

American Academy of Pediatrics (AAP) Medicaid and SCHIP Update June 30, 2005

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New and Noteworthy

1. Study Highlights Medicaid and SCHIP Design Differences
2. Policy Brief Examines Links Between National Security and Medicaid and EPSDT
3. Report Provides Overview of Spending on “Mandatory” and “Optional” Populations
4. Two New Reports Look at Effect of Increasing Medicaid Cost-Sharing
5. Urban Institute Releases Third Year SCHIP Evaluation Report
6. Study: Medicaid “Churning” Costs California

From the Federal Government

7. HHS Approves Second Multi-State Medicaid Drug Purchasing Pool

New and Noteworthy

1. Study Highlights Medicaid and SCHIP Design Differences

A paper published in the March 2005 issue of *The Journal of Health and Biomedical Law* provides a critically important look at the design differences between Medicaid and the State Children’s Health Insurance Program (SCHIP). The paper highlights the implications such differences have as the issue of restructuring Medicaid is debated at the federal level. The study’s principle finding is that when states are given the flexibility to do so, they tend to reduce the level of coverage in SCHIP to that found in standard health insurance products. This is contrasted with the comprehensive level of coverage and the specific child protections that have been the hallmark of the Medicaid program since the enactment of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The study finds that Medicaid and SCHIP benefits differ significantly – Medicaid serves its role as a legal entitlement to a broad array of services to meet children’s health needs, while SCHIP provides “benchmark” coverage without such an entitlement. The study also finds differences in the definitions of “medical necessity” used between the programs, as well as differences in contractual obligations for managed care plans. Specifically using early childhood development services as the frame for contract analysis, the study finds wide variation among separately-administered SCHIP programs in their use of coverage standards for such services, while these services would be required under Medicaid. The implications of these differences are discussed in light of current discussions over restructuring Medicaid. “Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP” can be found online at:

http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/Public_Health_Insurance_Design_for_Children.pdf

An executive summary can be found at:

http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/GW_Suffolk_2_7_2005.pdf

2. Policy Brief Examines Links Between National Security and Medicaid and EPSDT

An April 2005 policy brief of the George Washington University School of Public Health and Health Services examines the links between national security and Medicaid and EPSDT. The brief highlights the role that poor health status of military recruits played in the expansion of Medicaid with EPSDT in the 1960s. The EPSDT program today ensures coverage for all medically necessary diagnostic and treatment services that fall within the federal definition of “medical assistance” for virtually all Medicaid-enrolled children, with limited exceptions. The report traces the history of EPSDT coverage back to the health inadequacies discovered by President John F. Kennedy’s Task Force on Manpower Conservation. This Task Force investigated why, in 1962, 49.8% of Selective Service draftees failed peacetime medical

and/or mental aptitude exams, disqualifying them for military service. The Task Force found that this failure rate reflected the “unfinished business of the Nation.” Most of the Task Force’s recommendations focused on the development of programs for young adults rejected from the military draft. However, the Task Force also made recommendations regarding improvements in screening, diagnosis, and treatment of disease and conditions in early childhood and adolescence. This work, coupled with subsequent studies on the health status of infants and children, formed the contextual basis for President Johnson’s 1967 child health recommendations to Congress, later resulting in EPSDT. The report notes the need identified for providing broad developmental health benefits, and how this need carries into today, especially as national security remains a paramount concern. “National Security and US Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT” can be found online at:

http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/mil_prep042605.pdf

3. Report Provides Overview of Spending on “Mandatory” and “Optional” Populations and Services

A June 2005 Kaiser Commission on Medicaid and the Uninsured (KCMU) report studies Medicaid spending on “mandatory” and “optional” populations and services. States are required to provide a set of “mandatory” services, but can also choose to provide a set of additional “optional” services. “Optional” does not relate to the importance of the service, but rather whether or not the service simply must be covered by federal law. Moreover, Medicaid must cover “mandatory” populations, but can also expand coverage to additional “optional” populations. If a state extends Medicaid coverage to an “optional” population, it must generally offer the same benefit package that it offers its “mandatory” populations. The report provides important information as to where Medicaid funds are spent within these categories. The report shows that 21% of children enrolled in Medicaid in 2001 had “optional” eligibility. Overall, children comprised 36% of all “optional” enrollees in 2001, but only 8% of total expenditures for “optional” enrollees. Children were 17% of total Medicaid spending that year – 80% of this spending was considered “mandatory,” while only 20% was considered “optional.” The complete report can be found online at:

<http://www.kff.org/medicaid/kcmu060705pkg.cfm>

4. Two New Reports Look at Effect of Increasing Medicaid Cost-Sharing

Two new reports, one from the Center on Budget and Policy Priorities (CBPP) and one from the Kaiser Commission on Medicaid and the Uninsured (KCMU), look at the negative effects increased cost sharing in Medicaid has on enrollees. The CBPP paper cites a number of reports, including one that shows that increased copayments for prescription drugs in Quebec led to a 78% increase in adverse events and an 88% increase in emergency department visits. The paper also cites the RAND Health Insurance Experiment (HIE), which found that copayments led to a 44% reduction in episodes of effective care for low-income children. The CBPP paper cites a number of other reports on premiums, one of which indicates that those premiums set at as low as 1% of a family’s income were estimated to lead to a 15% reduction in enrollment. “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings” can be found online at:

<http://www.cbpp.org/5-31-05health2.htm>

The KCMU report specifically looks at 13 studies conducted between 2001 and 2005 in seven states where cost sharing has been implemented or increased. The report corroborates existing evidence on cost sharing, finding that premiums and cost sharing have a significant and immediate impact on low-income individuals coverage and access to care. These new reports show that premiums: serve as a barrier to obtaining or maintaining public coverage; disproportionately impact those with the lowest incomes but also led to disenrollment among those with incomes above 150% of the federal poverty level (FPL); and lead to many enrollees becoming uninsured. Similarly, these new studies uphold previous reports on cost sharing, finding that cost sharing results in unmet medical need and financial stress, even when amounts were considered “modest.” “Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences” can be found online at:

<http://www.kff.org/medicaid/7322.cfm>

5. Urban Institute Releases Third Year SCHIP Evaluation Report

As part of its *Assessing the New Federalism* multiyear SCHIP evaluation, the Urban Institute has released its third yearly SCHIP evaluation report. The authors follow 13 states, conducting in-depth interviews with SCHIP directors in these states. This year's report examines steps taken by SCHIP programs in 2004, and finds mixed results for the programs. Positively, a number of the 13 states took steps to reverse previous cuts; however, some states also kept prior cuts in place, and some imposed new cuts. However, overall, there were fewer cuts to SCHIP in 2004 in these states than in 2003. The study finds that all three study states that capped SCHIP enrollment in 2003 lifted these caps in 2004. Two states made enrollment processes more restrictive, while these same states also made other enrollment procedures less difficult, resulting in a "trade-off." Four other states also took actions to liberalize enrollment and renewal procedures in 2004. Only one state reduced outreach, but this is likely due to the fact that most other states have already reduced outreach to a point where there is little left to cut. SCHIP benefits largely remained unchanged in these states in 2004, as did provider reimbursement. Only two states increased cost sharing in 2004, while only one enacted a change to discourage "crowd out." The authors conclude that SCHIP is in a "holding pattern of sorts," as gains and losses have been recorded over the last three years, while many states spend 100% of their SCHIP allotments and at the same time \$1.3 billion is reverred to the federal treasury. "Ebbing and Flowing: Some Gains, Some Losses as SCHIP Responds to Third Year of Budget Pressure" can be found online at:

<http://www.urban.org/url.cfm?ID=311166>

6. Study: Medicaid "Churning" Costs California

"Churning," or the disenrollment and subsequent reenrollment of children into a Medicaid or SCHIP program, is of concern, as it not only disrupts continuity of care but also exacts administrative costs of the states where enrollment is disrupted. An April 2005 study of the California Endowment examines what churning costs the Medi-Cal (Medicaid) program in California. The study selects a group of children covered by Medi-Cal in December 2003 and examines the length of coverage and breaks in coverage over the preceding three years. The study finds that a significant percentage of children – 49% - were enrolled for three consecutive years in Medi-Cal. Approximately 18% were enrolled for less than 1 year, and the remaining approximate 1/3 were enrolled between 1-3 years. The study also finds that, of those children enrolled in Medicaid managed care in California, most are enrolled in the *program itself* longer than the managed care plan, as enrollment in the plan generally takes longer than enrollment in the program. Nonetheless, the study finds that 18% of children in Medi-Cal over the three years studied "churned" on and off the program at least once – meaning over 600,000 children lost and subsequently gained coverage. Of these, 88% had only one break in coverage, and approximately 60% of all children who lost and regained coverage were re-enrolled within four months. The study estimates that it cost the state \$120 million to re-process the 18% of children who "churned" over this timeframe. "How Much Does Churning in Medi-Cal Cost?" can be found online at:

http://www.calendow.org/reference/publications/pdf/access/TCE0422-2005_How_Much_Does_.pdf

From the Federal Government

7. HHS Approves Second Multi-State Medicaid Drug Purchasing Pool

On May 27, 2005, the US Department of Health and Human Services (HHS) announced the approval of a multi-state drug purchasing pool for the Medicaid programs of Louisiana, Maryland, and West Virginia. This is the second multi-state purchasing pool approved by HHS – the first was approved in April 2004 for five states (MI, VT, NH, AK, NV), which three additional states (HI, MN, and MT) later joined. The

three states in the newly announced drug pool will each maintain its own preferred drug list and exercise clinical oversight to assure access to needed medication for beneficiaries. These three states have signed agreements with a private company to negotiate lower prices on their behalf with manufacturers. In September 2004, the Centers for Medicare and Medicaid Services (CMS) issued a Dear State Medicaid Directors letter providing guidance on how states can implement multi-state drug purchasing arrangements. This letter can be found online at:

<http://www.cms.hhs.gov/states/letters/smd090904.pdf>

SUBSCRIPTION INFORMATION

To unsubscribe to the update, send a message to listserv@listserv.aap.org with the following command in the body of the e-mail message (with no subject heading):

UNSUB schip emailname@emailaddress
an example: UNSUB schip joesmith@email.com

If you wish to change the address at which you receive the updates, you must send an UNSUB command for the old address (as described above) and then send a SUB command, also to listserv@listserv.aap.org, to subscribe from your new e-mail address. When using an SUB command, you must include an identifying name. An example:

SUB schip Joe Smith

To subscribe to the update, also use the above SUB commands.

ABBREVIATIONS and ACRONYMS

AAP - American Academy of Pediatrics
CBPP – Center on Budget and Policy Priorities
CMS – Centers for Medicare and Medicaid Services
EPSDT – Early and Periodic Screening, Diagnosis and Treatment
FPL – federal poverty level
HHS – Health and Human Services, US Department of
HIE – Health Insurance Experiment
KCMU – Kaiser Commission on Medicaid and the Uninsured
SCHIP - State Children's Health Insurance Program

The Division of State Government Affairs sends the Medicaid and SCHIP e-mail update to the Academy's Executive Committee, Board of Directors, District Vice-Chairs, Chapter Presidents, Committee on State Government Affairs, Committee on Federal Government Affairs, Chapter Executive Directors, other interested AAP members and staff, and other subscribers. Send comments or questions to SCHIP@aap.org or contact Dan Walter at the American Academy of Pediatrics at (800) 433-9016 ext 4086.

Previous updates are available on the AAP Web site at:

<http://www.aap.org/advocacy/schiprep.htm>

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