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Creating Comprehensive and Stable Health Insurance Coverage for All Children: Identifying and Working to Resolve the "Four-Pathway" Challenge

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National Health Reform and the "Four-Pathway" Coverage Challenge

With the adoption of its FY 2010 budget resolution, Congress has signaled its expectation of action this year on legislation for "making affordable health coverage available for all, improving the quality of health care, reducing rising health care costs, building on and strengthening existing public and private insurance coverage, including employer-sponsored coverage, and preserving choice of provider and plan."[1] Underlying this broad goal lays the extraordinarily complex process of designing health insurance reforms that assure both universal coverage and the financial and operational mechanisms essential to achieving health care quality and system efficiency.

No population stands to gain more from national health reform than children. Although child health is heavily influenced by social and environmental factors;[2] access to early and continuous health care plays a vital role in children's healthy development, as well as in the amelioration of physical and behavioral health conditions that can impair children's passage through infancy, childhood, and adolescence.[3] In the U.S., where health care and health care financing move along parallel but separate tracks, creating high quality pediatric health care depends heavily on the extent to which child health coverage itself is stable and uninterrupted, with standards of coverage and payment that reflect the best thinking about the process and outcome of care.[4]

It is early in the legislative process of course, and the precise structure of health reform cannot yet be known. But the broad goals set forth by the President and Congress offer insight as to the model of coverage that might emerge. This emerging coverage model, which bears

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[1] Cong. Budget Resolution (April 2, 2009) §301.

[2] Neal Halfon et. al., "Transforming the U.S. Child Health System," *Health Affairs* 26:2 (March/April, 2007) http://content.healthaffairs.org/cgi/content/abstract/26/2/315?ijkey=G8P2i9LG4mR6.&keytype=ref&siteid=healthaff (April 4, 2009)

[3] Sara Rosenbaum and Paul Wise, Crossing The Medicaid–Private Insurance Divide: The Case Of EPSDT, *Health Affairs* 26:2 (March-April 2007) pp. 382-393.

[4] Lisa Simpson, et. al., Reauthorizing SCHIP: Opportunities for Promoting Effective Health Coverage and High-Quality Care for Children and Adolescents (Commonwealth Fund, 2008) http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Aug/Reauthorizing-SCHIP--Opportunities-for-Promoting-Effective-Health-Coverage-and-High-Quality-Care-for.aspx (April 4, 2009)

resemblance to the one enacted by the Massachusetts legislature in 2006,[5] translates on a national stage into what might be thought of as a **multiple-pathway model of health care financing:** (1) Medicaid; (2) the Children's Health Insurance Program (CHIP) (in states that administer Medicaid separately from CHIP); (3) employer-sponsored insurance for individuals with access to coverage through an employer plan; (4) Medicare for older persons and certain persons with disabilities; and (5) and financing via a new group purchasing arrangement (sometimes referred to as a health insurance "exchange" (HIE)). An HIE, in turn, might be federally or state-administered and which offers an array of affordable and accessible health plan products (including possibly a public plan product) to individuals who enroll through the HIE, as well as to employers that elect not to sponsor their own plan. Since the CHIP expansions will reach only an estimated 4-5 million of the nearly 9 million uninsured children in 2007,[6] children will depend on the new HIE pathway as it is developed.

With the exception of Medicare, which provides coverage only to a very small number of children with end stage renal disease (ESRD), the principal pathways that children will travel consist of the first four, that is, Medicaid, separate CHIP programs, ESI, and an HIE in the case of children without any of the other three forms of plan sponsorship. The advantage of this model is that it provides a coverage pathway for all children. The disadvantage is the potential created by a four-pathway model for coverage disruption.

Having multiple pathways to coverage -- at least two of which are income-sensitive -- mean that even modest fluctuations in family income or changes in family circumstances can move children from pathway to pathway and lead to breaks in coverage. Imagine, for example, a child in a family with two parents who, over a two-year period, change jobs, experience job loss, and are affected by fluctuating income and periods of unemployment. Depending on the state in which the family resides, it is conceivable that the children in such a family could literally move through all four pathways over a 24-month time period, as the family's income and changing job status move the child's coverage among Medicaid, CHIP, into ESI, and then out of ESI and into the connector.

Reducing coverage breaks in Medicaid and CHIP was a primary goal of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA),[7] but the techniques for promoting continuity of coverage are a state option, and it is not possible to know how many states will pursue them. (Past history suggests that during periods of economic downturn, states

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[5] Leighton Ku, et. al., *How Is The Primary Care Safety Net Faring in Massachusetts? Community Health Centers In The Midst of Health Reform* (Kaiser Commission on Medicaid and the Uninsured) *http://www.kff.org/healthreform/upload/7878.pdf (April 4, 2009)*

[6] CHIPRA is expected to reduce the number of uninsured children from nearly 9 million in 2007 to between 4 and 5 million children by 2013. Kaiser Commission on Medicaid and the Uninsured, *Next Steps in Covering Uninsured Children: Findings from the Kaiser Survey of Children's Health Coverage* (Washington D.C., January 2009); Kaiser Commission on Medicaid and the Uninsured, *Children's Health Insurance Program Reauthorization Act of 2009(CHIPRA)* http://www.kff.org/medicaid/7863.cfm (April 4, 2009)

[7] Georgetown University Health Policy Institute, Center for Children and Families, *The Children's Health Insurance Program Reauthorization Act of 2009* (Washington D.C. March, 2009)

scale back previous reforms aimed at achieving stable and uninterrupted coverage as a means of saving money).[8]

The consequences that flow from multiple coverage pathways create additional challenges for pediatric health care quality and quality improvement. In health insurance parlance, each separate pathway (Medicaid, CHIP, HIE coverage, and ESI) can be thought of as a "group health plan sponsor." Furthermore, in the modern insurance system, public and private group health plan sponsors seek not simply coverage against medical costs for plan enrollees but also membership in a system of health care, incentivized to high performance.[9] Thus, as plan sponsorship changes, so does the potential for a change in health care itself, raising the possibility of health care fragmentation: each sponsor could (and indeed does) maintain its own coverage rules, separate contracts with different health insurers and plan administrators, each of which select its own networks, uses its own quality, efficiency, and reporting standards, sets its own payment terms, and calibrates payments and incentives to its own preferences.

In short, under a multi-pathway scenario, not only would children's coverage fluctuate, but in caring for their patients, health professionals and health care providers could find themselves in constant flux as well, as the plan sponsor and plan administrator or insurer changes. In order for coverage to remain affordable and accessible, families must switch their children from sponsor to sponsor, thereby increasing the likelihood that children's providers will not be able to maintain ties to their patients. Plan switching also creates greater uncertainty for both parents and providers regarding coverage, the services that treating providers will be paid to furnish, the treatments that any particular health plan will finance, and the measures of quality that providers will be expected to adhere to and about which they will be expected to report.

CHPRA contains important provisions that, if jointly pursued by all group plan sponsors over time, may result in the development of common child health performance measures.[10] But as with state options for rapid enrollment and retention, how voluntary adoption will unfold cannot be known at this point. The problems associated with coverage instability are serious for any child, but especially so for children with serious and chronic health conditions for whom stability and continuity are considered crucial by pediatric sub-specialists and experts.

Of course, this set of problems is not new, since today's system of health care financing already creates multiple coverage pathways. At the same time, there is a special case to be made for attempting to reduce this fluctuation as part of national health reform, at least in the case of children. This special case rests on two considerations. The first is the critical role played by health care continuity in the case of child health and development; the second is the low cost of health care for children in comparison to the cost of adult care (child health care costs average

[8] Donna Cohen Ross and Laura Cox, *Beneath the Surface, Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families* (Kaiser Commission on Medicaid and the Uninsured, 2004) http://www.kff.org/healthreform/upload/7878.pdf (April 4, 2009)
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[10] Georgetown University Health Policy Institute, Center for Children and Families, *The Children's Health Insurance Program Reauthorization Act of 2009* (Washington D.C. March, 2009)

two-thirds those of adults).[11] Because children have relatively low health care costs, there could be room in health reform for innovations that – at least in the near term – may prove too costly for adults but that could go a long way to achieving both universality and stability.

Integrating Coverage Pathways and Achieving More Stable, Continuous, and High Quality Coverage as Part of National Health Reform

The aim of this proposal is to assure unbroken, continuous, and comprehensive coverage of children, creating conditions under which health care financing ultimately is positioned to better align with stable and high quality medical care anchored in the concept of a medical home and capable of meeting the full continuum of child health needs in coordination with educational, community health, and social service resources. This proposal is designed to work in a multi-sponsor system of health care financing of the type that appears to be the direction in which the President and Congress are moving.

1. Make all children eligible for coverage through the health insurance exchange

Presumably it will take a significant period of time to put a nationwide system of health insurance exchanges into place and to begin to enroll eligible individuals. During this transitional period, eligible children would remain in Medicaid, CHIP, and, of course, their existing employer-sponsored plans. Once the exchanges begin to enroll individuals and families with children, CHIP (which, in states with separately administered programs, typically operates as what can be thought of as a "mini" health insurance exchange for pediatric coverage products) might then be absorbed into the exchange system itself, thereby ceasing to operate as an independent group health sponsor. (To the extent that CHIP also acts as a premium subsidy for families wishing to enroll in an employer plan that is available, the exchange could continue to offer this as an option).

In addition, all Medicaid-covered children, both basic and CHIP expansion, could receive their *primary coverage* through a health plan product offered in their HIE. Most Medicaid children already are enrolled in comprehensive managed care plans, and thus the structure of sponsored coverage would essentially remain the same. Instead, however, state Medicaid agencies would make premium payments made to the HIE, and at HIE rates, in order to eliminate the pricing differentials that can drive down plans' and providers' willingness to treat low income children when the plan sponsor is Medicaid. Because children experience relatively low annual costs on average, the total cost impact associated with payment of Medicaid premiums pegged to HIE product pricing, rather than the lower prices that Medicaid agencies tend to pay, can be expected to be relatively modest.

This merger of publicly sponsored children into the exchange system at the time that other families begin to secure exchange products approach to covering children would leave only

[11] EPSDT and Children's Coverage Costs http://www.commonwealthfund.org/Content/Publications/Data-Briefs/2005/Sep/EPSDT-and-Childrens-Coverage-Costs.aspx (April 4, 2009). For example, in FY 2001, per capita costs for children in Medicaid averaged $1315, compared with $1,736 for adults.

children with ESI outside of the exchange system. (These children, of course, would be immediately eligible for HIE plan enrollment if their ESI were to be lost or interrupted).

The inclusion of all children without ESI in HIEs for their complete (or, in the case of Medicaid-eligible children, their primary) coverage could be expected to have three principal effects. The first would be to dramatically improve the potential for uninterrupted coverage as a result of modest income fluctuations or family or job changes. Medicaid and CHIP (now absorbed into the exchanges) would pay for exchange coverage, and exchanges would subsidize children's enrollment in exchange products in accordance with a system of subsidies ranging from complete subsidization in the case of the poorest children to partial subsidies for low and moderate-income children, as is the case with CHIP today.

The second principal effect would be the greater unification of health care quality improvement strategies within and across specific health care market regions. Exchange products would be drawing from the same pool of health care professionals and providers, thereby allowing health plans and exchange sponsors, in collaboration with health care providers, to develop and test common performance approaches and pediatric payment methods, as envisioned over the long term by the 2009 CHIPRA quality amendments.

The third principal effect is that the pool of individuals who derive coverage through the exchanges eventually would include more than 30 million additional children, This would appear to be an important consideration in relation to the overall financial stability of the exchange system, whose products can be expected to operate on the basis of modified actuarial principles capable of accommodating individuals across the age and health spectrum.[12]

2. Incorporate strong pediatric standards into the design of HIE health plan benefit products along with special pediatric cost-sharing protections

Under this approach, the health benefit products offered through HIEs, along with employer-sponsored plans, would become the dominant mechanism for financing the bulk of preventive, primary, and acute pediatric health care in the U.S. Under standards that have been developed for CHIP both initially and as part of the 2009 amendments, the pediatric standard of coverage for actuarially based products has evolved to consist of a benchmark pegged to widely available employer-sponsored products and well baby and well child care, all CDC-recommended childhood immunizations, adherence to key insurance protections such as mental health parity, and supplemental dental coverage.

In order to strengthen this evolving pediatric standard of insurance custom, the following elements could be added. The first would be the use of comprehensive pediatric developmental approaches to care in guiding coverage and payment, such as that articulated in the American Academy of Pediatrics' *Bright Futures* initiative.[13] A second addition would be vision and eye care benefits. A third change would be the use of a "pediatric medical necessity standard" that emphasizes the attainment and maintenance of healthy growth and development, as well as the amelioration of physical and mental health conditions that can affect growth and development.

[12] Robert Pear, Insurers Ease Stance on Pre-Existing Conditions, *New York Times* (March 24, 2009)
[13] Complete information about Bright Futures can be found at http://brightfutures.aap.org/ (April 4, 2009)

This special standard of medical necessity would mean that coverage decisions related to health care for children achieve alignment with the special standard of pediatric practice that guides the child health profession.

Exchange products, like CHIP and Medicaid products today, also could be designed to contain special cost-sharing features in the case of children whose enrollment is subsidized. Because of the special cost sharing rules that apply under Medicaid and separate CHIP programs, both Medicaid and CHIP agencies and the health plans with which they do business, have developed the types of technologies needed to adjust cost-sharing at the point of service, and (which can be offered as a supplement under CHIP) (which include along with employer-sponsored plans.

3. Retain the Medicaid entitlement for low income children in order to continue access to comprehensive coverage for a full range of treatments, in community settings, for preventive, primary, and serious and chronic health conditions

Even were pediatric quality standards of the type described above to be applied to all exchange products, they would inevitably offer less comprehensive coverage than Medicaid, as a result of Medicaid's special Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.[14] This benefit, which has no equivalent in the traditional private health insurance market (even one that is enriched as described above), does several things that health insurance ordinarily does not do:

- Medicaid covers classes of services (such as case management and personal attendant services) that are not typically found in commercial insurance

- Medicaid covers services in greater amount duration and scope than is the case for commercial insurance (e.g., physical or speech therapy needed to ameliorate the effects of a condition over time, without any fixed numerical or durational limits such as 10 visits in a 12-month period)

- Medicaid contains no treatment exclusions related to certain physical or mental conditions, a practice that is common to health insurance;

- Medicaid covers more procedures and treatments within a covered benefit class than might be the case for commercial insurance (e.g. longer term treatments for certain conditions as well as short term treatments)

- Medicaid utilizes a preventive and ameliorative pediatric medical necessity standard

- Medicaid permits coverage of health care treatments even when they are furnished in non-traditional settings (e.g., health care and case management in schools, child care programs, programs serving children receiving early intervention services, health services furnished from mobile vans or in homeless shelters or farmworker camps)

[14] "Crossing the Medicaid-Private Insurance Divide" *op. cit.*

- Medicaid pays for transportation services and special administrative supports such as public health nursing

- Medicaid pays special rates to health care safety net providers such as rural health clinics and community health centers in recognition of the additional costs they incur in providing special services and family supports such as translation and family support activities.

In light of the higher social and health risks faced by low income children, it is essential that Medicaid be retained for eligible children who are entitled to its coverage, even though they may derive their *primary* coverage through an exchange plan. This primary/secondary coverage relationship (which could be thought of as tiered coverage) is one that is envisioned under Medicaid's third party liability recovery provisions, which provides for coordination of benefits between Medicaid and primary insurers. Furthermore, in today's Medicaid managed care market, states vary in their approach to EPSDT coverage. Some include all EPSDT benefits in their contracts, while others remain the direct payer for (i.e., carve out) other services such as services furnished in schools and other non-traditional settings, higher levels or additional amounts of treatment beyond levels specified in their contracts, services in community or home settings. Numerous states also retain direct responsibility for making supplemental payments to safety net providers. While coordination of benefits is complex, it is an undertaking with which Medicaid (and some CHIP) agencies are familiar, and coordination principles can be articulated in both the Medicaid program and in the contracts between state agencies and exchange plans.

4. Permit parents of Medicaid-eligible children to enroll in health insurance exchange plans in order to preserve the principle of family coverage

Families enrolling in an exchange plan obviously would enroll as a family. But a question that arises in the scenario set forth here is how to preserve family enrollment in the case of low income families whose parents derive their subsidies through Medicaid rather than the exchange. One option would be to allow Medicaid-subsidized parents to enroll in an exchange plan along with their children. In this way, families could remain together as an enrollment group, regardless of whether their own premiums are subsidized by the Medicaid program or by the exchange.

Medicaid programs would pay the family subsidy to the HIE. In addition, states could be permitted, as is the case with optional Medicaid benefits today, to offer supplemental coverage to adults for services of great importance but potentially beyond the limits of exchange products for adults. Examples would be vision and dental care, a broader prescription drug formulary, or additional levels of rehabilitation coverage and specialized disease management coverage for parents with serious and chronic health conditions. As is also the case today, states would continue to pay special Medicaid rates to certain safety net providers who treat Medicaid patients, in recognition of higher levels of family, language, and other supports they furnish.

5. Require Medicaid participation by exchange health plans and align Medicaid conditions of participation with those that apply to the exchange

Obviously if Medicaid agencies are to enroll children in exchange plans and pay their premiums, they need to have contracts with the plans, and plans of course need to have a contractual relationship with state Medicaid agencies. It is far too early to know what conditions will attach to exchange plan participation, although even the managed care industry appears to envision not only prohibitions against enrollment denials but also more robust conditions for coverage and performance.[15] In this regard, the Medicaid conditions of participation for health plans mirror the types of common sense ground rules that would apply to any purchasing market: comprehensive information and disclosure to prospective and actual enrollees; clarity of coverage; adequacy of network; internal quality improvement oversight and measurement capabilities; external performance reporting; solvency and good business practices; and consumer protections related to emergency care, grievances and appeals, and coverage decisions. This managed care performance framework, which resembles that found in CHIP and Medicare, serves as a jumping-off point for exchange performance standards. At the point at which Medicaid begins to sponsor children's and families' exchange enrollment, performance standards could be aligned.

Concluding Thoughts

The full dimensions of national health reform will be put into place over many years. As each phase of reform is implemented, the key question becomes the vision that guides its evolution. Given the unique role played by health care in child health and development, the vision that should guide child health policy in health reform is an endpoint that promotes stability, equity, quality, and comprehensiveness. Achieving this endpoint necessitates not only more coverage but also a broadly-conceived effort – essential to the success of a multi-payer system – to reduce the risk that children will fall through coverage cracks or that the fragmentation and inefficiencies that affect pediatric health care today will remain unaddressed.

This analysis offers one approach to resolving the multi-pathway challenges that inevitably are the result of multiple group sponsors. It seems clear that a system that utilizes a single sponsor, whether publicly or privately administered, probably would achieve the end result with greater ease. But as Congress prepares to move down a multi-payer road, this proposal represents an attempt to assure that to the greatest degree possible, a multi-payer strategy moves children, along with the broad goals of pediatric health quality, successfully toward a future finish line.

[15] "Insurers Ease Stance," *op. cit.*