July 31, 2021

The Honorable Frank Pallone, Jr.                                                                   The Honorable Patty Murray
Chairman                                                                                                                       Chair
House Committee on Energy and                                                                 Senate Committee on Health,
Commerce                                                                                                                    Education, Labor & Pensions

Dear Chairman Pallone and Chair Murray,

As organizations dedicated to promoting the health of our nation’s children and pregnant women, we write to offer comments on the request for information (RFI) on public option legislation intended to expand access to quality coverage, improve affordability for families, and lower health care costs. We thank you for gathering stakeholder input on this important topic and share your vision that quality, comprehensive and affordable health care coverage must be universally available to everyone, regardless of income, age, race, disability, sexual orientation, or zip code.

As you craft legislation that establishes a federally administered public option to work towards achieving universal coverage, it is imperative that the unique needs of children are not forgotten. We must build on what is working for millions of children, pregnant women and their families by keeping Medicaid and the Children's Health Insurance Program (CHIP) strong. We must also work to cover all children and assure that all coverage sources provide children with access to timely, age-appropriate and affordable health care services (including dental, vision, hearing, mental health and pediatric specialty services) that meet their individual developmental needs and enable them to meet their full potential as adults.

Children are not little adults; they require services and care specifically suited to their unique developmental needs. Because of their continuous growth and development, children need a full set of pediatric and age-appropriate services. Missed screenings, diagnoses, and treatments can result in life-long health consequences that generate extensive and avoidable costs. When children see clinicians who know their medical history, can monitor their physical and socioemotional development, and provide them with appropriate interventions, they are more likely to have better overall health, be up-to-date on immunizations, perform better in school and receive care in the most cost-effective way.

Child health is also a strong predictor of adult health. Addressing health and development throughout childhood—from birth through adolescence—reduces school absenteeism and improves children’s readiness to learn leading to improved life outcomes, including better earning potential and overall health status. Conversely, the inability to access health care services threatens the physical, mental, and social health and well-being of children and their caregivers.

Over the last fifty years, our country has made tremendous progress ensuring children have access to comprehensive, high-quality, and affordable health coverage. From 1984 to 2016, the percentage of uninsured children declined from 29 percent to 4.5 percent. Thanks to Medicaid, CHIP, and the Patient Protection and

1 The Link Between School Attendance and Good Health. Mandy A. Allison, Elliott Attisha, Council on School Health. Pediatrics Feb 2019, 143 (2) e20183648; DOI: 10.1542/peds.2018-3648. https://pediatrics.aappublications.org/content/143/2/e20183648
Affordable Care Act (ACA), our nation had brought the rate of uninsured children to a record low. But over the last few years that progress slowed, stalled, and then reversed course. According to 2020 data from the US Census Bureau, 4.4 million children (5.7%) under age 19 lack the health coverage they need to survive and thrive. Between 2017 and 2019, 726,000 children lost health insurance, meaning much of the gain in children’s coverage from the ACA’s major coverage expansions implemented in 2014 was eliminated. These coverage losses occurred in a healthy economy with the lowest unemployment rate in decades prior to the economic shocks and job loss associated with the COVID-19 pandemic.\(^2\)

As millions of families experience financial stress during the COVID-19 pandemic and economic downturn, Medicaid and CHIP continue to act as an essential lifeline for children and families, ensuring children have access to vital services like vaccinations, developmental screenings, and appropriate treatment for acute, chronic and complex conditions. Between February 2020 and January 2021, nearly 10 million people enrolled in Medicaid and CHIP, including 3 million children. The programs are cost-effective, well-suited to distribute resources quickly and equitably to areas of greatest need and were designed based on the specific needs of children. They must be strengthened by increasing resources to improve outreach and enrollment, streamline eligibility, improve network adequacy, and reduce barriers to access.

We must continue to work towards a high-quality health care system that meets all children’s needs, regardless of their source of coverage. Any changes to our health care system must further improve coverage for children and pregnant women. They must not lose ground. It must be the primary responsibility of our federal and state leaders to protect and improve children’s coverage, regardless of its source.

Our guiding principles for protecting and improving health for all children are attached, and our more detailed comments are below.

**Coverage for Children Should Be Universal**

All children, adolescents, and young adults from birth to the age of 26 years who reside within our borders, regardless of income, race, sexual orientation, family composition, or immigration status, should be covered by an affordable, quality health insurance plan that allows access to comprehensive, essential care. Accessible health insurance coverage should pose minimal enrollment and renewal burdens, commence with the minimal waiting period needed to verify eligibility, offer continuous eligibility for a minimum of 12 months, and be portable across states. Health coverage for children must be reliable, stable, and consistent to prevent abrupt terminations, transitions, or waiting periods that could leave children with inadequate or no coverage. Pregnant women should have continuous coverage throughout their pregnancy with consistent access to their maternity care providers. If a change in coverage is necessary, transitions must be seamless and allow for a continuation of needed services and providers to maintain existing provider-patient relationships and ensure children and pregnant women have timely access to needed care in their medical and dental home.\(^3\)

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\(^3\) Principles of Child Health Care Financing. Mark L. Hudak, Mark E. Helm, Patience H. White, Committee on Child Health Financing. Pediatrics Sep 2017, 140 (3) e20172098; DOI: 10.1542/peds.2017-2098 https://pediatrics.aappublications.org/content/140/3/e20172098
Expanding coverage to parents and caregivers also has positive impacts on children. A comprehensive body of research highlights the powerful effect of increases in parental access to insurance coverage on their children’s access to insurance coverage. In fact, from 2013-2015, 710,000 children who were already income-eligible for Medicaid gained coverage, despite the fact that these children’s eligibility for coverage did not change under the Affordable Care Act. This is due in large part to parents gaining coverage under the Medicaid expansion and realizing that their children had been eligible for Medicaid all along. Research also demonstrates that when parents have health insurance, children are more likely to get the care they need. Increases in adult Medicaid eligibility levels were associated with a greater likelihood that children in low-income families received at least 1 annual well child visit. These findings reiterate the importance of parental coverage in ensuring that children can get the care they need to learn, grow, and thrive.

**To Meet Children’s Unique Needs. Look to Medicaid as the Standard for Benefit Design**

All children must have health coverage that provides all medically necessary, age-appropriate benefits to promote healthy child development, and all pregnant women must have coverage for maternity and newborn care. Medicaid—unlike most private health insurance plans—provides that coverage for children through its Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which guarantees specific benefits designed especially for children. EPSDT is the definitive standard of pediatric care, covering all preventive, diagnostic, and treatment services that are medically necessary for children, including those who have a chronic condition, functional impairment, or significant or multiple health risks. Through EPSDT, children have an array of services including developmental, dental, vision and hearing screenings, mental health services, and home and community-based services allowing health problems to be diagnosed and treated appropriately and as early as possible.

Using EPSDT as the model, pediatric benefits must be defined to include comprehensive dental, vision, physical and behavioral health services, as well as appropriate services and devices for children with special health care needs and complex or chronic health conditions — such as pediatric physical, occupational and speech therapies, home and community-based services, habilitative services, care coordination and case management, DME, etc. — without arbitrary limits or restrictions as the child grows and develops. In addition, there must be comprehensive coverage for maternity and newborn care to ensure pregnant women get the care they need to have healthy pregnancies and give birth to healthy infants. The benefit package should include the full scope of pediatric services outlined in the American Academy of Pediatrics’ Bright Futures guidelines and maternity care (preconception, prenatal, labor and delivery, and postpartum), as recommended by the Guidelines for Perinatal Care issued jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. These services reflect the latest clinical evidence available regarding effective, appropriate care to ensure the best health outcomes for women and their children.

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7 https://ebooks.aappublications.org/content/guidelines-for-perinatal-care-8th-edition
Because of their continuous growth and development, children's need for comprehensive benefits is particularly acute. Failure to ensure an adequate scope and design of benefits for children can result in life-long health consequences that generate extensive and avoidable costs. Any benefit design in a public health insurance option must ensure that children's specific needs will be met and should look to Medicaid as a baseline standard rather than using the essential health benefits (EHB) under the ACA as a model. Our organizations remain concerned with the adequacy of benefits for children in plans enrolled in the federal and state exchanges as those benefits are modelled after plans that are better suited to adults than children. The plans that serve as benchmarks for the exchange plans were not developed with consideration of children’s unique needs, unlike the EPSDT benefit standard. Children often need services with greater frequency and intensity than adults, so certain benefit limits (for instance, limits on number of visits, frequency of service or device replacement, etc.) established for adults may be inappropriate for children who are continuing to develop and grow. As such, we reiterate our strong belief that the federal government should establish a broader, federalized definition of pediatric services, based on Medicaid's EPSDT benefit, for all coverage sources that includes the full range of services children need for healthy development.

To ensure that the inclusion of the full range of services are covered, the HHS Secretary must be required to develop a standardized definition, of medical necessity, including a specific standard of pediatric medical necessity to be applied on a case-to-case basis, to assure that children and others can access essential health benefits meaningfully and consistently. In line with the AAP, the pediatric definition of medical necessity should be as follows: “health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the AAP, to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.”

### Affordability of Coverage

All children and pregnant women must have access to health care that is affordable for their families. Children and pregnant women must be able to get the care they need when they need it without jeopardizing their families' financial security. Research has demonstrated that cost-sharing for those with low incomes can prevent individuals eligible for coverage from enrolling, and those enrolled in coverage from seeking care. Even small cost sharing amounts can have these effects.

Public and private payers should establish cost-sharing policies that ensure affordability of health services for the entire range of household income. Annual out-of-pocket limits should be established at reasonable levels as a function of family income to protect families from significant medical debt. Deductibles, as well as copays and coinsurance charges per service or treatment, should not inhibit access to preventive or necessary care, regardless of the source of coverage. Reasonable out-of-pocket limits on premiums, deductibles and cost-

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sharing, such as those in Medicaid and CHIP, must be preserved. Such reasonable limits can protect families with children, especially children with special health care needs or complex conditions, from economic hardship. Financial protections are important for families across the economic spectrum, especially those who have limited resources.

Specifically, our organizations support the exemption of certain services, including primary care services, specialty visits, and generic drugs from any form of cost-sharing. We also believe that habilitative services should be exempt from cost-sharing, rather than limiting the exemption to rehabilitative services. Habilitative services and devices are designed to assist individuals in acquiring, improving, or retaining, partially or fully, skills and functioning related to activities of daily living and instrumental activities of daily living in the most integrated setting appropriate to their individual needs. As such, those services have not been considered rehabilitative and have been excluded in some plans. Coverage of habilitative services and devices is a critically important benefit for children who may suffer from a condition at birth (such as cerebral palsy, autism or spina bifida) or from an illness or injury that prevents normal skills development and functioning. The exemption of these services from cost-sharing reduces financial barriers to needed care and can help encourage families with children to seek care when they need it.

**Improving Access: The Right Care to The Right Child at The Right Time in The Right Setting**

According to CMS, Medicaid’s EPSDT benefit is designed to “assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.” Our groups believe that this bold vision statement should be adopted by lawmakers as they consider legislation to create a public option.

For children to receive accessible, continuous, comprehensive, and coordinated care from the medical home, payment for services must be timely and adequate. Payments for pediatric health care services must be structured to achieve parity with payments for similar services for adults.

Additionally, federal network adequacy standards are needed that assure access for children, especially those with special health care needs, serious or chronic health conditions, limited English proficiency, and those who are experiencing mental health or other challenges. These standards must ensure that provider networks include the full range of pediatric primary, ancillary, specialty, and subspecialty providers who typically care for children to ensure access to all covered benefits. Provider networks must be capable of providing services for all levels of complexity, including for rare conditions, without administrative or cost barriers for consumers.

Unfortunately, health insurance coverage does not always equate to adequate access to care. Many barriers currently exist that prevent children, regardless of their coverage source, from accessing the care that they need. This is especially true for children with medically complex conditions that may require specialized diagnostic or treatment services that are not readily available from providers in their state. Families seeking pediatric specialty care may have to travel hours to find a qualified specialist. Referring clinicians struggle to get the necessary prior authorization to allow their patients to seek care across state lines. Specialty clinicians

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on the receiving end of the referral face difficulty receiving payment for their services rendered. Overall, the process can be cumbersome for patients, families, and providers, contributing to delays in care.

All children must have timely access, without administrative barriers, to the full range of age-appropriate health care providers, including pediatric and perinatal specialists, subspecialists, and facilities. Children require developmentally appropriate and timely care from in-network primary, specialty, subspecialty, and ancillary pediatric providers with the training and expertise to care for children, regardless of where they live, even when those providers are in another state or region. Administrative requirements should not create obstacles for children and families in accessing the health care they need. It is imperative children receive preventive care, well-child visits, and developmentally appropriate screenings to identify challenges early and that they continue to access needed treatment services to achieve and maintain their highest level of functioning. Longer lag times between symptom onset and treatment due to challenges accessing needed services may not only result in poorer outcomes, but also in greater costs to patients and the health care system.

As Congress considers possible legislation to create a public option, our organizations are compelled to illustrate the importance of adequate payment and its relation to access to care. For example, Medicaid fee schedules and capitated payments to primary care and subspecialty physicians are significantly lower than payments for comparable services from Medicare and private insurance companies. Low Medicaid payment rates, delayed or unpredictable payments, and confusing or burdensome payment policies and paperwork are primary reasons that physicians limit participation in the program, leaving patients facing barriers to access for primary care and subspecialty health care services.\textsuperscript{12} Even at academic medical centers that serve as “safety nets” for uninsured or underinsured patients, reduced access for children enrolled in Medicaid may manifest as significantly longer wait times for subspecialty care.\textsuperscript{13} Raising Medicaid payment rates to adequate levels, reducing administrative burden to enroll and participate in Medicaid programs, and increasing certainty of payment can increase physician and hospital capacity and improve access for children enrolled in Medicaid.\textsuperscript{14} A recent study demonstrated that the short-term increase in Medicaid payments for primary care services in 2013-14 resulted in greater physician participation in the Medicaid program.\textsuperscript{15} On the contrary, recent studies found that profound pediatric workforce shortages are occurring in poorly paid subspecialties.\textsuperscript{16}

Furthermore, pediatric-appropriate federal network adequacy standards for all types of coverage are critical to helping ensure that families are not faced with exorbitant out-of-pocket expenses because they must seek out-of-network care for their child as there is not an appropriate in-network provider. In addition, standards must assure that all provider networks include perinatal providers to ensure timely access to maternity and newborn care.

\textsuperscript{12} AAP Survey of Pediatrician Participation in Medicaid, CHIP and VFC. Elk Grove Village, IL: American Academy of Pediatrics; 2012
\textsuperscript{14} Medicaid Policy Statement, Committee on Child Health Financing, Pediatrics May 2013, 131 (5) e1697-e1706; DOI: 10.1542/peds.2013-0419. https://pediatrics.aappublications.org/content/116/1/274
\textsuperscript{16} Differences in Lifetime Earning Potential for Pediatric Subspecialists. Eva Catenaccio, Jonathan M. Rochlin, Harold K. Simon Pediatrics Apr 2021, 147 (4) e2020027771; DOI: 10.1542/peds.2020-027771. https://pediatrics.aappublications.org/content/147/4/e2020027771
Children must have access to a sufficient range of pediatric providers with the training and expertise to provide appropriate, high-quality, and cost-effective care, including mental health care, for children who are generally healthy as well as those with the most complex and chronic conditions. Provider networks must ensure access to needed pediatric providers regardless of the state in which they live. Children with serious, chronic or complex health conditions, including children with special health care needs, must have in-network access to a range of pediatric providers, including primary, specialty and subspecialty care physicians (such as pediatric medical subspecialists and pediatric surgical specialists); pediatric nurse practitioners; pediatric mental health providers; other pediatric clinicians; and children’s hospitals to ensure that their particular health conditions are appropriately addressed.

Federal time and distance standards would be a generally appropriate measure of a network’s pediatric primary care capacity but cannot account for the many children who travel long distances and across state lines to receive necessary care from appropriate pediatric specialty providers, including children’s hospitals. A comprehensive, multi-faceted set of federal quantitative standards—such as enrollee ratios by specialty; wait times by specialty; geographic accessibility, etc.—will help assure that children have in-network access to the full range of covered services. An objective federal network adequacy standard must also include strong oversight and monitoring of networks to identify and address pediatric provider network gaps or barriers to access.

**Ensuring High Quality Care**

Children need quality initiatives specific to their unique needs and quality measures that can accurately assess their outcomes. CHIPRA’s Title IV created the Pediatric Quality Measures Program (PQMP) that plays a leading role in pediatric and perinatal measurement science, which includes developing, testing, refining and implementing quality measures; spreading measure use broadly; and maintaining and re-evaluating measures over a multi-year period. These measures need to draw upon the knowledge base of effective preventive, primary, and developmental child health services and respond to poverty and other social, as well as biomed, determinants of health.

The enactment of CHIPRA created the preliminary infrastructure needed for sufficient pediatric quality reporting: more than half the states report on the majority of the Child Core Set measures, PQMP’s Centers of Excellence have produced a number of needed pediatric-specific measures, the Secretary of HHS has promulgated a yearly report on the status of pediatric health care quality in the United States, and a higher match rate has been established for information system upgrades. Nevertheless, children and pregnant women continue to face challenges in achieving optimal health, so it is imperative that our quality measurement programs keep evolving to address them.

The Child Core Set, established under CHIPRA, leads the way as the first and only national set of pediatric-specific measures, but additional work remains to be done. For example, the Child Core Set does not yet address some of the key drivers of child health outcomes and health care spending, such as children with medical complexity or social and environmental determinants. Moreover, only one of the measures assesses inpatient care and no measures specifically address care for children with complex conditions (chronic or acute). It is critical to evaluate the Child Core Set systematically and regularly for any outstanding gaps drawing from evidence-based and expert consensus engaged in meaningful child health improvement initiatives, e.g., the National Quality Forum’s Child Medicaid workgroup and the CHIP Measure Applications Partnership.
committee. The investment in pediatric- and perinatal-specific measurement science requires continual support through PQMP similar to the support provided to measurement science efforts for seniors through Medicare.

Additional efforts must also be made to improve and align reporting on the Child Core Set. While major strides have been made to encourage state reporting, there is more work to do. The Child Core Set should set a standard for all payers, not just Medicaid and CHIP. Beginning in 2024, all states will be required to report the Child Core Set for Medicaid and CHIP populations. To achieve a more comprehensive understanding of quality for all children and reduce the reporting burden on plans and providers, the Child Core Set should be extended to all payers of child health care. This would replace the patchwork of misaligned and sometimes inappropriate measures. Moreover, to accelerate alignment, providers and payers should be encouraged to participate through financial support.

High quality care is informed by robust quality measurement. Quality improvement efforts must continue and be strengthened to help improve outcomes for children and pregnant women. As Congress considers possible legislation to develop a public option, we urge lawmakers to strengthen requirements to report on national pediatric-specific and maternity quality health care measures to assess and improve the quality of care on an ongoing basis.

**Other Considerations: Addressing Social Determinants of Health and Evaluating Return on Investment**

The RFI explicitly asks stakeholders what role a public option could play in addressing broader health system reform objectives, such as delivery system reform and addressing health inequities. While the Center for Medicare & Medicaid Innovation (CMMI) has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement to our health care system, it should be noted that the narrow focus of these demonstration programs on short-term quality improvement and cost savings forces the exclusion of models to improve payment and delivery of pediatric care, where the timeline for impact is outside of the budget window and the measurable effects spread beyond health care costs to school readiness, educational attainment, workforce participation, and safety net program use.

For example, early developmental screening, including social emotional screening with appropriate follow up and intervention can limit development of expensive adolescent mental health and substance use issues. High rates of immunization among children save substantial dollars each year, and models should continue to promote and support high rates of immunization. Having shared accountability for a population of children and making efforts to coordinate care, to reduce duplication, and to provide timely and effective care for children will lead to a healthier cohort of adults. Consequently, the “value equation” of children’s health care is more complex than that of adults and should be considered as Congress considers how to measure efficacy of a public option.

Moreover, children and pregnant women continue to face significant challenges outside of the health care setting that prevent them from achieving optimal health. For example, one in five US children lives in poverty. This is of deep concern, not only because poverty jeopardizes the ability of families to meet essential needs, but also because poverty creates stress, makes adverse childhood experiences (ACEs) more likely, and can marginalize or exclude children from healthy growth trajectories and readiness to learn before entering kindergarten. The research on social determinants of health, resiliency, ACEs, and toxic stress all make clear
that healthy child development is dependent upon safety, stability, security, and nurturing in the child’s home environment. As Congress explores how a public option could help with broader health care delivery reform, lawmakers should consider how integrated health systems could better address ACEs, resulting in decreased chronic illness burden, including mental health issues, as children reach adulthood.

Thus, a comprehensive understanding of what is unique about pediatrics must be woven into the design of a public option, including the implementation, the goals and measurement of outcomes, as well as the timeframe to expect return on investment or cost-savings. A publicly funded plan should also help develop or support accountable resources in communities such as programs involving social services that meet needs relating to housing and food security, literacy, mental health, trauma-informed care, and others. In short, a public option should support seamless coordination between medical and “non-medical” resources.

**As Systems Reforms Are Considered, Children’s Coverage Must Be Protected**

We applaud lawmakers for considering ways to expand quality coverage to more Americans, improve affordability for families, and lower health care costs, and look forward to working with you to ensure the unique needs of children are considered. However, our organizations would be remiss if we did not state this obvious fact: children’s coverage is particularly susceptible to changes in federal and state policies. As systems reforms are considered, children’s coverage must be protected.

As you consider possible legislation regarding a public option, we urge you to consider how it would interact with Medicaid and CHIP, proven-to-work public safety net programs that are designed for the specific needs of children. Policy designs that would move children who are currently eligible or enrolled in Medicaid and CHIP into a newly created public option, which may not have a comparable benefit package, could weaken existing children’s coverage.

Systems reforms take time. As you consider the next steps related to the formulation and introduction of legislation, our organizations strongly urge you to commit to protecting what is already working for millions of children and their families by keeping Medicaid and CHIP strong. Additionally, Congress could take more immediate steps to improve children’s coverage, such as expanding coverage to more children, increasing resources to improve outreach and enrollment, streamlining eligibility, strengthening enforcement of EPSDT, improving network adequacy, and reducing barriers to access.

In conclusion, our organizations appreciate the opportunity to provide comments on the RFI on design considerations for legislation to develop a public health insurance option. We applaud the authors for their commitment to working to assure the availability of and access to quality affordable coverage regardless of income, age, race, disability, sexual orientation, or zip code, and urge you to prioritize the unique needs of children. We look forward to continuing to work with you to improve the health and well-being of our nation’s children. If you have questions on any of the issues discussed in this letter, please contact Stephanie Glier at sglier@aap.org.
Sincerely,

American Academy of Pediatrics
Children's Defense Fund
Children's Hospital Association
Family Voices
First Focus Campaign for Children
National Association of Pediatric Nurse Practitioners