American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

September 16, 2014

Testimony of
James M. Perrin, MD, FAAP, President

On behalf of the
American Academy of Pediatrics

Before the
Senate Committee on Finance Health Care Subcommittee

American Academy of Pediatrics • Department of Federal Affairs
601 13th Street NW, Suite 400 North • Washington, DC 20005
Tel: 800.336.5475 • E-mail: kids1st@aap.org

My name is Jim Perrin and I join you today on behalf of the 62,000 primary care pediatricians, pediatric subspecialists, and pediatric surgical specialists of the American Academy of Pediatrics. I am a pediatrician from the state of Massachusetts, and am currently the President of the Academy.

Let me begin by thanking you for the opportunity you've afforded the AAP to testify before the Senate Finance Subcommittee on Health Care regarding the Children's Health Insurance Program. Since its bipartisan beginnings, CHIP has developed into a critical program for children and their families. CHIP finances health coverage for over 8 million children across the country and has improved three important aspects of children's health: access to coverage for medical services, utilization of those services, and the population health of millions of children who have benefitted from the program.

Coverage is important for a number of reasons. Uninsured children are three times more likely than children with insurance to lack access to a needed prescription medication, and five times more likely to have an unmet need for medical care. In addition, a just-released CDC report proves that uninsured children receive substantially lower rates of preventive care.

I ask you now to turn your attention to the children you know in your life. As you see with your own eyes, these children are not little adults, and we all know that care for children is different and reflects the realities of children's lives in America. For instance, the number one cause of death in U.S. children is injury, not heart disease or cancer; obesity is epidemic; and children and youth with special health care needs constitute around 15% of the population but 40% of the pediatric "spend."

Children manifest specific characteristics that set them apart from adults. Children depend upon caregivers and other adults to detect medical problems, access health care, translate the nature of their symptoms to clinicians, receive recommendations for care, and arrange for and monitor ongoing treatments.

As infants and children are in constant stages of development, their capabilities, physiology, size, cognitive abilities, judgment, and response to interventions continue to change and require continuous monitoring to insure that these changes are proceeding within a positive trajectory and that health care is tailored to their developmental stage.

Most children are healthy so that the epidemiology of pediatric disease is different from the adult population. Care for all children is marked by adequate immunization from infectious disease and well baby/well child check-ups to confirm and support healthy development. Nevertheless large and increasing numbers of children have chronic conditions that affect their health and development and require specific care to generate, maintain, and restore age-appropriate functioning to maximize their potential.

Additionally, children are different because they represent the most economically, ethnically, and racially diverse population in the U.S., with very high rates of childhood poverty. Resulting health care disparities put children at risk of adverse outcomes. These specific differences between children and adults require distinct and specific services for infants, children and

adolescents that include both preventive care as well as the full range of diagnostic, therapeutic, and ongoing counseling and monitoring of all children, including those with developmental disorders, chronic conditions, behavioral, emotional and learning disabilities.

We have not achieved coverage of these services for every child in the US, but we should all be proud and thankful for the vast strides we have made since SCHIP was established. Today, CHIP is critical in helping to ensure that no child falls through the cracks and that the vast majority of US children have access to the high-quality, affordable health insurance they need and deserve even as poverty in the pediatric population has stubbornly persisted. In fact, even with persistent poverty among children since SCHIP's enactment in 1997, the number of uninsured children has been cut in half, while the number of uninsured adults rose significantly. The reauthorization of the program in 2009 included several improvements, such as improved age-appropriate health benefits, including coverage of dental, mental health, and substance abuse services to the same extent as medical and surgical treatments, and a strong federal investment in child health quality improvement.

The AAP urges Congress to fully fund CHIP through at least 2019, and to do so during this Congress for a host of reasons. Initially, pediatricians are intimately familiar with the interaction between the federal and state governments related to Medicaid and CHIP. States in particular need time to plan and an understanding of what the federal government will do to make wise budgetary decisions. Children and families need the stability that a medical home offers and consistent rules regarding what their insurance covers, the managed care company with whom they will interact and the peace of mind that quality, affordable health care offers. Pediatricians need to know that they will be able to operate their practices with a reliable payer so that they can open their medical home to as many publicly-insured families as possible, recognizing that for too long, private insurance payment rates inadequately offset the low payment rates offered by public payers for so many children. Pediatricians will stretch the dollars that are provided to them, but stability and predictability help any business plan and grow.

CHIP works. For children enrolled in CHIP, most research has found that access to care and utilization of primary and preventive care improve after enrollment. Evaluations conducted in individual states or across combinations of states 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. 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. Finally, 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 likelihood of a physician visit and greater declines in rates of uninsurance as a result of the enactment of CHIP when compared with younger children from poor and near-poor households.

Finally, over and apart from the direct effects that CHIP has had on the access, utilization, and the 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 Title IV of the Act. CHIPRA 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 report. CHIPRA also allocated significant catalyzing investments to 10 states – that were collaboratively leveraged by the pediatric community to a total of 18 states – to encourage the creation of on-the-ground quality demonstration projects. In addition, 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.

CHIP has made important contributions to the advancement of health care delivery to near-poor children in recent years and has the potential to accomplish more 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 Congress has yet to appropriate funds for the program beyond 2015), but state-by-state variability in premiums and cost sharing in the form of deductibles, copayments, and coinsurance for CHIP stand-alone programs will need to be minimized to maintain true access to health care services, especially to subspecialty care.

Congress, the Administration, 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.

All those with an interest in advancing child well-being should closely monitor 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.

The AAP offers the following recommendations to strengthen CHIP for children:

- Fully fund CHIP at least through 2019.
- Expand awareness of CHIP among eligible families.
- Facilitate enrollment in CHIP for eligible children.
- Maximize comprehensive coverage and affordability for children whose care is financed by CHIP dollars.
- Enhance the quality measurement funding established in CHIPRA.
- Ensure adequate payment for physicians who care for CHIP patients.

Children and pediatricians owe tremendous thanks to Senators Rockefeller, Hatch, Wyden, and Roberts for their leadership in working to keep CHIP strong for children. America's pediatricians urge Congress to support the efforts of Senator Rockefeller and others in Congress to continue CHIP's success for at least four more years.

Our country cannot let this program end: families with more than eight million children across the country rely on CHIP to finance their health care coverage, and we owe it to them and our country's future to make sure it continues. Thank you again for all you do for children.