Quality Health Care for Children and the Affordable Care Act: A Voltage Drop Checklist

abstract

The Affordable Care Act (ACA) introduces enormous policy changes to the health care system with several anticipated benefits and a growing number of unanticipated challenges for child and adolescent health. Because the ACA gives each state and their payers substantial autonomy and discretion on implementation, understanding potential effects will require state-by-state monitoring of policies and their impact on children. The “voltage drop” framework is a useful interpretive guide for assessing the impact of insurance market change on the quality of care received. Using this framework we suggest a state-level checklist to examine ACA statewide implementation, assess its impact on health care delivery, and frame policy correctives to improve child health system performance. Although children’s health care is a small part of US health care spending, child health provides the foundation for adult health and must be protected in ACA implementation. *Pediatrics* 2014;134:794–802

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KEY WORDS

health insurance, Affordable Care Act, health reform, children, child health financing, federal policy, advocacy

ABBREVIATIONS

ACA—Affordable Care Act

CHIP—Children’s Health Insurance Program

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Like all major pieces of legislation, the Affordable Care Act (ACA) is a work in progress. It has many complex provisions and has set in motion a number of potential changes to established delivery systems and existing caregiving relationships. There are many benefits for children, including health insurance availability regardless of preexisting conditions, restrictions on annual or lifetime dollar limits on benefits, essential preventive care services without copays or cost-sharing, extension of coverage to young adults to age 26 on their parents' policies, and expanded insurance for parents. Despite these obvious wins for child health, the creation of health insurance marketplaces (also known as exchanges) is revealing unanticipated, indirect effects on the delivery of health care to children.¹ The ACA gives 50 individual states and their payers considerable autonomy and discretion on implementation. Efforts have been hampered by unanticipated technical difficulties as well as ongoing ideological battles and political wrangling, which have resulted in almost half of states not expanding Medicaid as well as substantial variation in state plans. Even in states pushing the ACA ahead, there are emerging concerns about destabilizing long-standing child health programs with lack of attention to the special needs of children. With no organized evaluation underway, a prioritized national effort involving pediatric clinicians, state and local policy makers, and child advocates is urgently needed to monitor health reform's impact on children and to ensure optimal implementation.

Recent publications have addressed the impact of the ACA on child health.¹⁻³ This article expands on these ideas using an organizing framework and a practical state checklist tool (Table 1). The "voltage drop" framework introduced by Eisenberg and Power⁴ describes the cascade of voltage drops from

insurance to quality of care received (Fig 1), outlining 7 steps: (1) insurance available; (2) insurance enrollment; (3) providers and services covered; (4) informed choice of plans, clinicians, and health care institutions available; (5) consistent source of primary care available; (6) referral services accessible; and (7) delivery of high-quality care. Each of these steps is critical in pursuit of quality care for all children.⁵ Insurance coverage, a main component of the ACA, is necessary but not sufficient to ensure quality health care. This framework and associated checklist examine ACA statewide implementation, assess its impact on health care delivery, and frame policy correctives to both protect and improve the child health system.

STEP 1: INSURANCE AVAILABLE

The ACA increases health insurance coverage for Americans including children and their parents. Although this is a major step forward, there are uncertainties that could jeopardize states from achieving enrollment goals. Perhaps the biggest concern is the future status of the Children's Health Insurance Program (CHIP), which currently covers nearly 8 million children nationwide. Introduced in 1997, CHIP was developed to help "working poor" families whose incomes were too high for Medicaid but too low to afford commercial health insurance. Although state-provided Medicaid for children will continue, CHIP requires reauthorization by October 2015. Although CHIP has been very successful in covering children, some have suggested that it would be advantageous to have children enrolled with their family through the marketplace. However, if CHIP is not reauthorized, it is anticipated that insurance coverage for children will decrease because of inadequate family enrollment and because, in some states, CHIP-enrolled children and their families may not qualify for subsidized marketplace coverage. Although the

ACA should decrease the number of uninsured children by 40% and uninsured parents by almost 50%,^{6,7} it is estimated that the number of uninsured children could more than double if CHIP is not reauthorized, resulting in higher numbers of uninsured children than if the ACA had not been enacted.⁶

In addition, it is estimated that >40 million children may face a complex eligibility scenario that jeopardizes health insurance coverage.⁸ Scenarios include families where a parent has an employer health plan that does not include dependent coverage or a child who doesn't live with 1 or both parents.⁹ Under these and other scenarios, obtaining and maintaining coverage may be challenging and require that qualified health plans offer child-only plan options or that states offer the option of CHIP enrollment.¹⁰

Finally, immigrant children and children of immigrant parents make up a large proportion of uninsured children and require special attention. Although >9 of 10 Latino children are US citizens¹¹ and eligible for public or private insurance, Latino children make up 40% of uninsured children.⁷ Those who are undocumented are prohibited from marketplace coverage. Legal immigrant children who live in states that have not implemented the CHIP option to cover them in the first 5 years of their residency will face additional barriers. Insurance will remain unavailable for some, requiring advocacy for statewide solutions and maintenance of strong safety net systems. The ACA reduces Disproportionate Share Hospital program payments that compensate hospitals for the costs incurred in caring for low-income patients, threatening the financial stability of safety-net hospitals, including many children's hospitals.¹² The ACA provides additional funding to federally qualified health centers, which are part of the safety net and may become a larger part of the health care delivery system.

TABLE 1 ACA Implementation: Child and Adolescent Health Checklist and Potential Solutions

Voltage Drop Step	Potential Solutions
1. Insurance available	
a. What are the eligibility thresholds for children in Medicaid and CHIP and how have they changed?	<ul style="list-style-type: none"> • Encourage Medicaid expansion and CHIP continuation
b. What is the state's plan for CHIP if funding is reauthorized or not reauthorized in 2015?	
c. Is there a child-only plan option for children with complex family coverage situations?	<ul style="list-style-type: none"> • Ensure child-only plan options
d. Did this state implement the CHIP option to cover legal immigrant children?	<ul style="list-style-type: none"> • Ensure coverage for legal immigrant children through CHIP or the health insurance marketplaces
e. What coverage options are available for undocumented children?	<ul style="list-style-type: none"> • Maintain the safety net for the uninsured
2. Enrolled in insurance	
a. Are plans affordable for low-income families?	<ul style="list-style-type: none"> • Consider subsidizing qualified health plans for low-income families • Fix the "family glitch"
b. What are the navigator plans for family-centered outreach and assistance? What funding is available for navigators and assistors after the first year?	<ul style="list-style-type: none"> • Target children and families and ensure clarity of enrollment options • Use lessons learned from successful Medicaid and CHIP outreach efforts to optimize community engagement in reaching families with eligible children
c. How will continuity of coverage be maintained with family income fluctuations that may cause children to go in and out of Medicaid/CHIP eligibility?	<ul style="list-style-type: none"> • Streamline and simplify enrollment, retention, and transfer policies • Allow for 12 months continuous eligibility • Encourage "dually certifying" plans to serve both Medicaid/CHIP and exchange enrollees
d. How will continuity of coverage be maintained when children age out of Medicaid/CHIP?	<ul style="list-style-type: none"> • Streamline and simplify enrollment and transfer policies for young adults in transition
e. Are there waiting periods before enrollment in CHIP?	<ul style="list-style-type: none"> • Eliminate or shorten waiting periods
3. Providers and services covered	
a. What services are included as "habilitative" for children with special health care needs? Do they include therapies such as occupational, physical, and speech therapies?	<ul style="list-style-type: none"> • Subsidize qualified health plans (QHPs) that create packages that cater to children and children with special needs • Ensure coverage of hearing and vision services, mental health, substance use treatment, and occupational, physical, and speech therapy • Use Medicaid, CHIP, and Bright Futures as models for children's benefits • Standardize and align benefits across coverage programs
b. Do pediatric services include coverage of hearing and vision services?	
c. Are mental health and substance use services included?	
d. What is the definition of "medical necessity"?	
e. Is dental coverage provided in exchange plans or are there stand-alone dental plans? What is covered and what are the copays? If stand-alone plans, are families required to buy dental coverage?	<ul style="list-style-type: none"> • Ensure dental coverage and access to pediatric providers • If stand-alone dental plans exist, ensure families cannot opt out of dental and ensure comprehensive affordable coverage with reasonable copays
4. Informed choice available	
a. Are there multiple plan and clinician choices within and outside Medicaid and CHIP?	<ul style="list-style-type: none"> • Ensure choice of plans and clinicians • Encourage clinician participation in multiple plans
b. Are there navigator outreach and enrollment processes specified to address families with limited English proficiency and health literacy?	<ul style="list-style-type: none"> • Ensure multiple modalities for enrollment • Ensure enrollment materials are of appropriate literacy level and in multiple languages
5. Consistent source of primary care available	
a. Are primary care clinicians part of multiple plans including Medicaid, CHIP, and exchange plans?	<ul style="list-style-type: none"> • Encourage providers to participate in multiple plans including Medicaid/CHIP
b. What is the participation rate of primary care clinicians in Medicaid/CHIP?	
6. Referral services accessible	
a. Are appropriate pediatric clinicians and essential community providers (ECPs) included in the provider networks?	<ul style="list-style-type: none"> • Qualified health plans must contract with ECPs including children's hospitals, federally qualified health centers, school-based health centers and others with expertise in children • Use Medicaid and CHIP pediatric provider networks and network adequacy standards • Align provider networks across Medicaid, CHIP, and marketplace plans • Ensure access to regionalized systems of specialty care
b. Is there currently a program for children with special health care needs and will it continue?	

TABLE 1 Continued

Voltage Drop Step	Potential Solutions
7. Delivery of high-quality care a. Are pediatric clinicians reimbursed at appropriate levels in parity to adult clinicians?	<ul style="list-style-type: none"> • Ensure appropriate and equitable reimbursement including continuation of Medicaid parity with Medicare reimbursement
b. Are there mechanisms to protect adolescent and young adult confidentiality including systems to block sending Explanations of Benefits (EOBs) to parents?	<ul style="list-style-type: none"> • Ensure electronic health records and health plans have mechanisms to protect adolescent and young adult confidentiality including blocking of EOBs and other insurance communications regarding “sensitive services”

Data from refs 2 and 9.

STEP 2: ENROLLED IN INSURANCE

Insurance eligibility does not guarantee enrollment. Although state marketplaces have rapidly been designed, informing families of their choices and enrolling them are demanding tasks. Of 6.6 million uninsured American children in 2009, approximately two-thirds were eligible but not enrolled in Medicaid or CHIP and are more likely to be of school age and of Latino ethnicity.^{13–15} Six states, California, Texas, Florida, Georgia, New York, and Arizona, account for half of these eligible uninsured children,¹³ although these states account for ~39% of the total child population.¹⁶ Despite insurance availability through Medicaid/CHIP and the marketplace, some eligible children may remain uninsured because of the following factors: (1) affordability concerns including the “family glitch,” (2) the “chilling effect,” and (3) lack of family enrollment because they are unaware of the need to enroll or choose to pay the penalty (Table 2).

First, although the ACA is supposed to be “affordable,” there is concern about premium costs for low-income families, which vary by state. Based on income, subsidies to health insurance premiums make marketplace plans affordable, but they may be inadequate. Estimates show that families with incomes between 200% and 400% of the federal poverty level could pay as much as 6.3% to 9.5% of their income for premiums in a plan that pays, on average, 70% of the cost of covered benefits.¹⁷ Not only would premiums be prohibitive for some, cost sharing may also cause hardship. Another

concern relates to what is known as the “family glitch.” The ACA stipulates that employers must provide affordable insurance for workers themselves but not for their families. Family members would be ineligible for subsidized coverage in the marketplace if the employee is offered self-only coverage, even if family coverage is unaffordable.¹⁸ Family coverage typically costs 3 to 4.5 times as much as individual coverage.^{19,20} Quick fixes to this glitch and larger subsidies for low-income families are clearly needed.

Second, immigrant children with undocumented parents may remain uninsured because of a “chilling effect,” with parents fearful of enrolling eligible children because of deportation worries. It is possible that online enrollment without face-to-face encounters and use of trained enrollment facilitators could reduce this chilling effect; however, early marketplace data show that Latino enrollment has been lagging.²¹ Studies found that Latinos were more likely than other groups to be unaware of the marketplaces²² and to have low health insurance literacy.²³ In addition, families may be unaware of the requirement for health insurance or may choose to pay the penalty. Finally, enrollment is complicated and navigators and families must understand that child coverage options may be quite different than for parents or other family members. Enrollment monitoring and augmented outreach efforts for targeted populations are critical. Successful Medicaid and CHIP enrollment strategies could be helpful to states.²⁹

Churning, defined as switching in and out of insurance plans because of insurance eligibility changes, is expected to increase. Child coverage options include Medicaid, CHIP, marketplace plans, or employer-based plans. Because coverage options are so closely tied to family income and employment, and because income and employment can fluctuate, especially for low-income families, eligibility for different coverage options is likely to be more fluid for children than for adults. Churning is expected with changes in Medicaid eligibility thresholds and income calculation, fluctuating family income and employment, and aging out. Churning is also more likely for families with incomes at or near the federal poverty level Medicaid floor, with moves to more costly and less comprehensive coverage. Some children may face additional barriers due to waiting periods for CHIP coverage.

A number of strategies can reduce churning-induced coverage gaps, including the following: eliminating or shortening enrollment waiting periods, adopting retention and transfer policies to avert coverage disruptions, and coordinating benefits and provider networks for children across Medicaid, CHIP, and marketplace products.^{2,24} Most state Medicaid and CHIP programs have established 12-month continuous eligibility policies; children in these states are 10 times less likely to experience shifts in their eligibility for coverage.²⁵ Because of the rapid pace of implementation, new state policies and systems are likely to be less than perfect,

FIGURE 1

The cascade of voltage drops from insurance to quality health care. (Reprinted with permission from Eisenberg JM, Power EJ. Transforming insurance coverage into quality health care: voltage drops from potential to delivered quality. *JAMA*. 2000;284:2101.)

requiring both continued monitoring and ongoing refinement and improvement.

STEP 3: PROVIDERS AND SERVICES ARE COVERED

Insurance does not guarantee service coverage. The ACA charges states with defining marketplace essential health benefits in a benchmark plan. Yet, for state marketplaces to be successful they need to enroll adults who would normally forgo the expense of buying health insurance on their own. Therefore, many products are being designed to be relatively inexpensive and attractive to this “young invincible” demographic group. Such marketing goals constrain prod-

ucts to minimally acceptable benefits, limited provider networks, and high deductibles that often resemble catastrophic care plans. This is not the insurance product for a child with special health care needs, yet many families may enroll in such plans unaware of their restrictions and costs. Although the benefits package may appear comprehensive, the associated copayments and deductibles may become catastrophic financial burdens to families already struggling to care for a child with a serious health condition.²⁶ Clear information on coverage and cost, cost calculators, and price transparency tools are necessary and special provisions made for

families caring for children with serious medical disorders.

It remains unclear how the establishment of the marketplaces will affect the future of employer-based coverage. Some employers may see the marketplaces as a cost-reducing alternative and eliminate health benefits, especially family benefits, which are already on the decline.²⁷ Some states may decide that their employees are better served by their marketplace, reducing duplication, minimizing state government exposure, and reducing financial risks. If this occurs, an ever-increasing number of children will enter the marketplace, thereby underscoring the importance of the adequacy of these plans.

TABLE 2 Important Health Reform Terms

Chilling effect: Failure to enroll in insurance because of concerns regarding discovery of legal status and fear of deportation.

Churning: Switching in and out of insurance plans because of insurance eligibility changes.

Essential health benefits: A comprehensive package of items and services required by the ACA of all health plans inside and outside of the health insurance marketplace.

They must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Family glitch: ACA subsidies are not available to families with access to affordable employer-based coverage. Affordable coverage is defined as individual employee coverage cost <9.5% of household income. Family coverage, however, may be unaffordable with no option for subsidies in the state marketplace.

Habilitative services: Defined by the National Association of Insurance Commissioners as “healthcare services that help a person keep, learn or improve skills and functioning for daily living.”²⁹

Maintenance of effort: Requirement that states keep the same eligibility levels for children in Medicaid and CHIP until 2019 or lose federal matching funds for Medicaid until it corrects the violation.

Qualified health plan: A health insurance plan certified by the health insurance marketplace that provides essential health benefits, follows established rules on cost-sharing (deductibles, copayments, and out-of-pocket maximum amounts), and meets other ACA requirements.

Tiered physician and/or hospital networks: Health insurance products that sort clinicians and/or hospitals into tiers on the basis of cost and quality performance.

Participants are incentivized or forced to seek care from “high-value” clinicians and/or hospitals. There may be differential deductibles or copayments for use of different clinicians or hospitals.

Data from ref 37.

The ACA requires that all plans have a comprehensive age-appropriate child benefits package including Bright Futures²⁸ and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits of medically necessary periodic screenings; vision, hearing, and dental services; and treatment. It makes state law the primary source of regulatory policy in defining essential health benefits and habilitative services defined as “health-care services that help a person keep, learn or improve skills and functioning for daily living.”²⁹ In the absence of state standards, insurers are permitted to define habilitative services coverage and to “substitute” greater rehabilitative services for adults in favor of lesser habilitative services for children.²⁹

Reviews of ACA benchmark plans in 5 states compared with their Medicaid/CHIP benefits found inconsistent coverage of some pediatric services.^{26,30} Habilitative services such as occupational or speech therapy or home care had limited or no coverage in benchmark plans. Compared with CHIP, mental health and substance use services were limited; psychological testing and therapy were not covered or had limited coverage.²⁶ Finally, a recent Government Accountability Office report found that family costs for children’s services defined as deductibles, copayments, coinsurance, and premiums were almost always more in benchmark plans than in CHIP plans.³⁰ It is critical to assess the adequacy and costs of state benchmark and marketplace plans and ensure that coverage options meet the needs of vulnerable children. Clinicians are likely to uncover other affordability issues or service deficiencies experienced by their patients. Effective and efficient mechanisms for monitoring these deficiencies are essential to correct these predictable shortcomings. States must adopt a comprehensive standard for pediatric benefits, limit substitution of benefits within benefit categories, and measure access to care and quality.

Finally, although children with Medicaid and CHIP have always had dental coverage, it is now included as an essential health benefit for all children. However, a particular concern is that many marketplace health plans do not offer dental care, thus offering a stand-alone dental plan. Enrollment in stand-alone plans may not be required in some states and may have additional premiums and copays. Efforts to mitigate these barriers must be a priority. In addition, dental provider network adequacy, access to dental care, and provision of quality care must be monitored.

STEP 4: INFORMED CHOICE OF PLANS, CLINICIANS, AND HEALTH CARE INSTITUTIONS

Provider and service coverage does not guarantee patient choice. Choice of plan and clinician are important components of market-driven health delivery systems. For informed choice, enrollment processes must be accessible to families with limited English proficiency and/or health literacy. A recent study found that health insurance literacy levels are low.²³ Another found that, despite reading-level guidelines for Medicaid-related materials in 45 states, 52% of Medicaid renewal applications failed to meet state guidelines.³¹ With rapid change and growing complexity, patient- and family-centered enrollment processes and outcomes must be tracked.

Tiered physician and hospital networks within and outside the ACA have been increasing. The ACA marketplace contains health insurance organized by 4 “metal” tiers of coverage, bronze, silver, gold, and platinum, with different levels of cost-sharing and access to provider networks. Most major commercial payers offer a tiered network product.³² Narrow network plans can create access barriers to care and may force families to access services outside of the network with additional cost-sharing. It is up to state regulators to ensure that insurers offer reasonable networks with

access to pediatric primary care and specialty physicians, facilities, and other providers delivered in a timely fashion and within a reasonable distance. Seattle Children’s Hospital has sued the state of Washington for failure to provide adequate coverage for children in some marketplace plans where the children’s hospital is tiered as out-of-network.³³ Although quality providers and facilities in community settings exist, many children with special health care needs require a children’s hospital and would face large out-of-pocket costs. High-deductible and narrow provider network plans can result in significant financial burdens for families.³⁴ High-deductible plans are common in ACA bronze and silver tiers, the most popular of unsubsidized plans in the Massachusetts Connector, accounting for greater than 90% of enrollment.³⁴

STEP 5: CONSISTENT SOURCE OF PRIMARY CARE AVAILABLE

Coverage and choice do not guarantee the availability of primary care. The presence of a pediatric primary care workforce that participates across public and private insurance is needed to ensure quality and continuity. Churning leads to disruptions in primary care relationships and is expected to be more likely for those near the Medicaid/CHIP income eligibility level. A recent report found that <3 of 10 surveyed pediatricians fully participate in Medicaid.³⁵ If a family has employer-based insurance and the insured member loses his or her job, the child may become eligible for Medicaid/CHIP. However, if the family’s provider does not participate in Medicaid/CHIP, they will have to find another clinician. Adequate primary care provider participation and availability are critical for continuity of care.

STEP 6: REFERRAL SERVICES ACCESSIBLE

Access to both primary and specialty care is crucial for children. Federal

guidance requires that health plans ensure sufficient numbers and variety of clinicians, yet these guidelines also give states great latitude to choose “essential community providers.” For children, essential community providers include the timely access to pediatric subspecialists, pediatric surgeons, pediatric mental and dental professionals, and hospitals with appropriate pediatric expertise and capability. CHIP-generated standards should be used to determine provider network adequacy and Medicaid, CHIP, and EPSDT-qualified providers must be part of marketplace plans.

To ensure high-quality pediatric care, great efforts have been expended over many years to establish regionalized care networks for high-risk newborns and children with serious disorders such as cystic fibrosis, sickle cell disease, cerebral palsy, autism, and trauma. Because the vast majority of health care costs are generated by older adults, most new payment and delivery models, including many accountable care organizations, are being developed to meet the needs of adult health care systems with little consideration for long-standing pediatric systems. Adult systems are far less dependent on regionalized systems because there are larger numbers of adult patients with common chronic health conditions. Children with chronic health conditions necessitate specialized regionalized systems for optimal care delivery. If pediatric regionalized systems and their purposefully designed access to pediatric specialty care are not maintained, the quality of child health care could suffer considerably. Pediatric-specific standards must be developed and monitored to ensure that provider networks offer children timely access to needed services. These child-specific performance measures should include provider-to-patient ratios for pediatric primary and specialty care, rural/urban geographic accessibility standards, waiting time, hours of operation, hospital

access, and location of medically underserved populations relative to providers.³⁶ Finally, provider networks must include clinicians and practices that are linguistically and culturally appropriate.

STEP 7: DELIVERY OF HIGH-QUALITY HEALTH CARE SERVICES

Care accessibility does not guarantee that high-quality care will be provided. This is dependent on an adequate workforce of child health clinicians, appropriate reimbursement, and quality measurement and improvement systems designed to address the special requirements of children's health care needs. Payment rates that ensure a vibrant delivery system in which children receive all recommended services are essential. Until this past year, Medicaid/CHIP physician payment rates had been, on average, 72% of Medicare rates and 64% of average private fees; low physician payment is the most significant barrier to Medicaid participation.¹⁹ The ACA requires that Medicaid reimbursement be on par with the Medicare rate for 2013 and 2014. This mandate is set to expire December 31, 2014. Ensuring continued rate parity is a critical advocacy goal.

High-quality care for adolescents and young adults requires protection of confidentiality. The ACA allows young adults to remain on their parents' health plan until they turn 26 years of age. However, problems may arise when many health insurers and electronic medical record systems are unable to block sending or sharing confidential information with the primary insured parent. Lack of confidentiality for “sensitive services” is a known barrier to care for adolescents and young adults. States must ensure that information-sharing processes are aligned with state confidentiality laws.

CONCLUSIONS

As states implement the ACA, there is an urgent need to ensure respect for the

special requirements of delivering health care to children. By using the voltage drop framework to understand the complex policy changes in a highly dynamic environment, we have outlined areas of opportunity and concern for children's health care delivery, which require careful assessment and monitoring of services and outcomes. There are multiple stakeholders in this effort, including individual clinicians and practices, professional child health organizations, federal and state Medicaid and maternal and child health offices, child advocacy organizations, policy makers, and others. Each has a different perspective and role in detecting problems and identifying solutions. Yet, there remains no coherent mechanism for integrating these various roles or assessing service provision or outcomes. There is an urgent need for a dedicated structure responsible for ensuring that current reform efforts improve and not threaten child health. This responsibility could be based in extant agencies, particularly those with a long-standing experience working closely with state initiatives, such as the Maternal and Child Health Bureau in the Health Resources and Services Administration, for example. Activities must include the following:

1. Using the proposed checklist in each state to ensure that all steps, from insurance to quality of received care, are adequately addressed in state benchmark and marketplace plans. If not, these are critical state indicators for monitoring and correction.
2. Developing effective methodologies and data sets that can shed light on the experience of children and their systems of care as the ACA is implemented and refined.
3. Monitoring and evaluating child enrollment, service utilization, quality of care, and health outcomes with real-time feedback to policy makers.

4. Learning from CHIP and other state models for implementation innovations and best practices.
5. Implementing best practices including solutions that address the outlined voltage drops to ensure

high-quality health care for children and adolescents for years to come.

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MOVE OVER “ORGANIC” —“GRASS-FED” DAIRY PRODUCTS HAVE ARRIVED: *While I tend not to drink much milk, the rest of my family does. We stock our refrigerator with gallons of skim milk for regular consumption, a quart of whole milk for my wife's coffee, and pints of cream for cooking. I love yogurt, so the refrigerator is also usually stuffed with many varieties. Recently, I purchased a small container of plain yogurt marked “grass-fed” for a blind tasting competition.*

Unlike the term “organic,” there is no federal regulation of the term “grass-fed” for dairy products. Milk designated as organic comes from cows pasture-grazed for at least 120 days of the year, while “grass-fed” implies that the dairy product is organic and that the animals only ate grass (with no other additives such as corn) for the entire year. Interestingly, most tasters, including me, remarked that the yogurt tasted fresh – almost herbal – and much different than popular national brands.

According to The Wall Street Journal (Life & Style: July 29, 2014), dairy products made from the milk of exclusively grass-fed cows are increasingly popular. While pricey (often one-and-a-half times as expensive as organic milk, and twice as expensive as regular milk), many consumers believe the milk is more nutritious than other varieties and worth the expense. Although milk made from grass-fed cows represents only a tiny portion of the milk consumed in the United States, the fact that consumers are willing to spend more for products with a perceived – although not proven – health benefit has caught the attention of the food industry. More producers are exploring niche markets, and even those not interested in the organic or grass-fed designation recognize that many consumers want fewer artificial ingredients in their foods.

As for me, I have not yet jumped on the grass-fed whole milk bandwagon, but I must admit that grass-fed yogurt is marvelous. I periodically buy a small container and revel in the fresh taste.

Noted by WVR, MD