access to covered services, including emergency services.

[xi] See 42 USC §1396.

[xii] See Polsky, et al., "Appointment Availability after Increases in Medicaid Payments for Primary Care," N Engl J Med 2015; 372:537-545 February 5, 2015 DOI: 10.1056/NEJM sa1413299. available at http://www.nejm.org/doi/full/10.1056/NEJMsa1413299.